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STRATEGIES OF PUBLIC HEALTH DENTISTS FOR SMOKING CESSATION IN PATIENTS

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Abstract: Health professionals, such as dentists, have credibility to influence the population they assist. Professionals who work with patients who use tobacco products can help them quit and reduce family smoking exposure. The aim of this study was to investigate the strategies used by dentists in Primary and Secondary Care for the cessation of tobacco use and derivatives in their patients and to evaluate differences in approaches for men and women. An exploratory descriptive cross-sectional study was carried out. The sample consisted of 16 dentists from the Public Network (8 from Primary Care and 8 from Secondary Care), chosen by lot (total of 44). Data collection was through the application of a questionnaire and open interview, addressing demographic and professional data, practices with users of tobacco products. The interviews were analyzed using Discourse Analysis using the Theory of Planned Behavior. It was observed that the dentists approached, identified the users, advised, but did not assist and follow them. Differences in approaches between genders were minimal. This study provided relevant information, its expansion may result in subsidies for the development of government strategies directed to this class.
Keywords: Cessation, tobacco exposure, discourse analysis, dentistry.

INTRODUCTION

Smoking is responsible for millions of deaths (annual) around the world, and this is predictable. The association of tobacco use and its derivatives with a series of diseases such as different types of cancer arising from the respiratory, gastric, urinary and reproductive systems, in addition to diseases such as coronary disease, arterial hypertension, stroke, obstructive pulmonary disease is undeniable. (COPD) such as bronchitis and emphysema, ulcers, diabetes, infertility, low birth weight babies, osteoporosis, ear infections (DESALU et al., 2009; LOMBARDI et al., 2011; WHO, 2011; OLIVETTI, 2014).

In Dentistry, smoking is related to a risk factor for oral cancer, greater severity/incidence of periodontal disease, lower insertion gain after periodontal therapy, difficulties in repairing bone grafts, inadequate blood filling of post-extrusion dental alveoli (OLIVEIRA, et al., 2015)

Concerns related to smoking are not restricted to users. It is estimated that passive smoking, defined as the inhalation of smoke from burning tobacco products by non-smokers or that involuntary exposure to cigarette smoke, or living with smokers indoors, was considered the third cause of preventable death in the world, causing 600,000 deaths of individuals exposed to smoke (SALMÓRIA, OLIVEIRA, 2006; REICHERT, 2008; MS, 2011-a; PASSOS, GIATTI, BARRETO, 2011; LADEN et al., 2013).

A study by Sigaud, Castanheira, Costa (2016) investigating the association of passive smoking in preschoolers and respiratory morbidity and hospitalizations for respiratory causes concluded that the prevalence was low (15.3%); however, the bivariate analysis correlated passive smoking with occurrence of rapid breathing, treated otitis and subdiaphragmatic retraction in the last three months.

According to the literature, in Brazil a large part of the population uses tobacco, mostly in urban areas. Smoking parents who expose their children to smoke can increase respiratory infections by up to three times. In children there is a greater concern, because they are in body development, especially the respiratory system, which is more sensitive to this exposure, and consequently have some respiratory disorder (SALMÓRIA, OLIVEIRA, 2006; LADEN et al., 2013)

A survey carried out with 217 children, aged between seven and ten years, with a smoking and non-smoking family nucleus, showed that

when comparing the groups, 48.85% of the children had a history of smoking in the family (passive exposure to smoke) and consequently, a higher prevalence of symptoms and respiratory diseases such as rhinitis, wheezing, dyspnea, coryza, asthma, pneumonia, acute bronchitis, with significant differences for coryza and rhinitis (ARAÚJO, SILVA, VABOS, 2006), in addition to the possibility of the syndrome of sudden childhood death, and middle ear infection.

Although there are controversies regarding the influence of the smoking behavior of the parents being low in the influence of the smoking behavior of the children, this credit being given more to peers, it is mentioned that the parents are examples to the children, still limiting the norms against the use of tobacco and its derivatives (legislation, prevention in the school environment, rules at home), promote in children a coercive social environment to smoking behavior, facilitating their access to tobacco ((VITÓRIA, RODRIGUES, VRIES, 2015))

In Brazil, in 1989, tobacco control became a government policy, with the launch of the National Tobacco Control Program (PNCT) by the Ministry of Health, handing over its execution to the National Cancer Institute José Alencar Gomes da Silva (INCA), who was responsible for planning and coordinating the program's actions and disseminating information about the use of tobacco products and the consequences for the population (MS, 2011-a). In 1990, Law Number: 8080 provides for the promotion, protection and recovery of health, as well as health care, in addition to the organization and financing of the respective services (INCA, 2016). This program articulates the Smoking Treatment Network in the SUS (Unified Health System), "(cessation, the Health Program [prevention], campaigns and other educational actions and the Promotion of Free Environments [smoking exposure])".

On June 16, 2003, Brazil joined the Framework Convention on Tobacco Control (FCTC), adopted by the member countries of the World Health Organization (WHO) (INCA, 2016). The FCTC proposed actions aimed at reducing the prevalence of consumption and exposure to tobacco smoke, to be implemented at regional, national and international levels (INCA, 2011; INCA 2016). These measures also include modification of the cigarette tax and price policy, restriction of advertising, in addition to the sponsorship of tobacco products, treatment of nicotine dependents, combating the illicit cigarette trade, and creation of legislation to prevent tobacco exposure. (MS, 2011-b).

