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Public Perception of Government Intervention: Development and Validation of the Effects of the Nanny State on Smoking (ENSS) Scale

İbrahim Hüseyin Cansever

Süleyman Demirel University, Isparta Health Services Vocational School, Isparta, Türkiye

ORCID iDs of the author: İ.H.C. 0000-0002-9999-6789

Main Points

- The opinions of individuals directly affected by the policy in a particular area are essential for evaluating the policy and the steps to be taken in the future.
- This study presents a novel scale for evaluating smokers' acceptability of tobacco control policies.
- In its final form, the scale includes all the preventive policies implemented to reduce cigarette consumption today.
- The statements in the scale will enable both the assessment of how the policies implemented in the current situation impact the affected population and to understand the views on practices that can be expanded.

Abstract

This study aimed to develop a unique, valid, and reliable scale to measure smokers' acceptability of tobacco control policies. Based on the "nanny state" conceptual framework, a draft scale was developed through a systematic scale development process. In the research, the factors obtained from the literature and the items included were examined in consultation with experts, content validity was tested, and reliability analyses were conducted. The data for this study were collected from smokers aged 18 years and older in Türkiye. The draft scale was first administered to 405 smokers; exploratory factor analysis was conducted to determine the underlying factor structure of the scale and a 7-factor form with 30 items was obtained. The updated scale included 7 dimensions: Price, Plain Package, Non-Smoking Area, Media, Disturb, Nanny State's Problems and Costs, and Public Perception. It was applied to 617 people who did not reply to the draft scale, and a confirmatory factor analysis was performed. As a result of the confirmatory factor analysis, the goodness of fit values of the scale were within acceptable limits. A scale was obtained to measure how those directly affected by the policy view the policies with the dimensions.

Keywords: Health policy, nanny state, scale development, smoking, tobacco Control Policy

Corresponding author:
İbrahim Hüseyin Cansever
E-mail:
ihcansever@hotmail.com

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Introduction

Around 1.3 billion people worldwide smoke, with more than 80% living in low- and middle-income countries (LMICs). Tobacco kills more than 8 million people every year. More than 7 million of these deaths are directly attributable to tobacco use, and about 1.2 million are due to secondhand smoke exposure by non-smokers (World Health Organization, 2022). Tobacco use is an important modifiable risk factor contributing to disability and premature deaths (Reitsma et al., 2021). The total economic cost of smoking (including health expenditures and productivity losses) is approximately $1.4 – 1.8 trillion, equivalent to 1.8% of the global annual gross domestic product (World Health Organization, 2021). In addition, the World Health Organization (WHO) report emphasizes that 22 billion tons of water are used in tobacco production worldwide, 2 million tons of packaging waste are generated, and trees cut for tobacco production account for 5% of global deforestation (World Health Organization, 2022).

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World Health Organization (WHO) emphasizes the primary role of governments in addressing lifestyle-related preventable risk factors (tobacco use, unhealthy diet, and harmful alcohol use) in a multi-sectoral manner (World Health Organization, 2003). Governments are responsible for protecting and promoting the population's health and addressing the injustices of health inequalities in society (Coggon, 2018).

Public health interventions by the government are regularly accused of paternalism, as it is emphasized that the government tends to use its power to force individuals to change their behavior (Bellefleur & Keeling, 2018). According to Dworkin (2014), paternalism is the intervention of a state or individual against another person's will, defended or motivated by the claim that the intervened person will be better off or protected from harm. Grill (2013) characterized the normative essence of paternalism as the conflict between respect for freedom and autonomy on the one hand and the protection and promotion of welfare on the other. Paternalism is criticized not because it improves well-being but because it violates freedom or autonomy to achieve it (Bellefleur & Keeling, 2020).

