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ORIGINAL ARTICLE

Longitudinal treatment of smoking in Primary Health Care: an evaluation research

Longitudinalidade do tratamento do tabagismo na Atenção Primária à Saúde: pesquisa avaliativa

Longitudinalidad del tratamiento del tabaquismo en la Atención Primaria de Salud: investigación evaluativa

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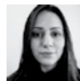

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ABSTRACT

Objectives: to evaluate the coordination of the attention for continuing treatment for smoking cessation in the Primary Health Care, from the perspective of users. **Methods:** the conceptual base was longitudinal care, which is an attribute of the National Policy of Primary Care. The methodological framework was that of an evaluative research, as informed by theory-based evaluation. Data collection used observation with moderate participation in the groups to abandon smoking, intensive interviews with 22 users, and analysis of medical records. The interviews used initial and focused coding, which are analytical stages of the Grounded Theory, with the aid of the MaxQDA® software. **Results:** the interviewees had a positive evaluation of their treatment for smoking, although they mentioned limitations for medium- and long-term continuity. **Final Considerations:** the smoking treatment sessions, even if infrequent, were found to be a successful experience for smoking cessation.
Descriptors: Tobacco Use Disorder; Smoking Cessation; Program Evaluation; Primary Health Care; Nursing.

RESUMO

Objetivos: avaliar como ocorre a coordenação do cuidado para a continuidade do tratamento do tabagismo na Atenção Primária à Saúde sob a ótica dos usuários. **Métodos:** adotou-se como base conceitual o atributo da longitudinalidade do cuidado da Política Nacional de Atenção Básica; e como referencial metodológico, a pesquisa avaliativa qualitativa à luz da avaliação baseada na teoria. Na coleta de dados, empregou-se a observação com participação moderada nos grupos de cessação tabágica, entrevista intensiva com 22 usuários e análise de prontuários. Nas entrevistas, foram aplicadas as etapas analíticas da *Grounded Theory* de codificação inicial e focalizada, com auxílio do software MaxQDA®. **Resultados:** os entrevistados avaliaram positivamente o tratamento do tabagismo, porém foram elencadas limitações acerca da continuidade em médio e longo prazo. **Considerações Finais:** as sessões de manutenção para a continuidade do tratamento do tabagismo, mesmo que eventuais, foram reconhecidas como uma experiência exitosa para a cessação tabágica.
Descritores: Tabagismo; Abandono do Hábito de Fumar; Avaliação de Programas; Atenção Primária à Saúde; Enfermagem.

RESUMEN

Objetivos: evaluar como ocurre la coordinación de la atención longitudinal del tratamiento del tabaquismo en la Atención Primaria de Salud bajo la óptica de usuarios. **Métodos:** adoptado como base conceptual el atributo de la atención longitudinal de la Política Nacional de Atención Básica; y como referencial metodológico, la investigación evaluativa cualitativa de acuerdo con la evaluación basada en la teoría. La recolecta de datos empleado la observación con participación moderada en grupos del cese del tabaquismo, entrevista intensiva con 22 usuarios y análisis de registros médicos. Las entrevistas fueron aplicadas las etapas analíticas de *Grounded Theory* de codificación inicial y focalizada, con auxilio del software MaxQDA®. **Resultados:** entrevistados evaluaron positivamente el tratamiento del tabaquismo, pero fueron enumeradas limitaciones sobre la continuidad a mediano y largo plazo. **Consideraciones Finales:** las sesiones de manutención para la atención longitudinal del tabaquismo, aunque eventuales, fueron reconocidas como una experiencia exitosa al cese del tabaquismo.
Descriptores: Tabaquismo; Cese del Hábito de Fumar; Evaluación de Programas; Atención Primaria de Salud; Enfermería.

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INTRODUCTION

Smoking is a world epidemic, causing more than 7 million deaths every year. Smoking is also a public health challenge, especially for low- and medium-income countries. Therefore, there must be public policies targeted at controlling and preventing smoking, to provide more support to smokers who want to abandon the habit[1-2].