In 2013, Ordinance Number: 571/GM/MS updated care for smokers within the System's Health Care Network for People with Chronic Diseases (INCA, 2016). Considering the relevance of tobacco control policy in the decline of chronic non-communicable diseases in Brazil, Ordinance Number: 761 of June 21, 2016 published the Clinical Protocol and Therapeutic Guidelines for Nicotine Dependence (INCA 2016). This approach is based on evidence and consists of combining a cognitive-behavioral strategy with pharmacological support, which is done by means of an intradermal patch or chewing gum or lozenge, and Bupropion Hydrochloride (first-line drugs) for smokers (INCA, 2016).

The cognitive-behavioral approach must be offered to every user who is interested in ceasing the use of tobacco products and who comes to be treated in a Health Unit that provides services to the SUS (Unified Health System). It is carried out in periodic sessions, preferably with support groups or individually (INCA 2016).

If the intervention for the cessation of the use of tobacco and its derivatives is essential for the medium-term reduction of mortality related to

smoking (WHO, 1999), the participation of all health professionals as well as the community in general is essential for these actions, as they are references of behavior, in addition to having influence in the community they attend.

Fabrício (2015) carried out a study evaluating 136 health professionals from Primary Care and the hospital area in the municipality of Dois Córregos with 31 community health agents, 03 social workers, 06 dental assistants, 12 nursing assistants, 02 biomedical professionals, 07 dentists, 16 nurses, 05 pharmacists, 02 speech therapists, 09 doctors, 02 nutritionists, 03 psychologists and 38 nursing technicians, through structured and self-administered questionnaires. The results showed that 67% of the participants were non-smokers, 20.5% were former smokers and 12.5% were still smokers.

It concluded that there were failures in the performance of the health professionals studied in the guidance for the cessation of the use of tobacco products, failures in knowledge and the absence of structured actions to approach users, guiding them regarding the harmful effects of tobacco and the termination benefits (FABRICIO, 2015).

Health professionals have credibility, in addition to maintaining frequent contact with their patients, playing an important role in educating them about the health risks resulting from tobacco use. He must be qualified and motivated to act and indicate cessation interventions, as most users want to stop using these products, and through brief clinical interventions, the professional has the opportunity to motivate and help his patients to stop the habit (FIORE et al, 2008).

A study comparing the cessation of the use of tobacco products (2010-2011) after advice given by dentists and physicians, concluded that adult smokers were more receptive to medical advice (64.8%) than to guidance from dentists in dental appointments (31.2%). Of the patients guided by doctors, about 52.7% received assistance, in addition to the simple advice for cessation, while from dentists assistance was 24.5%. They cited that 9.4 million tobacco users who visited a dental office in the period 2010-2011 did not receive any counseling for cessation, emphasizing the importance of intensifying the involvement of this health professional for counseling on cessation, changes in the level of Health System and, an undergraduate training that will prepare the dental surgeon for these objectives, in order to increase their self-efficacy for the involvement with their tobacco user patient for cessation (AGAKU, AYO-YUSUF, VARDAVAS, 2014).

Thus, it is considered that the dental surgeon, in contact with his patient and family, is in a privileged position to act in tobacco control in terms of cessation, prevention and reduction of tobacco exposure.

According to Fabrício, 2015, the topic of smoking is current and extremely relevant for health care, despite this, there is a shortage of Brazilian studies addressing the knowledge of professionals in the area of primary health care, regarding the cessation of product use program. tobacco derivatives. Primary and Secondary Care professionals are key elements in guiding the prevention and cessation of tobacco use and its derivatives in the Public Network, having the credibility of the population (TANNY, GODOI, GODOI, 2009).

According to Satcher (year) health professionals, health plans, and medical schools must treat tobacco dependence as a priority. In order to be successful, the user must be identified and the appropriate intervention carried out. The five steps for this intervention are: ask (identify), Advise, Access (evaluate), Assist and Accompany (5 AS`s- ask, advise, assess, assist, arrange).

In this context, this study aimed to investigate and describe the strategies used by primary and secondary care dentists in Brazil to stop the use of tobacco and derivatives in

their patients and to assess whether there were differences in approach between men and women.

METHOD

Cross-sectional, descriptive and exploratory study, with a qualitative approach, conducted with 16 dentists belonging to 'Primary Care (N=8) and Secondary Care of the Public Network (N=8) of a municipality in the south of the state of Paraná - Brazil, carried out from September to October 2017.

After approval of the study by the Permanent Committee on Ethics in Research Involving Human Beings of the Pontifical Catholic University of Paraná (Opinion Number: Data collection was carried out through individual oral interviews, scheduled by telephone, in the Basic Health Unit room where the professionals worked. The participant, after accepting to participate in the study and signing the Term of Free and Informed Consent, answered a self-administered questionnaire and a qualitative interview. The questionnaire had 12 objective and subjective questions, addressing demographic data, professionals, practices with users of tobacco products and smoking history. The interview script consisted of 11 open questions (adapted from Fabricio, 2015), addressing the strategies used by dentists in order to promote cessation in their patients, users of tobacco products.