The nanny state broadly describes a paternal state that intervenes unnecessarily and excessively in personal choices (Coggon, 2018; Jochelson, 2006). The nanny state is an essential concept in public health regulation (Fitzpatrick, 2004). It is used to criticize state practices that regulate and control the consumption of unhealthy foods and products such as tobacco and alcohol. The nanny state broadly describes a paternal state that intervenes unnecessarily and excessively in personal choices (Coggon, 2018; Jochelson, 2006). The idea of a nanny state carries connotations of an infantile political vision of a government that treats adults as children in reasoning situations. However, in practice, any measure to protect and promote health, whether or not it is "nannying" in this sense, is accused of being a nanny state (Coggon, 2018). While there is considerable debate about whether government intervention constitutes nanny statism, the role of government in preventive health is not indisputable (Hoek, 2015). Le Grand and New (2015) emphasized the need to carefully analyze what nannying involves and state paternalism. Nanny state policies can create a range of problems and costs. Increased cigarette taxes raise the cost of living and harm people experiencing poverty (who smoke more). Higher prices increase corruption. Over-regulation creates excessive bureaucracy and drains limited resources (Snowdown, 2022).

Evidence shows that tobacco control policies positively change individual preferences and have important implications for better health outcomes (Jochelson, 2006). For example, health warnings on cigarette packages provide information about the risks and encourage reducing cigarette consumption and quitting (Ngo et al., 2018). Similarly, bans and regulations on tobacco advertising, promotion, and sponsorship reduce tobacco sales and consumption worldwide (Blecher, 2008). Well-designed mass media anti-tobacco campaigns can reduce tobacco use, increase quit attempts, reduce youth initiation rates, and reduce secondhand smoke exposure (Durkin et al., 2012). Smokers exposed to mass media campaigns are more likely to quit smoking than those who are not (Naidoo, 2004). Research in low, middle, and high-income countries shows that taxation policy is remarkably effective in reducing tobacco demand (Jha & Chaloupka, 2000). Public attitudes change over time and are often influenced by the enactment of laws, as shown in many studies by the increased acceptability of smoking restrictions after the introduction of bans on smoking in public places (Pursell et al., 2007).

The biggest obstacle to implementing preventative policies is the low level of public acceptance (Diepeveen et al., 2013; Reynolds et al., 2020a). Few studies have been published on public attitudes toward preventive health policies and interventions (Diepeveen et al., 2013). Studies have also investigated how it characterizes public views on government interventions in preventing non-communicable diseases (Grunseit et al., 2019; Jain et al., 2021). Bellefleur and Keeling (2020) conclude their study with a question: *"How is the population affected by this policy, and how does it see these benefits and the possible negative effects of the policy?"* If the policy interferes with the freedom of certain persons, they need to be involved in developing the policy or intervention. Many OECD countries conduct perception surveys to assess or inform the design of regulatory policies. These can be used to understand what is behind the results of surveys, to identify what is acceptable to consumers, and to identify priority areas for future reforms (OECD, 2012).

Understanding the perceptions of individuals targeted by tobacco policies can provide the basis for future policy development and implementation (Diepeveen et al., 2013). This research aimed to develop a unique, valid, and reliable scale to measure the acceptability of tobacco control policies implemented to reduce smoking. Similar scales have been developed (Velicer et al., 1994) but do not include public perceptions and the problems and costs of the practices. This can contribute to developing and assessing tobacco control policies in Türkiye and other LMICs.

Material and Methods

Scale Design

The scale development followed a systematic approach of three stages (Figure 1).

Stage One: Construction

The first stage involved creating an item pool based on the published literature, including similar scales and interviews with seven experts working in the field. The draft scale's content and face validity were also tested at this stage. For content validity, Lawshe's (1975) technique was used, and the experts were asked to choose one of the options: "Appropriate," "Appropriate but should be corrected," and "Should be removed." In addition to the rating in the Lawshe technique (1975), the researchers asked the experts to write their opinions for each item: "If your answer should be corrected, what is your suggestion about how it should be corrected?" If your answer should be removed, "If your answer should be removed, why?". At the end of the stage, the draft scale form was administered to 20 smokers as a pre-test application to understand whether it was comprehensible.

