



Original Research / Orijinal Araştırma

Turkish Adaptation of the Prenatal Smoking Cessation Counseling Scale (PSCSC): A Validity and Reliability Study

Prenatal Sigara Bırakma Danışmanlığı Ölçeği'nin (PSBDÖ) Türkçe Uyarlanması: Bir Geçerlilik ve Güvenilirlik Çalışması

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Abstract

Aim: Smoking during pregnancy is a preventable risk factor, and healthcare professionals play a critical role in supporting women to quit smoking during pregnancy. This study aims at conducting a validity and reliability study of the Prenatal Smoking Cessation Counseling Scale (PSCSC) in Turkish.

Methods: This methodological study was conducted between June 2023 and January 2024 with the participation of 144 healthcare professionals providing prenatal care in a province in southeastern Türkiye. Data were collected using a demographic information form and the PSCSC. The cultural adaptation process was conducted in two stages: linguistic validity and content validity. Construct validity was assessed using exploratory factor analysis (EFA) and confirmatory factor analysis (CFA). Reliability analyses used Cronbach's alpha coefficients and the test-retest method.

Results: EFA revealed a two-factor structure consisting of 18 items, categorized as "Basic Counseling" and "Advanced Counseling". The Cronbach's alpha coefficient for the entire scale was 0.951; for the Basic Counseling subscale, it was 0.967, and for the Advanced Counseling subscale, 0.871. Test-retest analysis indicated a strong positive correlation ($r = 0.866$, $p < 0.001$). CFA results confirmed that the model demonstrated a good fit.

Conclusion: Based on the findings, the Turkish version of the PSCSC is a valid and reliable instrument. It can be effectively used in both clinical practice and research to monitor and evaluate smoking cessation counseling practices during pregnancy.

Keywords: Pregnancy, Smoking Cessation, Counseling, Scale Adaptation, Validity and Reliability, Healthcare Professionals

Özet

Amaç: Gebelikte sigara kullanımı önlenabilir bir risk faktörü olup, sağlık profesyonelleri gebelik döneminde sigarayı bırakma konusunda kadınlara destek olma açısından kritik bir role sahiptir. Bu çalışmanın amacı, Prenatal Sigara Bırakma Danışmanlığı Ölçeği'nin (PSBDÖ) Türkçe geçerlik ve güvenilirlik çalışmasını yürütmektir.

Yöntem: Metodolojik nitelikteki bu araştırma, Haziran 2023 ile Ocak 2024 tarihleri arasında Türkiye'nin güneydoğusunda bir ilde, doğum öncesi bakım hizmeti sunan 144 sağlık profesyonelinin katılımıyla gerçekleştirilmiştir. Veriler, demografik bilgi formu ve PSBDÖ aracılığıyla toplanmıştır. Kültürel uyarlama süreci iki aşamada yürütülmüştür: dilsel geçerlik ve içerik geçerliği. Yapı geçerliği, açıklayıcı faktör analizi ve doğrulayıcı faktör analizi ile değerlendirilmiştir. Güvenilirlik analizleri kapsamında Cronbach alfa katsayıları ve test-tekrar test yöntemi kullanılmıştır.

Bulgular: Açıklayıcı faktör analizi sonucunda ölçek, "Temel Danışmanlık" ve "İleri Düzey Danışmanlık" olmak üzere iki alt boyuttan ve toplam 18 maddeden oluşan bir yapı ortaya koymuştur. Ölçeğin toplam Cronbach alfa katsayıları 0.951; Temel Danışmanlık alt boyutu için 0.967 ve İleri Düzey Danışmanlık alt boyutu için 0.871 olarak bulunmuştur. Test-tekrar test analizinde yüksek düzeyde pozitif korelasyon ($r = 0.866$, $p < 0.001$) saptanmıştır. Doğrulayıcı faktör analizi sonuçları, modelin iyi uyum gösterdiğini ortaya koymuştur.

