REVIEW ARTICLE

Barriers and facilitators to implementation of smoke-free area policy in public places: a scoping review

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ABSTRACT

Enforcing laws requiring smoke-free areas in different locations is one way the government can lower cigarette consumption and exposure to cigarette smoke. The purpose of this study was, thus, to examine and summarize studies that identified facilitators and barriers to the implementation of a smoke-free area policy in public places. The researchers carried out systematic searches in December 2023 within these specific databases: Scopus, PubMed, ProQuest, Emerald Insight, and EBSCO and included studies on the implementation of smoke-free area policy that were published in English between 2018-2021. Out of the 684 research reports that were found, only 12 were accepted into the scoping study. The findings exhibited several barriers to the implementation of smoke-free area policy, including personal characteristics, the presence of tobacco sellers and smoking aids, lack of enforcement management, lack of support and collaboration from local government, lack of examples of policy implementation by local government, and no smoking signs or smoke-free policy signs. Meanwhile, the facilitating factors encompass fines and penalties, the presence of access to tobacco cessation services, smoke-free policy campaigns, and knowledge and attitudes toward smoke-free area policies. The evidence collected from the review's findings suggests that there are more barriers than facilitating factors. This indicates that numerous adverse behaviors in the implementation of the smoke-free area policy are still present. The subsequent step following this study is to carry out primary research to thoroughly investigate the execution of the smoke-free area policy in public places.

Key words:
barriers; facilitators; smoke-free policy; smoking; smoking bans

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INTRODUCTION

Smoking is one of the social norms in Indonesia that negatively affects the health of both individuals and the environment.[1] Smoking is detrimental to one's health. Nevertheless, it is also detrimental to the health of others, who have a right to breathe clean air and not to be exposed to any toxins from other people's cigarettes.[2] Initially, there are no apparent issues; however, as an individual persists in smoking, a multitude of ailments will progressively manifest in their body.[3]

One of the countries with a high percentage of smokers is Indonesia. About 60 million Indonesians are active smokers. Since the total number of active smokers in Indonesia is increasing day by day, Indonesia has become the third-highest smoking nation in the world in terms of current smokers. It is estimated that Indonesians spend IDR 330 billion to buy cigarettes a day, and 43 million children and 65.6 million women in Indonesia who are exposed to cigarette smoke are impacted by this. This is one of the reasons why Indonesia is ranked first in ASEAN with the highest number of active smokers, at 46.16%.[4]

Enforcing laws requiring smoke-free areas in different locations is one way the government can lower cigarette consumption and exposure to cigarette smoke. Any place or area that forbids smoking, as well as any activity related to the manufacture, distribution, marketing, or promotion of tobacco products, is known as a non-smoking area. Healthcare facilities, instructional spaces, kid-friendly playgrounds, houses of worship, public transit hubs, public areas, and other approved locations are among the designated non-smoking areas.[5] It is anticipated that the regular implementation of smoke-free areas will improve public health, particularly in terms of reducing the risk factors for smoking-related illnesses and deaths and fostering a culture of clean and healthy living.[6] Additionally, by promoting discipline, order, and regulatory compliance, it will enhance the public's perception of the area and its administration. The establishment of smoke-free zones will also affect the environment by enhancing air quality, particularly indoor air quality. In terms of the economy, it will raise families' economic standing by reducing cigarette expenses, particularly for low-income families. Similarly, it will result in a decrease in local government spending on health.[7]

During the literature search, a limitation was found regarding the elements that facilitate or inhibit the implementation of smoke-free area policies in public places. For that reason, this scoping review aimed to highlight and map the barriers and facilitators to the implementation of smoke-free area policy in public places. Furthermore, the outcomes of this review are crucial for advocating with stakeholders or policymakers to enhance the efficacy of implementing smoke-free area rules in public spaces.

METHODS

Arksey and O'Malley's methodology framework was adopted in this scoping review through the following five stages: 1) Research question identification; 2) Identifying relevant studies; 3) Study selection; 4) Data charting; and 5) Collating, 290ummarizing and reporting results.

Step 1: Research question identification

For this review, there were two research questions: What are the barriers to implementing a smoke-free area policy in public places? What are the facilitators of implementing the smoke-free area policy in public places?