A database was created in Microsoft Excel for the inclusion of responses. The oral interviews were recorded, transcribed and analyzed (by two previously calibrated researchers). The individual categorization and coding of each transcribed interview was carried out, a final codified categorization was discussed and formulated for later analysis.

The qualitative analysis was based on the Theory of Planned Behavior (TPB). This theory, by Icek Ajzen, as a theoretical-methodological framework, is useful for research in science teaching that involves measuring attitudes. According to TCP, attitudes, added to aspects related to perceived social pressure, available infrastructure and individuals' ability, are predictors of behavioral intentions in relation to a specific behavior.

TCP questions include the attitude of dentists, subjective norms, perceived behavioral control and behavioral intention to provide dental services, all items in the intention scale will be formulated in a general way about the intention to provide "Dental Services" (HIPÓLITO Jr., 2015).

RESULTS

PART I - QUESTIONNAIRE

Of the 16 participants (9 men and 7 women), the mean age was 42.6 years, with a range of 30 to 58 years, time working in Dentistry from 7 to 34 years, with 8 working in Primary Care and 8 in Secondary Care. Only one of the participants did not have a specialty in the dental area, 5 of these had two specialties, described in the Table.

Regarding work with patients who use tobacco or derivatives, 8 (50%) mentioned not working. About 7 (45%) mentioned not having received training for counseling cessation, however 12 (75%) performed this function individually (8 always, 5 sometimes and 3 never).

PART II- INTERVIEW

Role of the dental surgeon in relation to the patient who uses tobacco and derivatives:

In the analysis of the 16 interviews about the role, attitudes that the dentist must have towards patients who use tobacco or derivatives, 5 professionals spontaneously reported identifying (anamnesis, observation of clinical signs)**, to approach and guide** (3 of the 1st Care and 2 of the 2nd Care), users of tobacco and derivatives.

"First, I ask if the individual smokes, then,

if necessary, I show the condition of the teeth and gums with a mirror (presence of stains, calculus, inflammation, etc.) and relate the oral problem to smoking..." (1st).

Three professionals answered that they do not consider the role of the dental surgeon the steps of monitoring and assisting, as in the sentence: "I think it is the role of alerting, informing about diseases, the harmful effects of tobacco use, other things I think it is a little more difficult, we offer treatment I don't think so this is our case, but treating the lesions... is more of an alert and really informative" (2nd).

APPROACH STRATEGIES:

Afterwards, the participants were asked, according to the INCA guidelines (Ask, Advise, Evaluate, Accompany and Assist), about which approach strategies they used with the objective of cessation. Among these, 14 (8 from the 1st Care and 6 from the 2nd Care) responded that they provided guidance regarding the harm and consequences for oral and general health, described in Table2.

One of them mentioned: "The CD has the role of alerting the patient, as well as all health professionals, since the smoker is considered a sick individual".

Example: "Leave it to the person, so that they can bring up the subject, we wait for an opportunity" (to make a comment about smoking)

Regarding watching, the expression did not appear in speech spontaneously.

APPROACH STRATEGIES WHEN THE PATIENT DOES NOT WANT TO CEASE:

In relation to patients who refuse to stop with the addiction, some mentioned that they advise about the harm:

"You have an injury, it could turn into cancer, let's rethink this habit of yours?" Another mentioned not interfering:

"The final decision has to be made by the patient, I cannot interfere, we cannot impose anything" (one of the 2nd Care).

DIFFERENCES IN APPROACHES REGARDING GENDER/AGE

Participants were asked if there were differences in approaches regarding gender or age with the goal of cessation, reported in Table 3.

There was diversity regarding the approach of few dentists in relation to gender. These om women were more delicate, they addressed aesthetics as motivation, the risks with passive smoking children, while with men they used harsher words, as in the examples:

"With women we try to be more delicate, try to take a calmer approach. With a man, we can even talk like that with even harsher words, talking about cancer and all that stuff.".

Or

"Look at your children, you have children and they are passive smokers, and then you are harming your family. So sometimes I think I can convince this argument."

Other professionals also mentioned using different approaches considering age, reporting that the guidance must be more incisive for younger people, emphasizing the different tobacco products:

"They often don't believe they are addicted, because they usually use less, or use ways that they consider to be less harmful, in this case hookah or something else, so we have to try to approach them in other ways to try to convince them."

and

"But you so young, you are already smoking, but why did you start? Nowadays there is so much talk about having a healthy life, fitness, this is the age of the gym, having a beautiful body, and if you smoke, it harms so much. Even gaining muscle mass, you can see that smokers are generally skinny, they cannot gain weight."