Sonuç: Elde edilen bulgular doğrultusunda, PSBDÖ'nün Türkçe formu geçerli ve güvenilir bir ölçüm aracı olarak değerlendirilmiştir. Ölçek, gebelik döneminde sigara bırakma danışmanlığı uygulamalarının izlenmesi ve değerlendirilmesinde, hem klinik uygulamalarda hem de bilimsel araştırmalarda etkili bir şekilde kullanılabilir.

Anahtar kelimeler: Gebelik, Sigara Bırakma, Danışmanlık, Ölçek Uyarlaması, Geçerlik ve Güvenilirlik, Sağlık Profesyonelleri

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Introduction

Prenatal smoking is a modifiable factor that negatively affects maternal and fetal health.¹⁻³ Maternal smoking or exposure to passive smoking during pregnancy may be associated with congenital anomalies such as ectopic pregnancy, premature rupture of membranes, placenta previa, placental abruption, abortion, stillbirth, premature labor, low birth weight, and cleft lip.⁴⁻⁶ Despite all these risks, the global rate of smoking during pregnancy is estimated to be 1.7%. The prevalence of smoking during pregnancy is reported to be more than 10% in 29 of 174 countries and more than 20% in 12 countries.⁸ In a large-scale study conducted in 54 low- and middle-income countries, it was reported that the prevalence of any tobacco use during pregnancy was 2.6% and the highest prevalence was 15% in Türkiye.⁸ In studies conducted in our country, rates of smoking during pregnancy vary, with Tarhan and Yılmaz finding it 11.9% and Dilcen et al. finding it 13%.^{4, 16} Pregnancy is a period when regular check-ups are necessary, providing healthcare professionals with an excellent opportunity to motivate people to quit smoking.^{6,8,9} Therefore, healthcare professionals play an important role in preventing smoking and exposure to secondhand smoke during pregnancy.^{3,10} The World Health Organization recommends that healthcare professionals provide routine counseling and interventions to pregnant women who smoke or have recently quit smoking.¹⁸ In this context, it is recommended that short-term psychological interventions be implemented to help pregnant women quit smoking.¹⁰ Within the scope of smoking cessation interventions, the behavioral skills of healthcare professionals are emphasized. It has been reported that behavioral counseling methods such as explaining the reasons for quitting, coping with withdrawal symptoms, and supporting self-efficacy can be effective in individuals' smoking cessation processes.¹²⁻¹⁵ In Türkiye, there is no existing scale used to evaluate the practices and skills of healthcare professionals in prenatal smoking cessation counseling. Therefore, this study was conducted to determine the validity and reliability of the Prenatal Smoking Cessation Counseling Scale for healthcare professionals.

Methods

Type of the study and sample

The methodological study was conducted between June 2023 and January 2024 with healthcare professionals serving women in the prenatal period at a Training and Research Hospital and Family Health Centers located in the center of a province in southeastern Türkiye. The number of healthcare professionals to be included in the study was determined based on the principle that the number of items in the scale (18 items) should have been administered at least 5 to 10 times. Although the sample size was determined based on the 10 times the number of items rule²¹, this approach may have some limitations in DFA analyses.²² However, considering the simplicity of the model in the present study and the expected high factor loadings, the selected sample size is sufficient for reliable parameter estimations. Thus, the study was completed with 144 healthcare professionals. Data were collected by the researchers during working hours from midwives and nurses in the units (obstetrics and gynecology clinics, antenatal care units, family health centers etc.) serving pregnant women at the training and research hospital and family health centers using a face-to-face questionnaire. Healthcare professionals (44) were reached for test-retest. Inclusion criteria for the study were being a nursing or midwifery graduate, voluntarily participating in the study, and providing services to prenatal women. A test-retest analysis was conducted to assess the scale's stability over time. Two weeks after the initial administration, the same scale was re-administered to 44 nurses (Table 1). The data revealed a high positive correlation between the test and retest administrations for the total PSCCS score ($r=0.866$; $p<0.001$). This finding demonstrates that the scale provides consistent measurements over time and has a high level of reliability over time.