In Brazil, actions to prevent and control smoking have been supported by the National Program for the Control of Smoking (PNCT) since 1980. The objective of this program is reducing the prevalence of smoking and the morbimortality related to the use of tobacco products. PNCT functions through educational, communication, and health care actions associated with legislation and economic measures aimed at preventing against smoking, promoting its abandonment, and protecting the population from the risks of passive smoking[3].

Due to the actions developed for more than three decades by the PNCT, there has been a diminution in the social acceptance of smoking and an increase in the rates of users who seek the Single Health System (SUS) for treatments to stop smoking, showing how important it is for these services to give priority to the treatment of this population[4]. Moreover, studies have shown that guidance from a trained health worker is essential to aid the users who want to stop smoking. These workers become facilitators of the process, aiding in dealing with the difficulties in the beginning of the treatment, such as moments of craving and abstinence symptoms[4-5].

Primary Health Care (PHC) is in a privileged and strategic position to develop the actions prescribed by the PNCT, based on the characteristics of this type of assistance. Among the main attributes of PHC — immediate attention, longitudinal care, comprehensive care, coordination of care, family and community guidance, and cultural competences —longitudinal care guarantees that the assistance is continued, based on the construction of a bond and on the accountability of professionals and users through time[6]. These aspects are directly related to the success of smoking treatments, especially in regard to the long-term cessation of smoking.

Longitudinal care, in PHC, implies in two dimensions: being recognized as a regular and continuous source of care; and establishing a long-lasting therapeutic bond between users of the service and the health team. In the first dimension, the longitudinal care in PHC reflects on the long- term cooperation between users and health workers, providing efficient and long-lasting continued care. The second dimension is based on the formation of a bond; professionals and users become co-responsible as time advances, and the subjects assume the main role in their own treatment[7-8].

The quality of assistance is directly related to achieving these two dimensions of the longitudinal nature of care, since it allows for the worker to get to know users and their context, enabling the planning of adequate care and interventions. Therefore, evaluating the contexts connected to the treatment of smoking, especially considering the longitudinal nature of this type of care, makes it possible find how the population has been receiving this comprehensive and continuing care[8].

In this context, evaluating the longitudinal nature of smoking treatment in PHC makes it possible to find how actions developed by the PNCT have taken place after the sessions of the support group to stop smoking have ended, since this attribute has an important role to guarantee long-term integral care.

OBJECTIVES

To evaluate the coordination of the attention targeted at continuing treatments for smoking in the Primary Health Care, from the perspective of users.

METHODS

Ethical aspects

This study is part of a larger research named "The Program for the Control of Smoking in Primary Health Care: a qualitative evaluation". The project that originated this research respected all aspects of Resolutions No. 466/12 and 510/16 from the National Council of Health[9-10]. It was approved by the Permanent Ethics Committee for Research with Human Beings and by the Health Secretariat of the city where it took place. All users signed the Free and Informed Consent Form (FICF). The interviewees were identified through alphanumeric codes (E1 - E22) to preserve their anonymity.

Type of study

The conceptual framework of this study used the longitudinal care attribute of the National Policy of Primary Care (PNAB) [6], considering the theoretical framework necessary to discuss this concept in the execution of the actions of the PNCT, carried out in the PHC. The methodological reference was evaluative research under the light of theory-based evaluation. This type of evaluation seeks to verify the efficiency of a certain program based on its theoretical presuppositions, to understand the origins and outcomes of the program to be studied and to provide a coherent evaluation based on theory[11]. Aiming to improve the presentation of the results, the COREQ protocol was used (Consolidated criteria for reporting qualitative research).

Methodological procedures

Study setting

This study was developed in nine Primary Health Care Units (UBS) of a medium-to-large sized city in the Northeast of the state of Paraná, in Brazil. The city has 34 UBSs, but only 9 carried out PNCT-related activities in 2019.