Stage Two: Scale Purification

The second stage was to investigate and examine the factorial structure of the ENSS and reduce the number of scale items (40). The questionnaire was administered to 405 smokers over 18 and

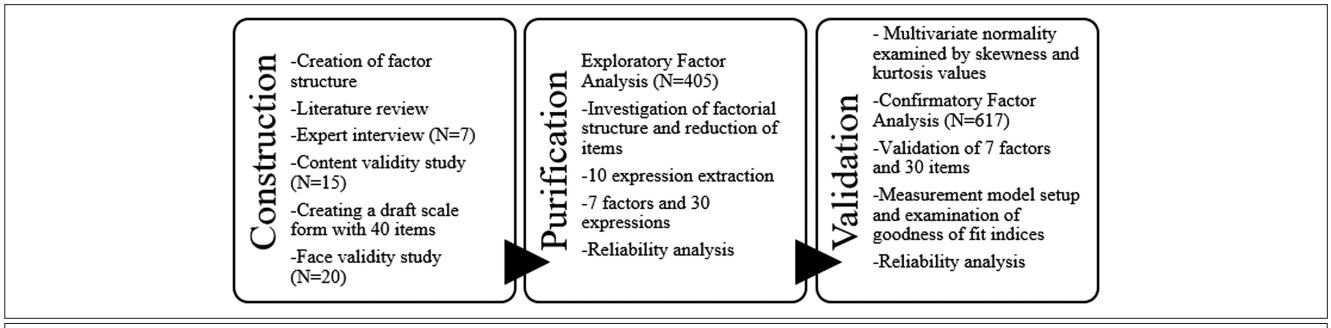

Figure 1. The Process of Scale Development.

used to investigate the factorial validity of the scale. A 5-point Likert-type scale (1: Strongly disagree, 5: Strongly agree) was used in the study. The scale also included 15 questions on demographic characteristics and smoking behavior (Table 1).

Stage Three: Scale Validation

The data was obtained from 405 participants regarding the draft scale form and exploratory factor analysis (EFA). The last stage includes the final 7-factor and 30-expression scale form and the confirmatory factor analysis (CFA) results with the data obtained from 617 participants.

Participants and Data Collection

The Social and Human Sciences Ethics Committee of Süleyman Demirel University (Approval No: 127/6, Date: 25.10.2022). University approved the research with a decision numbered 127/6. The study's universe consists of smokers over 18 in Türkiye. The convenience sampling method selected the participants from among smokers over 18. The data of this study (stage two and stage three) were collected between 25.10 and 26.12.2022. Informed consent was obtained from all participants.

Different participants were involved at each stage. Stage one included face-to-face interviews with 7 experts to create the dimensions and items. The draft scale formed after the interviews was presented to 15 experts. The experts were Public Health, Healthcare Management, Sociology, Public Policy, and scale development academics. Their opinions were obtained through an expert opinion form. The draft scale form was administered to 20 smokers as a pre-test application. Stage two and Stage three contained data collected online via Google Forms from 405 and 617 respondents, respectively.

Results

Stage One: Construction

Firstly, a pool of 42 items was formed based on the published literature and interviews with 7 experts. In determining the possible factors, the policies in practice and discussed in the literature, the concepts in the nanny state debate, and individuals' perspectives on the duties of the state and the policies it implements were considered. Each factor and item was analyzed and reviewed by experts in scale development, and a draft scale was created. The draft scale was first presented to 15 experts. After the content validity evaluation, necessary corrections were made to the scale; 2 items were removed because they had a CVI score lower than 0.50, and a draft scale with 40 items was formed. The draft scale form was administered to 20 smokers as a pre-test application and was found to be comprehensible.