Table 1. Test-Retest Reliability Analysis Results (N=44)

	Test	Retest	*
Total Prenatal Smoking Cessation Counseling Scale (PSCCS)	82.45 ± 11.60	83.02 ± 10.94	$r=0.866$ $p<0.001$
*Pearson Correlation			

Data Collection Tools

The “Demographic Form” and the Turkish form of the “PSCCS” created by the researchers were used in collecting data. In this study, the “Demographic Form” and the “PSCCS” developed by Li et al. (2021) were used as data collection tools.

Demographic Form: It was prepared by researchers based on literature and consists of five questions.

Prenatal Smoking Cessation Counseling Scale (PSCCS): The scale was developed by Li et al. as 18 items and a six-point Likert scale.⁹ The scale has two factors, the eleven-item factor 1 sub-dimension is called 'basic counseling' because it includes basic counseling skills, and the seven-item factor 2 sub-dimension is called 'advanced counseling' because it includes advanced counseling skills such as providing smoking cessation methods

and coping with withdrawal symptoms. Basic counseling covers "basic skills" such as explaining the harmful effects of smoking and encouraging the expectant mother to quit smoking using materials such as brochures, charts, and photographs. Advanced counseling covers some advanced skills such as providing smoking cessation methods and coping with withdrawal symptoms. The lowest score that can be obtained from the scale is 18, and the highest score is 108. As the score obtained from the scale increases, the level of prenatal smoking cessation counseling of healthcare professionals increases. The original Cronbach alpha coefficient of the PSCCS was found to be $\alpha=0.918$. Among the factors, the Cronbach alpha coefficient of Factor 1 was found to be 0.864 and the Cronbach alpha coefficient of Factor 2 was found to be 0.89.⁹

Language Validity

To assess the linguistic validity of the PSCCS and identify inconsistencies and omissions in the translated wording, it was translated from English to Turkish by five experts in women's health and public health who are fluent in both Turkish and English. For item comparison, one expert performed a back translation to clarify the linguistic and conceptual adequacy of the translation. This translation was found to be consistent with the original version of the scale.

Content validity

It was sent to five experts who were informed about the concepts in the content of the PSCCS and the purpose of the scale. As a result of the expert evaluations, the content validity index (CVI) of the scale was calculated as 0.85. For this study, the CVI value being above the acceptable value (0.70) indicates that the PSCCS has acceptable content validity.

Data Analysis

The research data were analyzed using SPSS for Windows 25.0 and LISREL 8.7 software. Descriptive statistics, KMO index, and Bartlett's Test of Sphericity were used for initial assessments. For construct validity, Exploratory Factor Analysis (EFA) was performed using Principal Component Analysis (PCA) with Varimax rotation. PCA was selected to explain the maximum variance, while Varimax was preferred to ensure a clear and theoretically distinct factor structure. Following EFA, Confirmatory Factor Analysis (CFA) was conducted within the same study group to verify the structural fit of the newly identified two-factor model. Reliability was assessed through Cronbach's alpha for internal consistency and Pearson correlation for test-retest stability. Model fit was evaluated using RMSEA, GFI, and CFI indices.

Limitations of the Study

Since the data of the study was collected after the February 6, 2023 earthquake, the number of family health centers providing service decreased or the number of healthcare professionals changing provinces, which is a limitation of our study.

Ethical Dimension of the Research

Permission was obtained from Adıyaman University Social and Human Sciences Ethics Committee (08.06.2023-423) for the collection of data in the research. Permission was obtained from the author who developed the scale for the validity and reliability analysis of the scale. In addition, written and verbal consent was obtained from the healthcare professionals before starting the research.

Results

It was determined that the average age of the participants was 31.56 (± 7.22), 121 (84.0%) were female and 23 (16.0%) were male, and 114 (79.2%) stated that they had not received smoking cessation training (Table 2).