Strategies and Approaches	Primary Care	Secondary Care
The person identifies, evaluates and advises	0	2
The person advises and treats the pathologies present	1	0
The person Identifies, advises, accompanies the consultation (active) Identifies, and	2	0
shows the consequences (active)	1	0
The person identifies, advises and refers (active)	1	0
The person waits for the opportunity (reports fatal experience) (passive)	0	1
The person asks and advises	1	2
The person advises	2	0
The person does not approach	0	1
The person talks about the harm to health	1	1
The person approaches as a "joke"	0	1
Approaches only when there are signs of smoking	0	1
The person informs, writes down the name of who wants to stop and forward (passive)	1	0
Use of posters (community)		
The person identifies and intervenes according to the motivational phase	1	0
	3	0

* Some participants answered more than one approach option

Table 2 – Strategies for approaching patients who use tobacco or derivatives

Differences in Approach	Primary Care	Secondary Care
It makes a difference in terms of gender	2	2
It makes no difference regarding gender	4	2
It makes no difference in relation to gender/age	3	3
It makes a difference in relation to age	5	2
It makes no difference with age	3	3
For fathers/mothers –(impact) children who are passive smokers	2	0
Patients with health problems	1	0
Closer and receptive people	0	1

* Some CDs responded to more than one response

Table 3 – Differences in approaches

Knowledge Acquisition	Primary Care	Secondary Care
Psychological preparation	0	1
Counseling	1	3
To evaluate	0	1
To follow	1	0
To watch	1	0
The person was never interested	0	1
Clinical sequelae of tobacco	0	1

Table 4 – Interest in acquiring knowledge

One participant also approached the closest and most receptive people with the experience of her father who had a stroke and had been involved with smoking since adolescence. Another mentioned that he addressed patients who during the anamnesis reported having a health problem related to tobacco.

CESSATION KNOWLEDGE/SKILLS:

It was observed that the majority of those surveyed mentioned knowing the harm caused by the use of tobacco and derivatives and its consequences for health, especially oral health. Others cited skills acquired through experience, years in the profession and also reading.

"We are trained more for oral consequences, so we warn about possible diseases, possible problems that this patient may have" (one of the 2nd Care)

Another considered the need to be intimate to intervene:

"I think it's a matter of establishing a bond with the patient, so that he trusts you more, I think there's a little bit left" (One of the 1st Care)

INTEREST IN ACQUIRING KNOWLEDGE ON THE SUBJECT:

The manifests of intention in the acquisition of knowledge are described in Table 4.

PATIENT FOLLOW-UP:

4 participants (two from the 1st Care and two from the 2nd) mentioned that sometimes, irregularly in the re-consultation, passively, only questioning:

"We ask what's up? How are you, are you still in the habit?" (1st)

BARRIERS ENCOUNTERED

With the aim of informing the development of cessation programs for patients who use tobacco and derivatives, the most frequent barriers observed by the dental surgeon (Table5) and at the patient level (Table6) were questioned.

The belief regarding 'the difficulty in losing the addiction was shared by 4 participants (one from the 1st Care and three from the 2nd Care), as in this sentence:

"The patient who smokes is generally aware of the risks that tobacco causes. And he is also aware that to stop it depends on him and it is complicated. So usually what we say goes in one ear and out the other"

Or

"I come across resistance from the patient who often replies that he came to the office to perform a scraping, cleaning and not to listen to advice, nor to be convinced to stop smoking. I'm not going to stop smoking, it's no use for you to say it, I'm not going to stop.

The patient's speech, according to the CD:

"I can't let go, it's like it's a preconceived idea and it's hard. 'Sometimes oral problems alone are not important enough to awaken the desire to quit smoking' (1st)

During the speeches, Facilitator elements emerged, according to the CDs, for the patient's approach to 'cessation' (Table7).

Through the speeches, facilitating and motivating elements also emerged at the patient level, described in Tables 8 and 9.

DISCUSSION

The objective of this study was to investigate and describe the strategies used by a group of dentists from the Public Network (Primary and Secondary Care) in a municipality in the north of Paraná-Brazil) for the cessation of tobacco use or derivatives in their patients, and to evaluate whether there were differences in the approaches of male and female patients.

In the sociodemographic results, it was observed that 56.25% of the sample were men and 43.75% women. Most (93.7%) had dental specialties in different areas, 5 of them (Primary

Barriers	Primary Care	Secondary Care
The person does not know other professionals working in prevention	0	1
Discrediting the success of your approach	2	3
The person does not believe in losing the habit	1	2
Patient believes that oral problems alone are not enough for cessation (preconceived idea)	1	0
Little/absence of training in graduation/courses	2	8
Patient's resistance to quitting addiction	2	1
Patients are not receptive	0	1
Patient resistance to stop smoking/cigarette is not harmful	1	0
Lack of follow-up (high number of patients)	2	0
"Passive" notes the data of the patient who wants to stop	1	0
The person does not feel like a member of the	1	0
smoking group team	1	1
Passivity/lack of skills in the face of failure	1	1
Lack of intimacy (patient)	2	1
Difficulties in knowledge/skills to address	0	2
The person says he has no difficulties (practices punctual action)	0	1
CD belief that there are quick treatments for cessation	0	1
Belief that it is due to chemical dependency	0	1
The person is unaware of the existence of treatment in the Public Network	0	1