Step 2: Identifying relevant studies

This review also used a comprehensive search strategy that was built iteratively through a literature review and by evaluating the outcomes of initial scoping searches to conduct systematic searches in the following electronic databases. Five electronic databases, including PubMed, EBSCO, ProQuest, Scopus, and Emerald Insight, were searched to find research articles that satisfied the inclusion requirements. We conducted a search using the following keywords: "public places," "smoke-free policy," and "smoking ban," which were derived from our inquiries. This review followed the Cochrane and Centre for Reviews and Dissemination guidelines in designing searches. Using the Peer Review of Electronic Search Strategies checklist, two reviewers who were not engaged in the search strategy development process examined the search strategies. The searches were reported as per the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) literature search extension.

Step 3: Studies Selection

The research articles that were found through the searches were managed and screened using the Rayyan program (Rayyan—Intelligent Systematic Review, **https://www.rayyan.ai/** (accessed on December 15, 2023)). Two reviewers (IP and DR) independently reviewed each study's eligibility using a standardized study selection form that was based on the specified research eligibility criteria. After deleting duplicates, the titles and abstracts of all retrieved records were screened, and the full texts of the studies selected in the first stage as potentially eligible were screened after that. Any differences of opinion about which studies should be included were settled through conversation between the two reviewers. Studies were eligible if they fit the inclusion criteria set by the researcher. Inclusion criteria were studies about smoke-free area policy in public places, studies that used any study design type except review articles, publications from 2018-2023, and published in English.

Step 4: Data charting

Charting the data was the next step. A table based on the Joanna Briggs model was created to extract details, traits, and findings from investigations. Two reviewers (IP and DR) examined each of the 12 included studies multiple times to ensure all the relevant information was included. To chart and record all pertinent, and significant data, we created a table. The following categories were included in the data charting stage: author and publication year; study purpose; country; study design; data collection; respondents (number of participants, characteristics) and results.

Step 5: Collating and summarizing the results

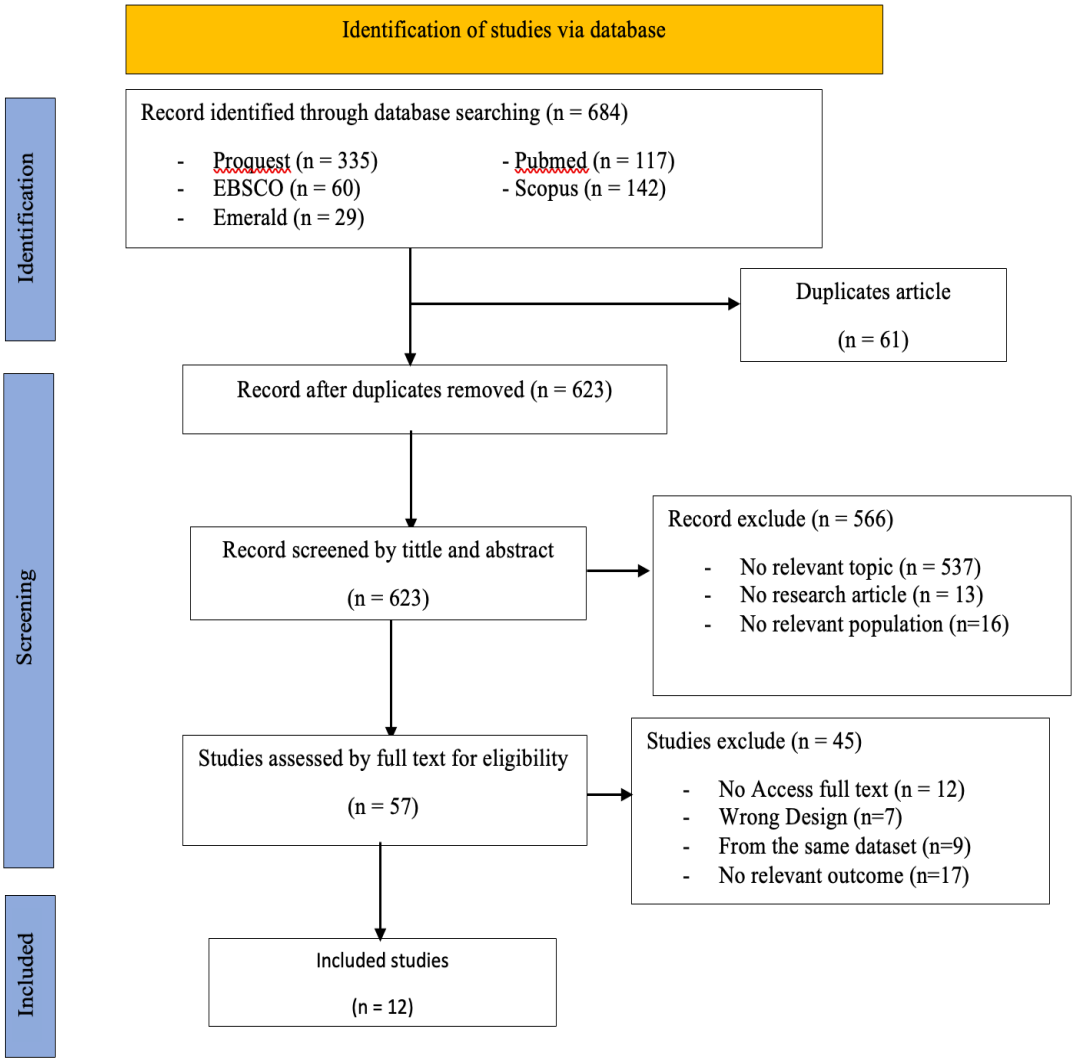
After identifying and classifying different data items using content analysis, we created tables, graphs, and narrative summaries that illustrated the scope, diversity, and character of the research effort. These summaries helped us highlight the major gaps in the body of knowledge and offer suggestions for further investigation.