Table 2. Descriptive Characteristics of Participants (N=144)

Demographic Characteristics		X $\pm$ SD
Age		31.56 (± 7.22)
		N (%)
Gender	Female	121 (%84.0)
	Male	23 (%16.0)
Working years	0-5 years	57 (%39.6)
	6-10 years	28 (%19.4)
	10 years and above	59 (%41.0)
Education level	High school	10 (%6.9)
	Undergraduate	108 (%75.0)
	Postgraduate	26 (18.1)
Have you ever received training on smoking cessation?	Yes	30 (%20.8)
	No	114 (%79.2)

Construct Validity

Varimax was used as the principal component extraction in the factor analysis of the study. The Bartlett test score of the PSCCS was 2575.105 ($p < 0.001$, Table 3) and the KMO value was 0.945, which is in the appropriate range for the global test. After this stage, exploratory factor analysis (EFA) was performed. As a result of the analysis, two values were found with the screeplot eigenvalues greater than 1.0. The first sub-dimension of the scale (basic counseling) consists of 14 items (1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 13, 14, 17, 18) and the eigenvalue value was found to be 11.737, explaining 65.205% of the variance. The second sub-dimension of the scale (advanced counseling) consists of four items (10, 12, 15, 16), explains 6.324 of the variance, and its eigenvalue was calculated as 1.138 (Figure 1).