Table 5 – Barriers at the CD level

Barriers	Primary Care	Secondary Care
Lack of assistance (monitoring)) Addiction / h	1	1
abit of smoking	0	3
Belief that one is not addicted (it would be easy to kick the habit)	1	0
Belief that smoking is not harmful	2	1
Belief that the harm "will not happen to him"	0	1
Disinterest in quitting smoking	1	0
Old habit and recurrence	1	0
Ashamed of seeking cessation programs	1	0
Omission that you are a user of tobacco products	1	0
Resistance in approaching the topic (Disconversation)	2	1
Valuing pleasure and "forgetting" the harm	0	3
Psychiatric comorbidities	1	0
Codependency on other addictions	1	0
"Psychological burden of addiction"	1	0
Relapse and "constant urge to smoke, calm down"	1	1

Table 6 – Barriers at the patient level

Facilitators	Primary Care	Secondary Care
Patient's desire to stop smoking	0	1
Self-confidence in ability to approach cessation	1	0
Patient with critical health status (fear)	1	0
Individual training through articles, courses, the internet and readings on the subject	5	1
Day-to-day experience of the profession (experience)		
Prior work with a cessation team	1	0
Self-confidence in ability to promote cessation	1	0
	1	0

Table 7 – CD-level facilitators

Facilitators	Primary Care	Secondary Care
Willingness (pre-disposition) of the patient to quit smoking	2	1
Awareness of the benefits of quitting smoking	0	1
Acceptance to stop smoking/decrease quantity	1	0
Not to tell anyone you're trying to quit (avoid peer pressure)	0	1
CD guidance/ insistence	1	1

Table 8 – Facilitators at the patient level

Motivators	Primary Care	Secondary Care
Quality of life (odor, food)	2	1
Fear (deterioration in health)	5	0
Self-esteem, aesthetics, bleaching	1	3
To receive good guidance and encouragement from the DC	3	0
"Willpower"	1	0
Community people reporting cessation	1	0
Spouse's adherence to termination	1	0

Table 9 – Motivators at the patient level

Cessation (Fitness)	Primary Care	Secondary Care
All the steps	2	0
To ask	0	1
To ask and advise	0	2
To ask, advise and follow up	0	1
To advise	2	2
To advise and evaluate	0	1
To ask and evaluate	1	0
To evaluate	1	0
Unable to advise/accompany/assist	1	0
It is hard to keep up	1	0
Difficult to follow and watch	0	1

Table 10 – Skills in the Termination Process

Care) in the Family Health Strategy.

To smoke is a serious public health problem, considered one of the main causes of morbidity and mortality in the world, compromising the health of the individual by causing preventable diseases and also premature disability. (SALAZAR, 2014). In the conversation regarding **role, attitudes** that the dental surgeon must have in front of these patients, most cited: identifying, approaching and guiding (advising) on the harmful effects of tobacco and derivatives to oral and general health, with the aim of encouraging the patient to quit. Three interviewees mentioned that it was not the dentist's role to participate in the follow-up and assistance steps. However, the INCA guidelines for health professionals are that they must identify, guide, evaluate and refer these patients for treatments and interventions. This method in relation to tobacco is also recommended by Satcher (...) and Binnie ( ) known as the 5As: (Ask - to identify, ask, Advise - to guide, provide greater knowledge to the user about the harmful effects of tobacco and derivatives, motivating cessation, Assess – assess your dependence and interest in cessation, Assist- assist, so that the patient establishes a date for cessation and has information on how to do it, Arrange- follow-up, consists of scheduling support during this termination process.

The dental surgeon as a health professional, in addition to diagnosing and treating lesions in the oral cavity, after due training, guidance and interaction with the other members of the team responsible for the anti-smoking program, must actively participate in the cessation process in all activities. its steps (5 As). Although controversial, studies have shown that although Cd is aware of the negative effects promoted because of cigarettes and derivatives, their participation in anti-smoking campaigns and programs has been minimal (JOHNSON, 2004).

Ratifying, in the study by Fabricio (2015) 92.7% of professionals had never carried out activities for the cessation of the use of tobacco products, although 47.1% had had this qualification in the professional training course. Of the participating professionals, 66.2% recognized their knowledge of treatment as insufficient, with the concept of smoking incorrectly answered by about 62.5% of professionals, especially Community Health Agents (93.6%). while for dentists it was 57.1%. Most professionals (73.5%) recognized the relevance of the topic and mentioned that they would like to learn more.

Most of those surveyed in this sample, although working with the community participating in the Health Units, also feel unprepared for the practice with users of tobacco and derivatives, and especially with the warning of the fragility of their family members, especially children, smokers liabilities. Ribeiro et al. (2015) evaluated 58 parents, with an average smoking time of 15.3 years, and an average number of cigarettes smoked per day of 20.1. It found that 59% did not know what environmental tobacco pollution - PTA (the smoke of tobacco products in closed environments) was, and although 60% mentioned knowing what a passive smoker was, 52% believed that their children could not suffer respiratory damage, in addition to not knowing what these losses would be. He noticed the parents' lack of knowledge about environmental pollution from tobacco at home, and the harm that cigarettes can cause to their children's health. When parents were asked if they had already been advised about the influence of passive smoking on their children's health, most answered that they had not.

However, the respondents expressed an interest in obtaining greater knowledge regarding the psychological preparation of the patient, advising, evaluating, monitoring, assisting, and even clinical sequelae resulting

from the use of tobacco and derivatives. They thought they were unprepared for not having received more consistent information about the cessation process during their undergraduate training or even in postgraduate courses. However, one of them mentioned that he was not interested in obtaining more knowledge on the subject.