The strategies of the municipal Program for the Control of Smoking (PCT) state that the UBSs with health care workers trained in the field of care to smoker patients and previously trained by the Health Secretariat (SESA) should periodically provide treatment to the smoking population by offering groups to support the abandoning of smoking.

In the city evaluated, the groups are developed once a week, for one month, lasting for a mean of one hour. Each team responsible for the treatment has autonomy in regard to the development of activities throughout the meetings and for the follow up sessions,

as long as they follow the basic PNCT recommendations. Aspects related to teaching techniques adopted during the session, as well as the participation of different professionals and the systematization of activities to be developed with the participants, are defined by the professionals from each UBS.

Data sources

The study included 22 PHC users who participated, in 2019, of the groups from the municipal Program for the Control of Smoking (PCT), until the groups finished their activities. The following inclusion criteria were adopted: having participated in the group to stop smoking in 2019, regardless of the outcome of the treatment, and being 18 years old or older. Users who were not found after three consecutive attempts in different days were excluded.

Collection and organization of data

Data collection took place from December 2019 to May 2020, including the techniques of observation with moderate participation in the groups to abandon smoking; intensive interviews with the users; and analysis of medical records. The observation with moderate participation took place during the sessions of the groups to stop smoking carried out during data collection. The elements that stood out in this observation were the dynamics and organization of the groups; the inherent aspects of the treatment provided by the interdisciplinary teams; the content addressed; the procedures carried out; the interaction in the group; and the reactions of the participants. The information was recorded in the researcher's field journal.

Due to the new coronavirus pandemic (SARS-CoV-2), identified in the country during data collection, the intensive interviews had to be done using two different methods: 13 of them were carried out before the pandemic, in the home of the users, according with their availability of time; and 9 interviews were carried out through video calls. In both cases, the interviews lasted for a mean of 30 minutes. The change in the modality of interview did not prejudice the content collected.

All interviews were carried out by the researcher, recorded in a digital audio recorder, and later transcribed in full. A guide was used to aid in the interview, with questions about the identification of the interviewee; their participation in the group to stop smoking; perceptions about the treatment; suggestions and evaluation of the program; medication received; and continuity of treatment.

The collection of data from the medical records was carried out as the interviews were being done, using a form elaborated by the researcher with information about the interviewee's history of smoking and clinical history, including information on the sociodemographic profile and degree of dependency on nicotine — the latter, evaluated using Fagerström's test. Information that was not in the records was added at the time of interview.

Data analysis

Data were analyzed using triangulation[12], since it allows for the combination of multiple data collection techniques and their use in a process that involves interaction, intersubjective criticism, and comparison. For the data analysis stage, therefore, the statements of the participants of the study were used, as well as the observation of the practices of care and the data from the records.

To aid in the organization and analysis of data, the MAXQDA® software was used, version 20.0.8, license nº 230594870. The interviews were analyzed using the initial and focused coding, which are stages of the Grounded Theory analysis[13]. In the initial coding, the data started being analyzed according with the incidents in each sentence transcribed. In the focused coding, the incidents were grouped and regrouped to generate the categories of the study, which focused on the understanding of how the participants evaluated the PCT and the continuity of the care to stop smoking. Questions involved the actions during the treatment, long-term treatment, and the follow up after the groups of smoking cessation were finished.

This analytical process led to two categories: "Sessions for the continuity of the treatment of smoking in the Primary Health Care", which describes how the follow up sessions to continue the treatment of smoking after the support groups were finished; and "Shortcomings of the systematized longitudinal follow up in the treatment of smoking in the Primary Health Care", which discusses the shortcomings mentioned by the interviewed users in regard to the systematized longitudinal follow up of the continuous treatment of smoking.