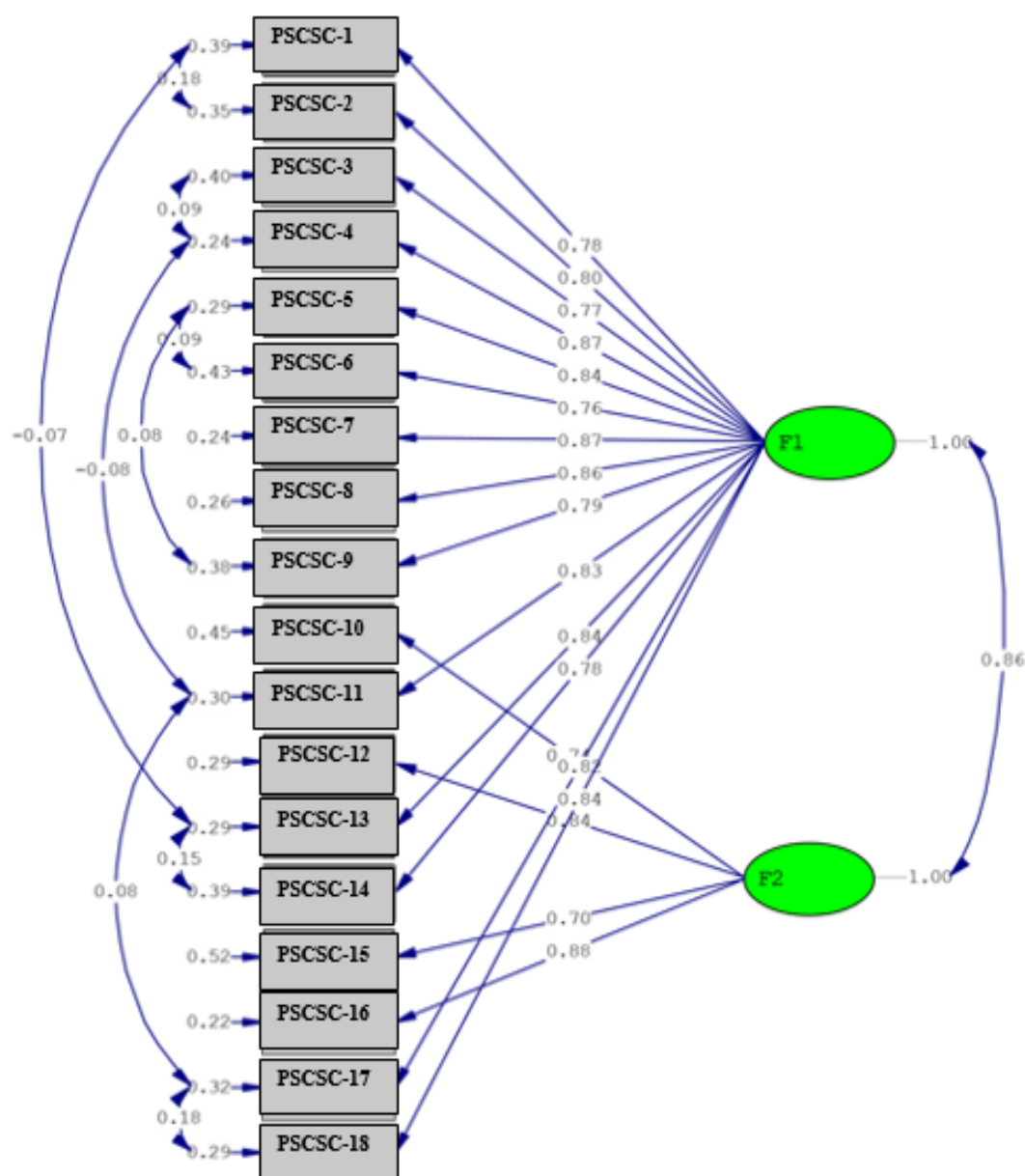


Figure 1. Model for factor analysis of Prenatal Smoking Cessation Counseling Scale (PSCCS)

The factor loading of all items of the PSCCS is higher than 0.30 (Table 3). Following the determination of the factor structure through EFA, Confirmatory Factor Analysis (CFA) was conducted using LISREL 8.7 within the same participant group to verify the structural validity of the newly identified model.

Table 3. Construct validity of the Prenatal Smoking Cessation Counseling Scale (PSCCS): individual item loadings from the exploratory factor analysis (n = 144)

Sub-Dimension	Items	Factor 1	Factor 2	Total item correlation
Basic Counseling				
	PSCCS 2	0.834		0.781
	PSCCS 3	0.806		0.757
	PSCCS 8	0.786		0.831
	PSCCS 5	0.784		0.828
	PSCCS 1	0.778		0.769
	PSCCS 4	0.771		0.845
	PSCCS 7	0.759		0.854
	PSCCS 11	0.755		0.804
	PSCCS 6	0.742		0.731
	PSCCS 9	0.723		0.764
	PSCCS 18	0.721		0.832
	PSCCS 17	0.710		0.815
	PSCCS 13	0.689		0.837
	PSCCS 14	0.660		0.786
Advanced Counseling				
	PSCCS 15		0.862	0.569
	PSCCS 10		0.755	0.643
	PSCCS 16		0.741	0.788
	PSCCS 12		0.685	0.770
Eigenvalue		11.737	1.138	
Percent total variance		65.205	6.324	

The results of the Confirmatory Factor Analysis (CFA) demonstrated that the two-factor structure of the PSCCS provides an acceptable model fit to the data (Table 4).

Table 4. Confirmatory Factor Analysis (CFA) goodness of fit indices (GFI) and Content consistency (Cronbach's α coefficient) of the Prenatal Smoking Cessation Counseling Scale (PSCCS)

	Structural equation modeling variables	Suggested variables
χ^2/df	1.911	≤ 5
Root mean square error approximation (RMSEA)	0.04	≤ 0.08
Goodness of fit (GFI)	0.93	≥ 0.90
Comparative fit index (CFI)	0.98	≥ 0.90
Incremental Fit Index (IFI)	0.98	≥ 0.90
Non- Normed Fit Index (NNFI)	0.98	≥ 0.90
Normed Fit Index (NFI)	0.97	≥ 0.90
Content consistency of the PSCSC		
PSCSC Subscales	No. of items	Cronbach's α coefficient
Factor 1	14	0.967
Factor 2	4	0.871
Total	18	0.951

Abbreviations: CFA, confirmatory factor analysis; CFI, Comparative Fit Index; GFI, goodness of fit index; IFI, incremental fit index; PSCSC, Prenatal Smoking Cessation Counseling Scale; RMSEA, root mean square error of approximation.