RESULTS

Search Results

As many as 683 studies were discovered throughout the literature search. The remaining 622 papers were then further analyzed in accordance with inclusion criteria determined by titles and abstracts following the removal of 61 duplicate articles. Articles that failed to meet the inclusion requirements were eliminated during the title and abstract screening

process. To ascertain relevancy, a total of 56 full-text articles received independent screening and discussion. The identification of final papers through the research flow of articles can be observed in Figure 1.



Preferred Reporting Items fot Systematic Reviews and Meta-Analyses ectension for Scoping Review (PRISMA-ScR) search flowchart

General Characteristics of Studies

A total of 12 papers were reviewed in the current scoping review. The included studies were performed in eight countries: Indonesia (n=4), United States (n=1), Vietnam (n=1), Nepal (n=1), Spain (n=1), USA (n=1), Gambia (n=1), Netherlands n=1) and Bangladesh (n=1).

Table 1. Extraction Data

Author and year of publication	Aim	Study Design	Country	Number of participants	Results
Suarjana, et al. 2020[8]	To evaluate adherence to the SFP and investigate any social norms that may have an impact on compliance.	mix of cross-sectional compliance survey and qualitative exploration	Indonesia	n=538: health facilities (n=40), schools (n=40), children's playground (n=14), work places (n=76), worship places (n=35), public transportation (n=40), public places (n=278), and sport center, park (n=15)	Barriers: limitations of no-smoking signs, availability of ashtrays in public places, inadequate knowledge of the regulation, insufficient enforcement by the local government, and inadequate internal monitoring by the manager. Facilitators: Better stakeholder participation in all phases of the smoke-free law's implementation ought to be taken into account. In addition to socialization and education, their involvement should also include enforcement through improved internal monitoring, legal knowledge and attitude, venue managers' assistance, government enforcement system, and smoking social norms.
Chowdhury, et al. 2023[9]	To evaluate the degree of adherence to smoke-free rules and the Tobacco Control Act in public areas inside a northeastern Bangladeshi metropolis.	cross-sectional study	Bangladesh	Public places (n=10)	Barriers: smoking status, the presence of smoking aids (ashtrays, matchboxes, and lighters), the availability of shops selling tobacco products Facilitators: virgorous enforcement of smoke free legislation, the involvement of multiple stakeholders, there was a display of ‘no smoking’ signage, The managers and owners should be well-trained and updated about the laws regarding smoking in public places, including the fines and punishment levied in the cases where these laws are breached.