RESULTS

The study included 22 users who were followed up by the PCT in the APS. From them 21 were female and 1 male, from 27 to 69 years old. According with data from the referrals of patients to treat smoking, 12 users had searched the UBS voluntarily, 6 as referred by physicians or other professionals, 2 received the suggestion from friends or work acquaintances, and 2 received the suggestion from relatives. 19 participants had already tried to quit smoking before and said they had been able to do it at least once but could not remain without smoking for long. Regarding their level of dependence on nicotine, most reported their dependence as "high" or "very high".

The users had a positive evaluation of the PCT treatment in the PHC, highlighting the bond that the health professionals managed to establish as they conducted the support groups to stop smoking. However, they also recognized some limits to the longitudinal nature of this type of care, as the categories of this study show.

Sessions for the continuity of the treatment of smoking in the Primary Health Care

The interviewees believe that the treatment for smoking provided by the UBSs in the city is essential to aid in the process of smoking cessation. They also believe that the dynamics of the treatment in the support groups promoted interaction between participants and that the knowledge acquired there helped and facilitated the cessation of smoking.

> *Every time I tried to stop smoking alone I couldn't, but in the group I saw it's possible.* (E13)

> *I thought I needed to seek help, that, with help, I would be able to stop, and I received really good support from the group.* (E11)

> *In the group there were people to talk, we gave support to each other, this made us want to continue and finish the treatment all the more.* (E14)

> *The information and motivation we receive helps a lot, because with no help it's hard to stop* [the addiction]. (E15)

After the group treatment meetings were over, its continuity was also recognized as essential for successful smoking cessation. The sessions to follow up on the PCT treatment took place when the participants went back to the PHC, after the groups had finished their meetings. The strategies for the attention varied depending on the organization of the health workers. These follow ups took place in a new group meeting, individual medical consultations, and telephone contact.

Thus, each UBS adapted its follow up sessions according with their local reality, and conducted them based on the decisions of the professionals who were responsible for the PCT. When they decided to have a new group meeting with the users, this meeting usually took place from 15 days to one month after the groups had finished.

> *I went to a consultation with them I think one month after the group was over. It was good: the psychologist of the group wanted to know how I was doing, if I had quit and why I continued smoking.* (E1)

> *I went to the four sessions and, 15 days later, I went back to the follow up. That day was like a meeting everyone participated in; they asked if we were managing to quit.* (E4)

> [...] *later they called us for a final meeting to know how we were doing, if we needed medication, more support, if we needed to go back to participate in another group. But only me and another person went, and we both had quit.* (E5)

> *The follow up is good, because you get to know how the others are, you find out if they quit smoking, if it was hard for them. It's very important because, sometimes, you're having trouble and you talk with the professional, you know what happened to the others too, if they managed to quit, if they used medication, you have an example and if the person did it, you think you can do it too.* (E17)

> *Sometime later, I think one or two months later, one of the professionals called me asking how I was doing, if I had quit smoking, if I was showing symptoms of abstinence.* (E4)

The users had a positive evaluation of this follow up contact about the treatment, and stated that, when this happened, it helped them remain abstemious for longer, being thus an important form of support for smoking cessation in the long term.

When the return to the UBS to follow up on the treatment was focused on individual medical consultation, the focus was on pharmacological therapy, since the physician was the professional responsible for giving new prescriptions when necessary. This follow up was optional, and the users evaluated their need to schedule it and to continue taking the medication.

> *We were advised to schedule a follow up with the doctor if we needed more medication.* (E5)

> *There was a follow up just for the medication for anyone who needed mor prescriptions, but I think only a few people went there. It was just with the doctor; the group, itself, did not have a follow up.* (E8)

> [...] *I only went back to get more drugs from the doctor, but I didn't go back to the group.* (E16)

The provision of treatment for smoking in the PHC is extremely relevant, and the users recognized that this assistance could aid them to quit smoking. However, from the nine UBSs that this study included, three did not have follow up sessions after the groups were finished. Furthermore, among those that did, there was no standardized time, and the health professionals who were responsible for the PCT directed these actions. In some cases, the participants themselves decided if a return to the UBS was necessary.