Stage Two: Scale Purification

In stage two, to investigate and examine the factorial structure and validity of the ENSS and reduce the number of scale items (40), the questionnaire was administered to 405 smokers over 18. Then, EFA was conducted using factor analysis with the Direct Oblimin method to extract the factors. Here, items with factor loadings >0.40 were considered, and factors with eigenvalues >1 were selected (Gorsuch, 1983). In addition, the Kaiser – Meyer – Olkin (KMO) sampling adequacy measure was used to indicate the factorability of the data (Tabachnick & Fidell, 2007). The stage obtained a KMO value of 0.894, indicating the adequacy of the sample for factor analysis (Kaiser, 1974). Bartlett's test of sphericity was also significant (X^2 = 7892.567, df = 435, p = .000). The research revealed a 7-factor structure and reduced the scale to 30 items. The naming of the factors followed these. The sub-dimensions were named (1) Price, (2) Plain Package, (3) Non-Smoking Area, (4) Media, (5) Disturb, (6) Nanny State's Problems and Costs, and (7) Public Perception. The scale explained 70.693% of the total variance. As a result of the reliability analysis, it was seen that both the whole scale (0.905) and the 7 factors separately had sufficient internal reliability (.682 – .932) (Table 2).

Stage Three: Scale Validation

After removing the factors from the EFA, stage three was applied to confirm the underlying factor structure of the ENSS. The 7-factor, 30-item scale derived from the EFA was administered to 617 smokers over 18. Confirmatory factor analysis (CFA) was conducted to determine the goodness-of-fit index between the currently factorial structured model. Within the scope of CFA, the recommended chi-square (X^2) ratio degrees of freedom (df), Adjusted Goodness of Fit Index (AGFI), Comparative Fit Index (CFI), Normed Fit Index (NFI), Tucker-Lewis index (TLI), Root Mean Square Error of Approximation (RMSEA), Standardized Root Mean Square Residual (SRMR) fit index values were used to reveal the model fit (Hooper et al., 2008) The measurement model provided a good fit with X^2/df = 3.517, AGFI = .874, CFI = .928, NFI = .903, TLI = .917, RMSEA = .064 and SRMR = .0763 (Jackson et al., 2009). All the fit indices required to obtain a good model fit exceeded the threshold value, thus demonstrating the general acceptability of the measurement model. Confirmatory factor analysis (CFA) explained 73.667% of the total variance. As a result of the reliability analysis, it was seen that both the whole scale (.895) and the 7 factors separately had sufficient internal reliability (.765 – .941) (Table 2). The item-total correlation was

Table 1.
Demographic Profile of the Study Participants.