Author and year of publication	Aim	Study Design	Country	Number of participants	Results
Cham B, et al. 2021[10]	To close this important knowledge gap by evaluating, for the first time, the degree and determinants of adult and adolescent exposure to secondhand smoking in indoor and outdoor public spaces, as well as adherence to smoke-free laws in The Gambia.	A population based survey	Gambia	The target population, i.e., 15–64-year-old individuals. Participants (n=3343)	Barriers: male gender, lack of knowledge of smoke-free laws, poorer household income, and lower levels of education. Facilitators : Higher educated individuals had a reduced likelihood of being around secondhand tobacco smoke than lower educated individuals.
Gatto, et al. 2019[11] 9/6/24 9:54:00 AM	To evaluate understanding, attitudes, and convictions about the policy, the actions of the enforcement branch, and general policy compliance.	Mix methods	US	Students, faculty, and staff (n=5242)	Barriers: feel uncomfortable or they thought the other person would get upset if give a warning to the person who violates it Facilitators: education, and enforcement.
Cheung, et al. 2022[12]	To evaluate a social media campaign promotive of stronger campus support for an existing campus no smoking/no vaping policy	A quasi experimental	USA	Undergraduates students (n=160)	Facilitators: The university should launch social media campaigns and otherwise increase publicity about the policy, enforce the policy more strictly, increase campus signage reminding students that it is smoke- and vape-free, increase health education, designate specific areas of campus as smoking areas, increase campus access to tobacco cessation services, and offer support groups for students who are addicted to nicotine.
Fu M, et al. 2023[13]	To examine how they see acute-care hospitals adhering to the current smoke-free policies, and explain if they are in favor	A cross sectional multicenter study	Spain	University (n=15), students (n=7660)	Facilitators: After smoke-free legislation are put into effect, other tactics may be used to encourage compliance. Signage, communication initiatives, and smoking cessation promotion are a few examples of these.

Author and year of publication	Aim	Study Design	Country	Number of participants	Results
	of smoking prohibitions on hospital and college campuses, both indoors and outdoors.				
Yunarman, et al. 2020[14]	To assess conformance and investigate implementation problems.	Mixed methods design	Indonesia	The facility groups such as health facilities, educational facilities, place of worship, workplaces, indoor public facilities (n=105)	Barriers: lack of knowledge, lack of sensitization, lack of coordination, and limited budget.
Wahyuti, et al. 2019[15]	To assess this bill's conformity and investigate any implementation issues.	Mixed methods study	Indonesia	Facilities (n=192), government officers (n=11), university students (n=8)	Barriers: a lack of cooperation and support from nearby universities and non-governmental organizations, lax enforcement, and a lack of leadership from the community in upholding the law. Facilitatots : Other possible policy measures include more money for enforcement, improved public awareness and monitoring, and more.
Basnet LB, et al. 2022[16]	To evaluate the factors that contribute to active smoking in public areas and the degree to which smoke-free policies are followed in Biratnagar, Nepal.	Cross sectional study	Nepal	Public places (n=725)	Barriers: insufficient authority to uphold the law, The presence of active smoking by owners, managers, and staff, the absence of a "no smoking" sign at the door, and the fact that the public space is a restaurant, entertainment, retail location, or a transit or transportation hub were all strongly linked to smoking in public areas.
Dang, et al. 2018[17]	To investigate the opinions, attitudes, and behaviors of patrons on adherence to tobacco	Cross sectional study	Vietnam	Restaurant’s customer (n=1746)	Barriers: lacked of no-smoking signs, and it was rare or never observed that smoking patrons were informed of the restaurant's smoking ban if they were smoking. Additionally, customers may have felt uncomfortable or

Author and year of publication	Aim	Study Design	Country	Number of participants	Results
	control laws in Vietnamese restaurants located in Hanoi.				unable to tolerate passive smoking, lack of monitoring due to lack of officers, lack of strong law enforcement, and lack of intergovernmental cooperation. Facilitators: People's knowledge, support for the implementation of smoke-free laws, and the government's bolstering of compliance monitoring and evaluation procedures, particularly in restaurants.
Nasution, et al. 2022[18]	To assess the difficulties and compliance with SFP implementation in Medan City, which is now deficient.	Mixed methods study	Indonesia	Public places (n=144)	Barriers: the absence of signage, and the selling of cigarettes. Facilitators: Policymakers at the municipal and national levels should take action by committing more funds to SPF, improve monitoring and enforcement.
Garritsen, et al. 2021[19]	To investigate the opinions of important players at various sports teams in the Netherlands regarding the practical application of outdoor SFPs and the factors that affect it.	Qualitative study	Netherlands	Sport clubs (n=25)	Facilitators: support, talking to smokers, creating and disseminating policies, the athletic club's qualities, a shift in the societal norm around smoking, and backing from regional and national organizations.

Facilitators for implementation of smoke-free area policy in public places

Four factors can support the implementation of smoke-free area policies, consisting of fines and penalties, the presence of access to tobacco cessation services, smoke-free policy campaigns, designating specific areas as smoking areas, and knowledge and attitudes toward smoke-free area policies. Further analysis of each facilitator found in this study is described below.