Shortcomings of the systematized longitudinal follow up in the treatment of smoking in the Primary Health Care

Although group sessions were finished, the users indicated that the continuity of the treatment to quit smoking, including returns to the UBS to follow up sessions, is essential to quit the habit of smoking. The users recognized the need for health workers to spend more time during and after the conclusion of the treatment, stating that the weekly meetings did not last long enough to answer their needs and the number of meetings was small, considering the effectiveness of long-term treatment.

> *In my opinion, there should be more meetings, I think four weeks are too few. I think there should be longer conversations, one hour is too little: when we start to talk, the meeting is over already. I think it should last longer each day or there should be more sessions.* (E1)

> *One thing I think could change is that there could be more meetings, because when the group was over, some people were still smoking, but the meetings were already over. I though there were few meetings. Only one month is too little time for those who want to quit smoking; I think it would be good if there were about three months of meetings.* (E14)

The lack of continuity of the treatment after the groups were finished was also mentioned by the interviewees. Although the follow up sessions are recognized in the documents on which the PCT is based, it was not very frequent in daily practice.

> *No one called, no one wanted to know if I had stopped smoking after the group, or if I wanted to participate in the group again.* (E12)

> *There was no follow up from the UBS. I thought it was weird, even, they didn't contact me to see if I had quit smoking. They don't know who quit or if the treatment was actually effective.* (E14)

> *After the group was over, I had no more contact with the people, they didn't say anything about going back to the UBS. And, since*

> *I didn't continue the medication treatment, I didn't go back there either. The girls who conducted the group didn't contact me anymore to know how I was. So I don't know how the group turned out, because I didn't go back after it was over.* (E16)

The users indicated the need for follow up after the group was concluded, stating that they did not feel prepared to continue the treatment of smoking cessation with no professional help.

> *The treatment to quit smoking should be longer, because four weeks are too few; I think it should be about three months, because, after its finished, we're alone. So, I think there should be a longer treatment with us after the group is over.* (E1)

> *Sometimes, I fear relapsing. So, if it continued, if I could talk to the people in the group again, it would be nice.* (E10)

> *I think there should be more meetings, the meetings could be weekly still, but later there should be meetings monthly or every 15 days.* (E15)

Another aspect that reiterates the need for longitudinal and periodical follow up in attention is how difficult it is to continue free from smoking. This contributes for people to resume smoking after the support groups are over.

> *I managed to control it for two months, but I made the mistake of smoking just one more and ended up going all back again.* (E4)

> *I was really well without smoking, but I went through some events that caught me of guard, then I said that I was going to smoke just one, and that was it, I went back to smoking all over again.* (E13)

> *I didn't smoke for one month after the group was over but ended up going back.* (E17)

After they talked about the lack of follow up sessions carried out by the workers responsible for the treatment, the users suggested that scheduled meetings should be carried out after the meetings of the support group, reiterating the importance and the need for longitudinal systematized follow up.

> *I think there could be another meeting after the group is over, after some time, to see how the people are doing. If they continue to smoke or if they already quit. It would be interesting for us to meet again after some time.* (E10)

> *I think there should be more meetings, the meetings could be weekly still, but later there should be meetings monthly or every 15 days, because, then, the follow up would be better. Because, then, whoever couldn't quit in the first meeting, could do so in the next ones.* (E15)

> *I think there should be follow up after it's over. For example, the girls* [community health agents] *come visit me at home. They could ask how I am, if I'm still smoking. Or, otherwise, there should be a follow up of the UBS group later; I think that would be important.* (E16)

The treatment for smoking in the PHC was evaluated as relevant, and the participants recognized that this assistance can help them quit smoking. However, the continuity of treatment must be reorganized according with the theoretical framework of the Program. The attention to this population can be improved by longer treatment and a scheduled follow up, as suggested by the participants and indicated in the PCT. Still, follow up treatment sessions were found to be important for long-term smoking cessation, since interviewees who did not have this follow up recognized this need, suggesting that it could be included in the PCT activities.