The chi-square to degrees of freedom ratio (χ^2/df) was 1.911, which is below the recommended threshold of ≤ 5 , indicating an acceptable model fit. The Root Mean Square Error of Approximation (RMSEA) was 0.04, suggesting a close fit of the model, as values less than or equal to 0.08 are considered acceptable. Additionally, the Goodness of Fit Index (GFI) was 0.93, the Comparative Fit Index (CFI) and Incremental Fit Index (IFI) were both 0.98, and the Normed Fit Index (NFI) and Non-Normed Fit Index (NNFI) were 0.97 and 0.98, respectively. All indices exceeded the generally accepted threshold of ≥ 0.90 , indicating a strong model fit. These results provide strong evidence supporting the construct validity of the PSCCS in the Turkish context.

The content consistency of the PSCCS was evaluated using Cronbach's alpha coefficient (Table 4). For Factor 1, which includes items assessing basic counseling skills, the mean composite score was 65.52 (± 14.59), and the Cronbach's alpha coefficient was 0.967, indicating excellent internal consistency. For Factor 2, which includes items related to advanced counseling skills such as coping with withdrawal symptoms and providing cessation methods, the mean composite score was 17.27 (± 4.58), and the Cronbach's alpha coefficient was 0.871, indicating excellent internal consistency. These results confirm that both subscales of the PSCCS are reliable for assessing prenatal smoking cessation counseling practices among healthcare professionals. Cronbach alpha values were examined to determine the content consistency of the PSCCS and as a result of the analyses, it was determined that the Cronbach alpha values were within the acceptable range.

Discussion

Smoking during pregnancy is a significant public health problem worldwide. The rate of individuals aged 15 and over in Türkiye was 28.3% in 2022, and this rate was found to be 15.5% in women.¹⁷ There are various initiatives by the Ministry of Health in Türkiye regarding smoking cessation. However, there is no scale that evaluates prenatal smoking cessation counseling. The PSCCS is a scale designed to measure the smoking cessation counseling of primary care healthcare professionals during the prenatal.⁹

Scale validity is the degree to which the measurement tool can measure the variable it is intended to measure accurately without confusing it with another feature. Reliability shows how consistently the measurement tool measures the variable it is intended to measure and whether the results are free from errors.^{21,22} The PSCCS was found to be suitable for Turkish society and a valid and reliable tool for measuring smoking cessation counseling in women during the prenatal period.

In order to evaluate reliability in scale studies, Boateng et al. accepted the alpha coefficient of 0.70 as the threshold value.¹ In this study, the alpha coefficient for the total scale was calculated as 0.967, while the sub-dimensions including basic counseling in the first factor sub-dimension and some skills such as providing smoking cessation methods and coping with withdrawal symptoms in the second sub-dimension were calculated as 0.967 and 0.871. In the development study of the scale, the total alpha coefficient of the scale was found to be 0.918, and two factors were found to be above 0.85.⁹ These results were found to be above the reliability value of the scale, and similar results were obtained with the original scale.

Exploratory Factor Analysis (EFA) conducted for the structural validity of the Prenatal Smoking Cessation Counseling Scale is a type of structural equation model that can measure the relationship between observed variables and latent variables. The goodness of fit indexes frequently used in the literature are Comparative fit index (CFI), Normed Fit Index (NFI), Non-Normed Fit Index (NNFI), Incremental Fit Index (IFI) and Root mean square error approximation (RMSEA).²² For a model to be acceptable, the value obtained by dividing the chi-square by the degrees of freedom should be two or less.¹⁸ It was determined that the data obtained in our study showed a good fit to the model.