Demographics	Categories	Stage Two		Stage Three		Demographics	Categories	Stage Two		Stage Three	
		N	%	*N*	%			*N*	%	*N*	%
Gender	Female	151	37.3	244	39.5	Do you plan to quit smoking?	I plan to quit in 1 month	50	12.3	78	12.6
	Male	254	62.7	373	60.5		I plan to quit in 6 months	43	10.6	51	8.3
Age	18 – 25	140	34.6	310	50.2		I plan to quit in 1 year	101	24.9	161	26.1
	26 – 35	108	26.7	110	17.8		I do not plan to quit	211	52.1	327	53
	36 – 45	99	24.4	132	21.4	Why do you plan to quit smoking?*	Religious reasons	17	4.2	22	3.6
	46 – 55	49	12,1	53	8,6						
	56+	9	2.2	12	1.9		Social reasons	34	8.4	44	7.1
Education level	Primary education	13	3.2	12	1.9		Economic reasons	89	22	142	23
	High school	25	6.2	63	10.2		Health reasons	170	42	259	42
							Family reasons	53	13.1	52	8.4
	Bachelor	242	59.8	421	68.2		Other reasons	53	13.1	68	11
	Master degree	71	17.5	67	10.9		I do not plan to quit	179	44.2	269	43.6
	Doctoral degree	54	13.3	54	8.8	To what extent do you know the harmful health effects of smoking?	I do not know at all	7	1.7	10	1.6
Average Monthly Income Level⁺	Under 5500₺	158	39.0	295	47.8		I know a little	19	4.7	20	3.2
	5501 – 10,000₺	76	18.8	124	20.1		I know	61	15.1	109	17.7
	10.001 – 15,000₺	86	21.2	97	15.7		I know well	89	22.0	145	23.5
	Over 15,000₺	85	21.0	101	16.4		I know very well	229	56.5	333	54
How many years have you been smoking?	Under 5 years	109	26.9	214	34.7	Do you have any health problems that require regular check-ups?*	Cancer	5	1.2	10	1.6
	6 – 15 years	152	37.5	232	37.6		Heart disease	8	2	2	3.6
	16 – 25 years	94	23.2	119	19.3		Respiratory system diseases (COPD, Asthma, etc.)	28	6.9	40	6.5
	Over 26 years	50	12.3	52	8.4		Diabetes	15	3.7	21	3.4
How many cigarettes do you smoke on average per day?	1 – 10	146	36.0	237	38.4		Hypertension	15	3.7	22	3.6
	11 – 20	185	45.7	268	43.4		Kidney disease	5	1.2	8	1.3
	21 – 30	48	11.9	70	11.3		Liver disease	4	1	8	1.3
	Over 31	26	6.4	42	6.7						
How long after waking up do you usually smoke your first cigarette?	Within 5 minutes	80	19.8	135	21.9		Other	22	5.4	41	6.6
							I have no health problems	325	80.2	485	78.6
	6 – 30 minutes	111	27.4	172	27.9	Which of the following problems do you experience in your daily life?*	Fatigue	266	65.7	387	62.7
	31 – 60 minutes	84	20.7	116	18.8		Insomnia	191	47.2	292	47.3
	More than 60 minutes	130	32.1	194	31.4		Spiritual tension	163	40.2	248	40.2
Have you changed your cigarette brand in the last year?	I changed due to personal preference	68	16.8	123	19.9		Forgetfulness	136	33.6	206	33.4
	I changed because of the price	119	29.4	177	28.7		Stress	240	59.3	363	58.8
	Did not change	218	53.8	317	51.4		Decreased reflexes	51	12.6	62	10
Do you want to quit smoking?	Yes	218	53.8	324	52.5		Shortness of breath	100	24.7	152	24.6
	No	187	46.2	293	47.5		Difficulty climbing stairs	153	37.8	215	34.8
Have you tried to quit smoking in the last year?	Yes	156	38.5	251	40.7		None of them	13	3.2	23	3.7
	No	249	61.5	366	59.3						

*This is a multi-response variable. ⁺The minimum wage in Türkiye is 5500 Turkish Liras.

Table 2.
Results of Exploratory Factor Analysis and Confirmatory Factor Analysis.