DISCUSSION

The results of this research clearly show the importance of the treatment to control smoking provided by PHC, whose assistance revolves around support groups for smoking cessation in the UBSs of the city evaluated; it also shows the need to systematize sessions and follow up with the treatment after the groups have concluded, since they would directly influence the outcome of the treatment and long-term smoking cessation.

Due to the multiple factors that are involved in smoking, especially physical and chemical dependence on tobacco, users have trouble quitting the substance with no continuous professional help. In this context, it is highly important for health professionals to provide efficient assistance to smokers, aiming to give adequate support to those who want to quit this addiction[14].

The participants recognized the treatment received in the PHC as something essential for the process of smoking cessation in the aspects related to the dynamic of the group in structured meetings, which were offered weekly. The group approach makes it possible for participants to exchange experiences, allowing the formation of a bond between workers and user. This aspect of the therapy significantly contributes for the success of smoking cessation and is recognized as an essential attribute of longitudinal care[15].

However, the treatment of smoking had shortcomings in regard to the provision of long-term longitudinal care. Attributes of this type of care were found to be limited in practice, such as the continuity of care after the first four weekly sessions.

The treatment for smoking cessation in the PHC consists in a structured therapy/intensive approach, associated with pharmacological treatment when necessary. The PCT, supported by the principle of longitudinal care, suggests that the total time of treatment should be 12 months, involving the stages of initial evaluation of the user, group intervention, and posterior sessions to follow up and maintain abstinence[16].

The PCT states that the structured advice or intensive approach, when carried out in group meetings, should include at least four initial sessions, preferably every week; later, there should be two sessions, bimonthly, to start the stage of abstinence maintenance; and, after that, there should be monthly sessions to prevent relapsing until one year has passed from the start of the treatment. This model is used by the SUS network since 2001. It is important to note that each team being treated should adapt recommendations to local reality, always respecting the evidences and regulations of the program[3,16].

In the programs of attention evaluated, these regulations were not implemented in regard to the continuity of long-term

treatment, which is a shortcoming of the coordination of the care aimed at maintaining a comprehensive treatment of smoking. The number of regular weekly meetings with later follow up, as recommended by the PCT, was a shortcoming of the program, since many users do not start to quit smoking until the four initial meetings concluded, meaning that, later, they need assistance, according with the principle of longitudinal care.

Group treatment brings benefits for the cessation of smoking, but there must be a follow up of the user later for more than one month[14]. A systematic revision study gathered random trials to compare the effects of interventions in groups to quit smoking in the long term. It found that carrying out at least two sessions in group, with later follow up for at least six months leads to more success in stopping smoking, which reiterates the need for longitudinal care as a routine in the treatment of smoking[17].

Another study, which analyzed the efficacy of interventions for smoking according with the duration of treatment, found that treatments that last six months or more are statistically more significant when compared to shorter ones, suggesting that longitudinal care has a positive effect on smoking cessation and long-term abstinence, especially in behavioral group interventions[18].

The PHC does not have an organized provision of follow up sessions, and each team determines which approach should be taken, for how long, and may even decide not to carry out these sessions. A study that analyzed strategies of post-discharge follow up for hospitalized smoker patients found that the interventions carried out during hospitalization lose their effectiveness when there is no follow up[19]. This finding may be compared with the PCT interventions in the PHC, considering that the interruption of the treatment after the weekly structured meetings influences the efficacy of smoking cessation, which reiterates the need for the follow up of the users in the long-term, to support them in the case of possible relapses.