In the study by Silva, Marson, Casavecchia (2010), most dentists also said they were unprepared to make cessation methods available to patients, (67,55) claiming that they had not received information on how to guide cessation in undergraduate and postgraduate courses. -graduation, however (55%) somehow helped their patients to stop smoking. These data suggest that undergraduate courses must provide effective guidance on intervention methods for cessation, motivating oral health team professionals to use them in the 5 spheres.

AS FOR THE STRATEGIES USED:

Most participants 14 (87.5%) restricted themselves to guiding (asking – identifying and advising) their patients regarding the harm and negative effects produced by tobacco and derivatives, for oral and general health. These guidelines suggest that they are more informative than interventional, restricting themselves to asking, identifying and advising, not mentioning the indication of treatment, or assisting and monitoring. There were no differences between Primary and Secondary Care. Despite this, 2 Primary Care DCs said they had skills in the cessation process in all its stages.

Similarly, the literature mentions that although about 50% of users try to stop using tobacco products, only 57.5% receive advice from a health professional and few receive adequate follow-up (BRASIL, 2015). According to the Special Research on Smoking (PETab. 2011) about 40% of health professionals do not give due importance to smoking as a risk factor and/or disease (INCA, 2011).

Contrasting with the present study, King et al. (2013) carried out a secondary data survey, investigating the prevalence and characteristics of users of tobacco products (n=13,371), who visited a health professional in the last 12 months in the USA, concluded that 2/3 were advised to stop smoking smoke. Of the participants, 87.9% said they were asked if they used tobacco products. Of current users who visited a health professional, 42.6% were asked if they would like to stop, of which 67.5% answered yes.

Among the smokers studied who wanted to quit tobacco use, 78.2% received assistance regarding cessation, distributed through leaflets 50.6%, videos, websites or other information, 37.5% were referred to specialized programs or counseling, and 57.8% received specific medication. Of the total (78.2%) about 23.1% received the three forms of assistance, 49.5% received 2 forms and 73% only one type of intervention and health care.

DIFFERENCES IN APPROACHES

When asked if there were differences in the approach between men and women, the vast majority (7 from Primary Care and 5 from Secondary Care) revealed that they did not make any differences. However, those who did, reported being more delicate with the woman, addressing aesthetics, in cases of dental whitening, approach with impact on children (passive smokers) in cases of mothers (2 CDs of Primary Care), while for men they manifested in a more "incisive", harsh way. It was also reported differences in approaches regarding age, the speech was differentiated, specific to younger people.

KNOWLEDGE/SKILLS:

Among the dentists who participated in the survey, there was little expression of knowledge and self-efficacy for referral to smoking

treatment. Participants limited themselves to approaching and raising awareness among patients, but not to monitoring and assisting cessation, which suggests that they did not have subsidies regarding existing treatment options, often not even to whom to indicate them, or because they were not participants. active in this function, as reported by one of the participants.

Although these were not the objectives of the study, during the qualitative research, concepts of barriers that the CD faces in the cessation process emerged, such as discrediting the success of their approach, little or no training in the subject, unaware of the composition of the multidisciplinary team working in the cessation, the patient's resistance to quitting the habit, the DC's lack of time at the UBS for follow-up, and lack of knowledge about existing treatment options.

But between **barriers presented by the patient,** the omission of tobacco use by the patient was cited, the belief that the harm resulting from this use will not occur to him, the lack of follow-up by the dentist, the shame of participating in cessation programs, the pleasure expressed by the user, the recurrence, psychiatric comorbidities, and codependency on other addictions.

As facilitators at the CD level: the patient's motivational phase (willingness to stop smoking), whether he is in a critical state of health (fear), and the professional's self-confidence, experience, knowledge and skill for the approach were observed.

Regarding the motivating and facilitating elements for the aforementioned approach, the following were obtained: awareness of the benefits of cessation (health, aesthetics, predisposition, avoiding social pressure when in the process, improvement in the quality of life (odor, food), spousal adherence, reports from people in the community, encouragement and adequate guidance from the dentist.

FINAL CONSIDERATIONS

This study promoted a preliminary exploratory understanding of the strategies used by a group of dentists in order to obtain cessation of tobacco use and its derivatives in their patients. It was observed that the professionals surveyed approach and make their patients aware of the harmful effects of tobacco and derivatives and their consequences for health, with an approach more focused on inquiry and advice, however most do not carry out the follow-up and assistance to them, the which reduces the success of interventions.

As for gender, some CDs address it in different ways, being kinder to women, addressing aesthetics (teeth whitening, skin), and more rude to men. They also emphasized differences related to patient age.

Although this study has relevant information, it is restricted to a group of dentists with specific characteristics. Its expansion can bring results with information capable of supporting government strategies aimed at developing training programs for this class of health professionals.

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REFERENCES

Agaku, I.T.; Ayo-Yusuf, O.A.; Vardavas, C.I. A comparison of cessation counseling received by current smokers at US Dentist and Physician Offices during 2010-2011. **American Journal of Public Health**. V. 104, n. 8. 2014.