Dimensions	Items	Factor Loading		% of variance	α	AVE
		EFA	CFA	(EFA - CFA)	(EFA - CFA)	- CR
Price	Future increases in cigarette prices will cause me to smoke less.	.906	.907	5.764/ 6.326	.897/ .900	.74/ .90
	Current cigarette prices make me smoke less.	.898	.865			
	Rising cigarette prices make it more likely that I will quit smoking.	.826	.813			
Plain package	The current warnings on cigarette packs (pictures and text) make me smoke less.	.876	.853	3.747/ 3.658	.853/ .835	.62/ .86
	Current warnings on cigarette packs (pictures and text) make it more likely that I will quit smoking.	.863	.875			
	In the future, more warnings (pictures, text, etc.) on cigarette packs will make me smoke less.	.846	.873			
	I support the government putting warning labels (pictures and text) on cigarette packs to reduce smoking.	,558	,475			
Non-amoking area	Smoking bans in certain areas (e.g., public organizations and enclosed spaces) make me smoke less.	.770	.830	6.759/ 3,795	.849/ .889	.62/ .83
	If smoking is banned in new areas (bus stops, playgrounds, etc.) in the future, I will smoke less.	.705	.835			
	I support the government banning smoking in certain areas to reduce smoking.	.616	.690			
Media	In the future, the ban on cigarette adverts and increased censorship of images (on platforms such as Netflix, Disney Plus, etc.) will cause me to smoke less.	.880	.947	31.345/ 30.131	.932/ .941	.71/ .94
	The ban on cigarette advertisements and the censorship of images (billboards, television, clothes, etc.) cause me to smoke less.	.849	.801			
	Increasing the ban on cigarette advertisements and displays (billboards, television, clothing, platforms, etc.) raises my likelihood of quitting smoking.	.773	.929			
	Exposure to advertisements (public service announcements) about the harms of smoking (on TV, social media, etc.) causes me to smoke less.	.721	.832			
	Increasing the number of advertisements (public service announcements) about the harms of smoking would increase the likelihood of quitting smoking.	.693	.717			
	In the future, encountering more advertisements (public spots) about the harms of smoking (on TV, social media, etc.) will cause me to smoke less.	.689	.828			
Disturb	It bothers me to encounter services for cessation of smoking.	.785	.791	4.416/ 7,852	.682/ .765	.57/ .84
	It bothers me that cigarette advertisements and images are prohibited.	.747	.782			
	It bothers me to see advertisements (public service announcements) about the harms of smoking.	.672	.860			
	It bothers me that the places where I can smoke are decreasing day by day.	.547	.554			
Nanny state's problems and costs	The government's continuous increase in the tax on cigarettes led me to use smuggled chewing tobacco, smuggled cigarillos (cigars weighing no more than 3 grams), smuggled cigars, etc.	.933	.921	13.829/ 15,391	.854/ ,877	.62/ .89
	The government's continuous increase in cigarette tax leads me to use electronic cigarettes.	.855	.824			
	The government's continuous increase in the tax on cigarettes leads me to use smuggled tobacco.	.840	.848			
	I think that the policies implemented by the government to reduce the use of cigarettes by society increase smuggling and illegality.	.547	.650			
	The government's tobacco control policies, such as tax increases and smoking bans, interfere with my freedom.	.427	.643			
Public perception	The primary purpose of tobacco control policies, such as tax increases and smoking bans, is to support the healthy life of individuals.	.816	.817	4.833/ 6.515	.820/ .850	.57/ .87
	Tobacco control policies, such as tax increases and smoking bans are justified and correct interventions.	.740	.781			
	If I want to quit smoking, I think the government will support me sufficiently.	.680	.777			
	The government should enact laws to prevent damage to citizens' health.	.625	.674			
	The government has an essential role in protecting the health of its citizens.	.522	.734			

Note(s): EFA, Exploratory factor analysis; CFA, Confirmatory factor analysis; α, Cronbach alpha; AVE, Average Variance Extracted; CR, Composite Reliability.

analyzed, and it was seen that the relationship between the items and the scale total was positive. When the method of dividing the test into 2 halves was used for the reliability analysis of the scale, the items were divided into 2 halves as odd and even, and it was seen that the reliability of the 2 halves was very high with a rate of .953. Finally, to measure the reliability of the scale, the lower 27% and upper 27% group averages were examined, and it was seen that there was a significant difference between the 2 groups ($p < .000$). Convergent and divergent analyses were performed for similarity and discriminant validity of the factors, and Average Variance Extracted (AVE) and Composite Reliability (CR) values are shown in Table 2. Confirmatory factor analysis was performed using AMOS (Version 25.0), and other analyses were performed using SPSS v.23.0 (IBM SPSS Corp.; Armonk, NY, USA)).

The confirmatory factor analysis diagram is shown in Figure 2.

As seen in Table 1, most of the participants included in the study (stage two and stage three) were male participants in both stages. In both stages, it was observed that a significant portion of the participants were 35 years of age and below. It was also observed that the education level of the participants was a bachelor's degree and above. Most participants had been smoking for 6 – 15 years, and the average rate of those who said they smoke 11 – 20 cigarettes daily was higher. It was observed that most participants wanted to quit smoking and had not tried to quit smoking in the last year. Most of those who wanted to quit smoking wanted to quit for health reasons. In support of this, it was observed that most participants were well aware of the adverse effects of smoking on health. Most of the participants stated that they experienced fatigue, stress, and insomnia in daily life. The participant characteristics are similar to the statistical data on smokers in Türkiye. It is known that men and individuals over 35 years of age are more likely to smoke in Türkiye (Turkish Statistical Institute, 2023).