The scale consists of a total of 18 items with two sub-dimensions. As a result of the EFA analysis of the scale, it explains 65.205% of the total variance. In the development study of the scale, it was determined as two factors and 18 items.⁹ While the factor 1 sub-dimension of the scale includes items that include questions about on four basic counseling, the factor 2 sub-dimension includes 4 items that include some skills such as providing smoking cessation methods and coping with withdrawal symptoms. The structure of the scale was tested using Confirmatory Factor Analysis (CFA), which confirmed that the 18-item model with two sub-dimensions (Factor 1: 14 items; Factor 2: 4 items) demonstrated an excellent fit. This finding indicates that despite the redistribution of certain items compared to the original version, the new two-factor structure is both theoretically sound and statistically valid. While the factor 1 sub-dimension of the scale includes items that ask questions about four basic counseling items, the factor 2 sub-dimension includes four items that address skills such as providing smoking cessation methods and coping with withdrawal symptoms. Confirmatory Factor Analysis revealed that the scale, with its two-item, two-sub-dimension structure (Factor 1: 14 items; Factor 2: 4 items), is at an excellent level. This demonstrates that even if the items were rearranged, the new two-factor structure remains theoretically and statistically valid (Table 4).

In the original study of the scale conducted by Li and colleagues, they found a distribution of 11 items in Factor 1 (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11) and 7 items in Factor 2 (12, 13, 14, 15, 16, 17, 18). In our study, however, 14 items

were identified in Factor 1 (1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 13, 14, 17, 18) and 4 items in Factor 2 (10, 12, 15, 16).⁹ In our study, items 13, 14, 17, and 18 from Factor 2 in Li et al.'s original scale study shifted to Factor 1. Similarly, item 10 from Factor 1 in Li et al.'s original scale study shifted to Factor 2 in our study. Consistent with the original scale developed by Li et al., this study also exhibited a two-sub-dimensional structure. However, when the item distributions are examined, the items in the factors differ from the original scale. This difference is thought to stem from the time period in which the scale was developed and the different cultures and institutional perceptions of the participants included in the study.

The level of smoking cessation counseling provided by healthcare professionals influences success in quitting smoking during pregnancy.^{15,19,20} This study, which validated and reliably adapted the PSCCS into Turkish, is believed to be an important tool for determining the level of smoking cessation counseling provided by Turkish healthcare providers during pregnancy.

Conclusion

This study demonstrated that the Turkish version of the PSCCS is a valid and reliable tool. It can be used to assess and improve smoking cessation counseling practices among healthcare professionals during the prenatal.

Conflict of Interest

None.

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AI Usage Statement

Artificial intelligence-assisted translation tools were used during the process of translating the manuscript into English.

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Appendix-1. Prenatal Smoking Cessation Counseling Scale (PSCCS)

	I completely disagree	I somewhat disagree	I am undecided	I agree	I somewhat agree	I completely agree
1. If the expectant mother lives with a smoker, I explain the benefits of household members abstaining from smoking and get the expectant mother to encourage them to quit smoking.						
2. If the expectant mother lives with a smoker, I explain methods by which the expectant mother can avoid secondhand smoke.						
3. I confirm the expectant mother's intention to quit smoking in each interview						
4. I use interview techniques such as active listening, acceptance, empathy, and motivational interviewing to encourage the expectant mother to quit smoking.						
5. I encourage the expectant mother to quit smoking based on her personal traits (personality, medical history, reasons for smoking, etc.).						
6. If the expectant mother lives with a former smoker who has quit smoking, I compliment household members on quitting smoking and get the expectant mother to ask them to keep it up.						
7. I explain the harmful effects of the toxic substances contained in tobacco (nicotine, tar, carbon monoxide, etc.).						
8. I confirm the smoking abstinence status of the expectant mother and her household members						
9. I confirm the expectant mother's stages of behavioral change toward quitting smoking in each interview.						
10. I use anti-smoking materials like pamphlets, charts, and photos to encourage the expectant mother to quit smoking.						
11. I explain the expectant mother's new role and responsibilities as a mother.						
12. I provide information on smoking cessation outpatient services and smoking cessation clinics that are covered by medical insurance.						
13. I explain that smoking cessation treatment is 'reliable' and 'not very expensive'						
14. I explain that smoking cessation treatment increases the success rate of quitting smoking.						
15. I recommend the use of online easy-to-use smoking cessation support services and programs						
16. I provide some methods on how to deal with withdrawal symptoms after quitting smoking (irritability, headaches, sleeplessness, etc.).						
17. I recommend the expectant mother to ask for support from her family, friends, co-workers, and other acquaintances.						
18. If the expectant mother is still smoking, I communicate that she can start smoking cessation treatment at any time.						