Araújo, A.M.F.; SILVA, A.H.M.F.T.; VABOS, R.V. Prevalência de sintomas e doenças respiratórias em crianças na idade escolar, fumantes e não fumantes passivas. **Pulmão**. Rio de Janeiro, v.15, n.1, p.16-19. 2006.

Binnie, V.I. Addressing the toppic of smoking cessation in a dental sitting. Periodontol 2000-2008 48 170-8. 2008.

Brasil – Ministério da Saúde – INCA [página na Internet]. Inca alerta para câncer de pulmão em fumantes passivos. Disponível em: http://www.inca.gov.br/tabagismo/atualidades/ver.asp?id=567 [acessado 05.09.2011]. [Links]

Brasil. Ministério da Saúde. DATASUS. Sistema de Informações sobre Mortalidade - SIM [Internet]. Brasília; 2011 [citado 2015 maio 8]. Disponível em: http://www2.datasus.gov.br/DATASUS/index.php?area=060701 [Links]

Carvalho R.F.A., et al. Percepção dos pais a respeito do tabagismo passivo na saúde de seus filhos: um estudo etnográfico. **Rev Paul Pediatr.** 2015. V. 33(4):394-9. [Links]

Cazavecchia, G.; Marson, F.C.; Silva, C. O. Avaliação das práticas e atitudes do cirurgião-dentista no controle do uso de tabaco pelos pacientes. Rev. Dental Press. Periodontia Implantol, v. 4, n.1, p. 79-89, jan/fev/mar. 2010.

Desalu, O.O.; Adekoya A.O.; Elegbede, A.O.; Dosunmu, A.; Kolawole, T.F.; Nwogu, K.C. Conhecimentos e práticas para a cessação do tabagismo entre médicos nigerianos. **J. Bras Penumol**. v. 35, n.12, p. 1198-203, 2009.

Fabrício, N.F.T.N. **Avaliação do conhecimento dos profissionais de saúde sobre o programa de cessação do tabagismo**. 2015. 90 p. Dissertação de Mestrado- Universidade Estadual Paulista "Julio de Mesquita Filho" Faculdade de Medicina**,** Botucatu, 2015.

Fiore, M.C. et al. Treating tobacco use and dependence: 2008 update. Rockville, MD: US Department of Health and Human Services, 2008.

HallalI, A.L.C. et al. Prevalência e fatores associados ao tabagismo em escolares da Região Sul do Brasil. **Rev. de Saúde Pública**, 2009. Acessado em 10/09/2016. Disponível em: http://www.scielo.br/pdf/rsp/2009nahead/724.pdf

Hipólito Júnior, E. **Comportamento dos farmacêuticos, indicadores de estrutura e processos das farmácias comunitárias privadas do estado do Paraná.** 2015. Dissertação de Mestrado (Ciências Farmacêuticas), Pontifícia Universidade Católica do Paraná – PUC Pr. 109 p. 2015. Disponível em: http://acervodigital.ufpr.br/handle/1884/37615?locale-attribute=en. Acessado em 10/08/2016

IBGE. Disponível em: https://www.google.com.br/?gws_rd=ssl#q=ibge Acessado em: 02 de nov de 2015.

IBGE. Wikipédia, a enciclopédia livre. Disponível em: https://pt.wikipedia.org/wiki/Arapongas
Acessado em: 05 de maio de 2018

INCA - Instituto Nacional de Câncer José Alencar Gomes da Silva. Programa Nacional de Controle do Tabagismo [Internet]. Rio de Janeiro: INCA; 2013 Disponível em: http://www2.inca.gov.br/wps/wcm/connect/acoes_programas/site/home/no brasil/programa-nacional-controle-tabagismo/programa-nacional [Links]

INCA. **Diário Oficial da União**. Portaria nº 761 de 21 de junho de 2016. Por um mundo sem tabaco- "Valida as orientações técnicas do tratamento do tabagismo constantes no Protocolo Clínico e Diretrizes Terapêuticas – Dependência à Nicotina".B Disponível em: http://www.in.gov.br/autenticidade.html pelo código 00012016062200068 Acessado em 04/08/2016

Johnson N.W. The role of the dental team in tobacco cessation. Eur J Dent Educ. 2004; 8(suppl 4): 18-24.

King, B.A.; Dube, S.R.; Babb, S.D.; Mcafee, T.A. Patient- reported recall of smoking cessation interventions from a health professional. **Preventive Medicine** Elsevier, v. 57, p. 715- 717, 2013.

Laden F., Chiu Y.H., Garshick E., Hammond S.K., Hart J.E. A cross-sectional study of secondhand smoke exposure and respiratory symptoms in non-current smokers in the U.S. trucking industry: SHS exposure and respiratory symptoms. **BMC Public Health**. V.13, n.93. 2013 [Links]

Lombardi E.M.S., Prado G.F., Santos U.P., Fernandes F.L.A. O tabagismo e a mulher: riscos, impactos e desafios. **J Bras Pneumol.** V.37, n.1, p.118-28. 2011.