Discussion

The current study aimed to develop a scale to assess the acceptability of government interventions to reduce smoking. The final scale consists of 7 dimensions and 30 items as follows: (1) Price (3 items), (2) Plain Package (4 items), (3) Non-Smoking Area (3 items), (4) Media (6 items), (5) Disturb (4 items), (6) Nanny

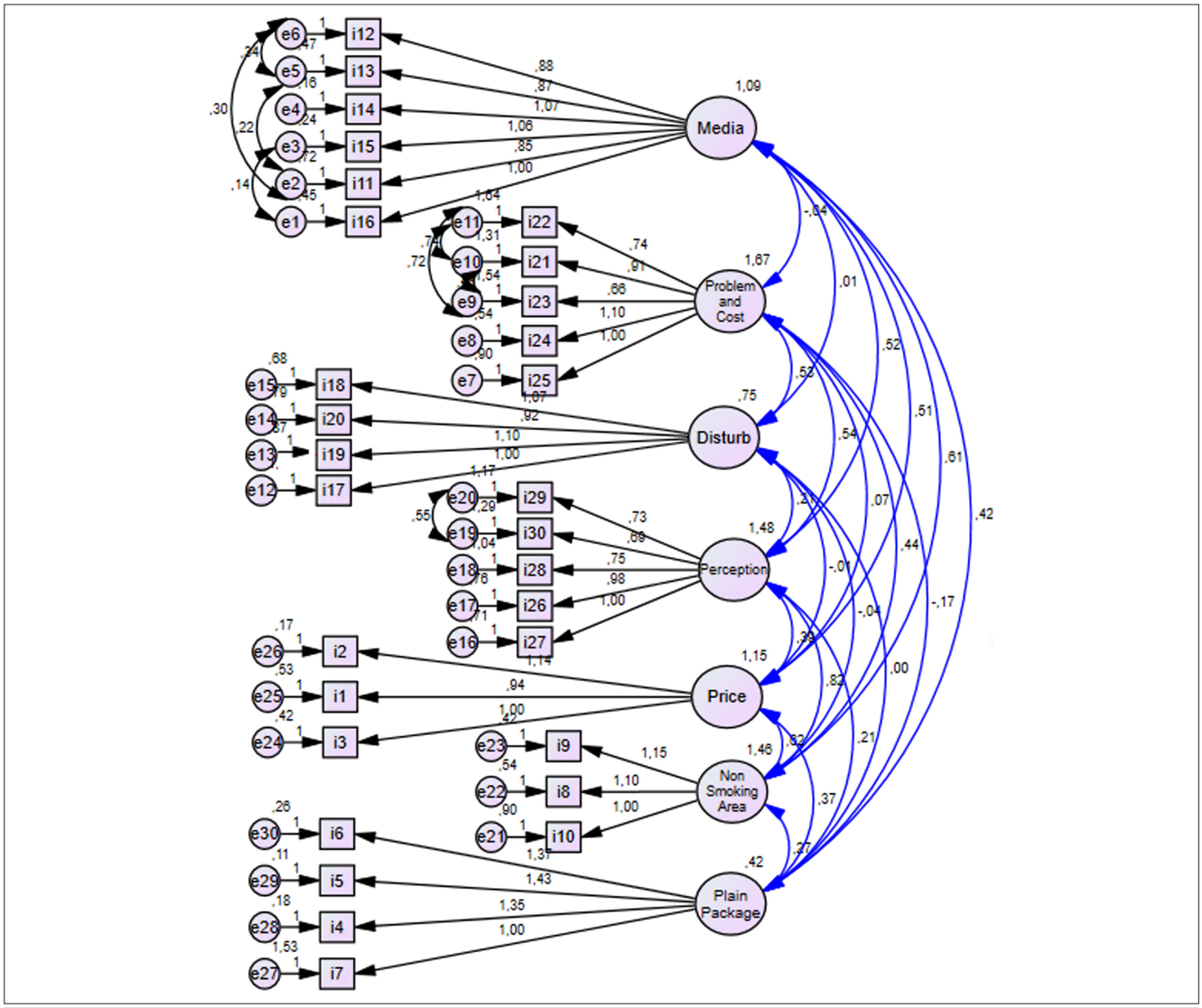

Figure 2. Confirmatory Factor Analysis Diagram.