Appendix-2: Prenatal Sigara Bırakma Danışmanlığı Ölçeği (PSBDÖ)

	Hiç katılmıyorum	Biraz katılmıyorum	Kararsızım	Katılıyorum	Biraz katılıyorum	Tamamen katılıyorum
1. Anne adayı sigara içen biriyle yaşıyorsa, aile bireylerine sigarayı bırakmanın faydalarını anlatır ve anne adayının sigarayı bırakması için teşvik etmesini sağlarım.						
2. Anne adayı sigara içen biriyle yaşıyorsa, anne adayına pasif içicilikten korunmanın yollarını anlatıyorum.						
3. Her görüşmede anne adayının sigarayı bırakma niyetini onaylıyorum.						
4. Anne adayını sigarayı bırakmaya teşvik etmek için aktif dinleme, kabullenme, empati ve motive edici görüşme gibi görüşme tekniklerini kullanırım.						
5. Anne adayını kişisel özelliklerine (kişilik, tıbbi geçmiş, sigara içme nedenleri vb.) göre sigarayı bırakmaya teşvik ederim.						
6. Anne adayı sigarayı bırakmış biriyle yaşıyorsa, ev halkını bu kararlarından dolayı tebrik eder ve anne adayından bu durumun devamlılığını sağlamalarını istemesini rica ederim.						
7. Tütünün içerdiği zehirli maddelerin (nikotin, katran, karbon monoksit vb.) zararlı etkilerini anlatırım.						
8. Anne adayının ve hane halkının sigarayı bırakma durumunu onaylıyorum.						
9. Anne adayının sigarayı bırakmaya yönelik davranış değişikliği aşamalarını her görüşmemde onaylıyorum.						
10. Anne adayını sigarayı bırakmaya teşvik etmek için broşür, tablo ve fotoğraf gibi sigara karşıtı materyaller kullanırım.						
11. Anne adayının anne olarak yeni rol ve sorumluluklarını anlatırım.						
12. Sağlık sigortası kapsamındaki sigara bırakma hizmetleri ve poliklinikleri hakkında bilgilendirme yaparım.						
13. Sigarayı bırakma tedavisinin 'güvenilir' olduğunu ve 'çok pahalı olmadığını' açıklarım.						
14. Sigarayı bırakma tedavisinin sigarayı bırakma başarı oranını artırdığını anlatırım.						
15. İnternet üzerinden kullanımı kolay sigara bırakma destek hizmet ve programlarının kullanılmasını tavsiye ederim.						
16. Sigarayı bıraktıktan sonra yoksunluk belirtileriyle (sinirlilik, baş ağrısı, uykusuzluk vb.) nasıl başa çıkılacağına dair bazı yöntemler sağlarım.						
17. Anne adayına ailesinden, arkadaşlarından, iş arkadaşlarından ve diğer tanıdıklarından destek istemesini tavsiye ederim.						
18. Anne adayı hala sigara kullanıyorsa sigarayı bırakma tedavisine her an başlayabileceğini iletiyorum.						