Ministério da Saúde. INCA. Instituto Nacional do Câncer. A situação do tabagismo no Brasil: dados dos inquéritos do Sistema Internacional de Vigilância do Tabagismo da Organização Mundial da Saúde realizados no Brasil entre 2002 e 2009. Rio de Janeiro: **INCA**, 2011. (A)

Ministério da Saúde. Instituto Nacional de Câncer – INCA. Convenção- Quadro para o Controle do Tabaco [Internet]. Rio de Janeiro: INCA; 2011. [citado 27 Out 2013]. Disponível em: (B) http://bvsms.saude.gov.br/bvs/publicacoes/inca/convencao_quadro.pdf

Oberg M. et al. Worldwide burden of disease from exposure to second-hand smoke: a retrospective analysis of data from 192 countries. **Lancet**. 2011; 377(9760):139-46. [Links]

Oliveira, R.V. et al. Avaliação dos hábitos de higiene bucal de fumantes. Evaluation of oral hygiene habits of smokers. **Braz J Periodontol.** December. V. 25-issue 04. 2015.

Olivetti, R.F. **Tabagismo e suas consequências: uma abordagem sobre a importância da adoção de hábitos saudáveis**. 2014. Monografia. Universidade Tecnológica Federal do Paraná, Curitiba, 2014.

OPAS. Informe sobre Control del Tabaco en la región de las Américas: a 10 ãnos del convenio Marco de la Organización Mundial de la Salud par el Control del Tabaco. 2016. disponível
em: http://iris.paho.org/xmlui/bitstream/handle/123456789/28380/97892753188 67_spa.pdf?sequence=1&isAllowed=y&ua=1

Passos V.M.A., Giatti L., Barreto S.M. Tabagismo passivo no Brasil: Resultados da Pesquisa Especial do Tabagismo, 2008. **Ciênc Saúde Colet**. V.16, n.9, p.
3671-78, 2011.

Pesquisa Especial de Tabagismo (PETab) – Relatório Brasil Global Adult Tobacco Survey – Brazil Report Encuesta Global de Tabaquismo en Adultos – Informe Brasil Instituto Nacional de Câncer (Brasil). Organização Pan-Americana da Saúde. Rio de Janeiro: **INCA**, 199 p. ISBN: 978-85-7318-182-1 (INCA) 978- 92-75-73137-6 (OPAS). 2011.

Perez-Stable E.J., Juarez-Reyes M., Kaplan C.P., Fuentes-Afflick E., Gildengorin V., Millstein S.G. Counseling smoking parents of young children: Comparison of pediatricians and family physicians. **Archives of Pediatrics & Adolescent Medicine.** V. 155, n.1, p. 25-31. 2001.

Reichert J., et al. Diretrizes para cessação do Tabagismo. **J Bras Pneumol**. v. 34, n. 10, p. 845-80, 2008.

Ribeiro et al. Percepção dos pais a respeito do tabagismo passivo na saúde de seus filhos: um estudo etnográfico. **Sociedade de Pediatria de São Paulo**. Published by Elsevier Editora Ltda. 2015.on line.

Salazar, P. R. O uso do tabaco entre trabalhadores técnico administrativos em educação de uma universidade pública do estado de Minas Gerais. Dissertação de Mestrado- Faculdade de Medicina da Universidade federal de Juiz de Fora. Juiz de Fora, 2014.

Satcher, D. Five major steps to intervention (The '5 A´s").Treating Tobacco Use and Dependence. PHS Clinical Practice Guideline. Ano Disponível em:

Salmória J.G., Oliveira B.R. Crianças de Centro de Educação Infantil: exposição ao fumo passivo. Maringá. v.5, p.16-23, 2006. [Links]

Sigaud, C.H. de S.; Castanheira, A.B.C.; Costa, P. Associação entre tabagismo passivo domiciliar e morbidade respiratória em pré-escolares. **Rev. Esc. Enferm. USP** v.50, n.4 São Paulo July/Aug. 2016.

Tanni S.E., Godoy I., Godoy I.Tabagismo – intervenções motivacionais e farmacológicas. In: Cukier A., Godoy I., Pereira M.C., Fernandes P.M.P. Pneumologia: atualização e reciclagem. Rio de Janeiro: Elsevier, p.107-14, 2009.

Vitória, P.D.; Rodrigues, C.N.; Vries, H. de. O que os pais devem saber e fazer para prevenir o tabagismo e as suas consequências em seus filhos. Aletheia cap. 7, p. 165-189. 2015.

WORLD HEALTH ORGANIZATIONS. Guidelines for the conduct of tobacco- smoking surveys among health professionals: report of a WHO meeting held in Winnipeg, Canada, 7-9 July 1983 in collaboration with UICC and ACS. Geneva: WHO; 1983.

WHO. The World health report 1999: making a difference. Geneva; Combating the tobacco epidemia. p. 65-79, 1999.

WHO. World Health Organization. Report of the Global Tobacco Epidemic, 2011: Warning about the dangers of tobacco. World Health Organization, Geneva 2011. [consultado 2015 Dez 30]. Disponível em http://whqlibdoc.who.int/publications/2011/97889240687813_eng.pdf.

WHO. World Health Organization. Tobacco. Fact sheet no 339 [Internet]. Geneva: 2015. [Links]