State's Problems and Costs (5 items), (7) Public Perception (5 items). The reliability analysis showed that the whole scale and the seven factors had sufficient internal reliability. The demographic characteristics of the people who participated in the study and the demographic characteristics of smokers in Türkiye are compatible. The majority of the participants in the study were males and individuals over 35 years of age, and the highest number of smokers in Türkiye is gathered in these 2 groups. This increases the reliability of the results obtained from the scale.

The views of individuals directly affected by the policy in a particular field are very important for evaluating that policy and the future steps to take. Low public support for government interventions in health policy can hinder implementation. Data collected over time are needed to demonstrate any long-term impact on public health (Howell, 2005). It will also be helpful to present the data obtained. For example, Reynolds et al. (2020b) analyzed data from 6498 abstracts and found that communicating evidence of a policy's effectiveness increases support.

The views of those affected by policies and how they perceive the implementation have been overlooked in the policy-making process (Grunseit et al., 2019; Jain et al., 2021). The developed scale includes the standard procedures of the countries and the practices holistically supported by WHO. The items in the scale will enable both the assessment of how the policies implemented in the current situation impact the affected population and to understand the views on practices that can be expanded in the future. In this context, it can potentially guide the policies that can be put forward.

The 5 dimensions in the scale (Price, Plain Package, Non-Smoking Area, Media, and Public Perception) enable measuring how the practices are generally perceived. As seen in the scale, the practices affect smoking to a greater or lesser extent. These 5 dimensions play a critical role in seeing how the feedback is received from the practices put forward to reduce cigarette use. In addition, 2 dimensions (Disturb, Nanny State's Problems, and Costs) are included in the scale to see the positive and negative reactions to state interventions. The first of these dimensions helps reveal which interventions disturbed smokers more. The Nanny State's Problems and Costs dimension provides insight into the adverse reactions to state interventions associated with the nanny state, which is the core of the scale. Since state interventions in the field can lead to many negative consequences, this dimension is essential in the scale. Understanding the results obtained from the scale will provide in-depth information and thus provide valuable opportunities to improve the relevant policies and the welfare of individuals.

It is crucial to obtain society's views on government interventions and use them in the relevant field (Bellefleur & Keeling, 2020). This study addresses the lack of literature on the perspectives of individuals affected by the policies to reduce smoking that all countries have implemented for many years. The number of countries in the world with at least 2 Monitor, Protect, Offer, Warn, Enforce, Raise taxes (MPOWER) policies in place was 98 in 2020, and the number of people living in these countries was approximately 4.4 billion. It is seen that the MPOWER policy will become more widespread with each passing year, and governments will expand their measures (World Health Organization, 2021).

Limitations and Directions/Suggestions for Future Research

There are some limitations to be acknowledged. Firstly, the scale does not capture the perspectives of all stakeholders in the policy-making process regarding government interventions to reduce smoking. Since the data for the scale were collected from a sample taken from only one country, the results cannot be generalized to other settings. Further studies are needed to validate the current structure of the scale in other countries. The current study offers interesting and different sub-area initiatives to measure the attitudes of individuals directly affected by state interventions. This is the first study in Türkiye that aimed to see the effects of the policies implemented by countries to reduce smoking among smokers.

There is plenty of scope for further research. Firstly, the ENSS measure focused only on those directly affected by the policy (only the restriction of those over 18 years of age was applied). Future research may subject this study to specific segments and inter-regional comparisons. The results may be affected by particular conditions such as gender, income, and age. They may also enable the comparison of regions with different practices within a country. In addition, the differences between countries can also be the subject of future studies by collecting data from countries where the same/similar policies are adopted.

Data Availability Statement: The data that support the findings of this study are available on request from the corresponding author.

Ethics Committee Approval: This study was approved by the Ethics Committee of Süleyman Demirel University (Approval No: 127/6, Date: 25.10.2022).

Informed Consent: Informed consent was obtained from the participants who agreed to take part in the study.

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