The process of smoking cessation after the treatment received in the PHC is a challenge for the smoker, since feelings such as anxiety and depression are common in this stage and may be coupled with other factors, such as craving, that is, the intense desire of smoking and the common symptoms of abstinence. These symptoms, when together, directly influence the process of relapse. However, the follow up of this user may contribute for the cessation of smoking in the long-term, avoiding these relapses[20].

This reality may be observed in a study that identified the degree of motivation of users to stop smoking after the PHC treatment ended. When the four sessions of the groups of smokers were finished, the users showed a high degree of motivation to maintain their abstinence; however, with time, this outcome tends to change if there is no longitudinal follow up[21]. Therefore, the systematization of long-term follow up after the smoking groups are concluded would be able to give support to smoking cessation, allowing users, through scheduled meetings, to continue receiving the support of health workers.

Considering this context, it is essential for PHC not only to treat smoking in routine care, but also to broaden this type of care, prioritizing strategies that guarantee longitudinal care to the users, ensuring that professionals and users are co-responsible for the treatment and allowing for the effects of the interventions received to be followed up, thus guaranteeing the continuity of treatment.

Study limitations

The limitation of this study is the fact that data only showed the reality of a single city in Paraná, preventing outcomes from being generalized for the entire country. Therefore, future studies should evaluate care for smokers in other settings and contexts.

Contributions to the fields of Nursing, Health or Public Policy

The National Program for the Controlling of Smoking has invested in actions to fight and control smoking in the Brazilian population for more than 30 years. It has become an international example of effective public policy action in the struggle against tobacco. In this setting, nurses have stood out due to their actions in the Program, since their technical-scientific capacity and engagement in the interventions prescribed give them a highly relevant role.

Considering the emerging need for the qualification not only of the nurse, but of all workers in this context, and the improvement of actions targeted at the population of smokers, studies that evaluate the PNCT may contribute for its planning and improvement. Furthermore, researches that seek to evaluate settings from the perspective of the users allow one to understand the real needs of the population, thus attending to their demands.

In regard to the practice of nursing care, the study shows the constant need of training professionals to take part in the actions prescribed to control smoking. These workers must be able to attend the population who wants to stop smoking, understanding smoking in a broad sense, since the nurse has a fundamental role in this treatment, often being responsible to conduct the groups or being a part of the interdisciplinary team responsible for doing so. Therefore, this professional must be aware of current directives for the treatment, so as to provide qualified care and develop actions to promote cessation and prevent smoking during the daily practice of the PHC, directly and indirectly practicing the interventions prescribed by the PNCT.

Moreover, since there is a constant need for the development, training, and innovation of nursing care practices, focused on the main health issues that affect the population around the world, smoking is an extremely relevant issue. This is why it is necessary to develop evidence-based nursing practices to approach patients who smoke.

This study allows for innovations in nursing assistance in the scope of the treatment of smoking in the PHC, aiming to capacitate future nursing professionals to provide effective treatments to smokers and guaranteeing longitudinal care, so long-term smoking cessation can continue effectively.

FINAL CONSIDERATIONS

Evaluating the continuity of the treatment of smoking in the PHC showed that the treatment provided to those who wish to quit smoking is essential for their ability to do so. However,

despite the efforts of some UBSs to provide follow up sessions, users found that there is no systematized longitudinal follow up after the four scheduled sessions of smoking cessation groups.

There are challenges to consolidate the longitudinal care in the treatment of smoking from a practical standpoint, due to shortcomings in regard to the duration of the treatment or to the need of long-term follow up after the groups have concluded their meetings.

The fact that the users themselves are interested in continuing care after the group meetings are finished shows that a better organization is necessary for longitudinal follow up. Furthermore, the users who had later follow up, even if infrequent, found it to be a success for smoking cessation.

This study demonstrates that there are no systematized follow up sessions, and that these sessions are less frequent than prescribed by the protocols that determine PCT practices. Therefore, it is necessary to invest in the continuity of care, aiming to better organize the continuity of the treatment and, thus, to offer users longitudinal follow up with the workers who are responsible for the Program.

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