One of the things that can be a facilitating factor is fines and penalties, which is in agreement with research conducted by Chowdhury et al., and Garritsen et al.[9,19] Furthermore, in accordance with research that has been conducted by Cheung et al., and Fu et al. [12,13,] the presence of access to tobacco cessation services can support people to comply with the policy and help them stop smoking. Specifically, one way to conduct a campaign is through social media.[12,13] The smoke-free policy campaign is, in fact, vital for implementing the smoke-free policy. The last factor that includes facilitating factors is a person's knowledge and attitude. Studies have uncovered that a person's knowledge and attitude towards the implementation of a smoke-free area policy can be influenced by the applicable norms in society, i.e., social norms.[8,10,11,12,17,19]

Barriers to implementation of smoke-free area policy in public places

Besides facilitating factors, various things can act as barriers to the implementation of smoking area policy in public places. These factors are divided into personal characteristics, the presence of tobacco sellers and smoking aids, lack of enforcement management, lack of support and collaboration with local government, lack of examples of policy implementation by local government, and no smoking signs or smoke-free policy signs. In this study, the reviewed articles had more elements that inhibited the implementation than those that supported it. The following descriptions provide additional analysis of each barrier identified in this review.

The first factor is internal factors. Several things are included in the personal characteristics. Lack of awareness was the most significant barrier.[8,10,17] The second factor is smoking status.[9,18] In addition, a study conducted by Cham et al.[10] explains that gender and fears of a lower income can affect the implementation of the policy. Evidence from the included studies revealed that lack of sensitivity becomes one of the barrier factors. Moreover, the final factor included in personal characteristics is the individual's feelings of discomfort if he does not smoke in public places, as explained in Dang et. al.'s research[17].

Additionally, the presence of smoking aids like ashtrays, matchboxes, and lighters and the presence of tobacco sellers can be factors influencing people to smoke in a smoke-free area.[8,9,18] In articles that have been reviewed, barriers often found are the absence of no-smoking signs or smoke-free area policy signs.[8,16,18] Lack of enforcement management, such as lack of internal monitoring by managers of public places, lack of resources for monitoring, limited budget to do monitoring, and discomfort and fear of giving a warning are also among the barrier factors.[8,11,14,15,16,17] In addition, lack of support and collaboration and lack of examples of policy implementation by local governments may affect the implementation of the policy.[15,16,17]

DISCUSSION

The research evidence on the facilitators and barriers to the implementation of the smoke-free area policy in public spaces has been thoroughly

reviewed in this article. The following is a more detailed analysis of each facilitator identified in this study.

Facilitating factors for implementation of the smoke-free area policy in public places

The first thing found in the included studies is the presence of access to tobacco cessation services. This is linked to research by Luck KE et al.,[20] which explains that as the culture of smoke-free public spaces grows, the majority of participants require empowerment and support to try to cut back on their daily cigarette consumption. This is related to the government's initiatives to establish treatment programs for tobacco dependence. These cessation therapies make it "easy" to participate actively in the treatment of tobacco dependency by providing comprehensive access to medication, screening and referral systems, and prescribing guidelines.

The second factor is fines and penalties. The combination of a formal enforcement mechanism with sanctions and a community-based strategy should be taken into consideration by decision-makers.[21] Along similar lines, a study discovered that solid implementation practices can enable the enforcement of indoor smoke-free legislation. Participants in a study highlighted the progressive strategy used by participating managers who had put in place a complete indoor smoking ban that included "leniency," positive messaging, and warnings.[22]

Another study mentioned that designating specific areas as smoking zones is one of the factors that support the implementation of smoke-free policies. This was also found in another study explaining that smokers cited general smoking restrictions on properties as the single biggest obstacle to compliance. The residents who smoke want e-cigarette use to be permitted, as well as smoking spaces on the property. Otherwise, they believed they would keep coming up with ways to "hide" their indoor smoking habit. An outdoor smoking location would assist smokers avoid smoking indoors, according to numerous non-smoking staff members and residents.[23]

Further, in implementing a smoke-free area policy, a campaign is needed. Information delivery in question is the dissemination of information related to a smoke-free area policy. Dissemination of this information must be carried out by the government so that each leader or policy implementer can execute it in accordance with the instructions for implementing non-smoking areas in each work area. For the need for good communication with target groups, such as in the forms of outreach and guidance to the community, it is crucial to implement comprehensive public health campaigns using both non-health and health-related strategies in closed workplaces, public transit, and public areas. Public health experts should lead these programs, which should be coordinated by local government and involve community leaders. They should cover a range of subjects, such as the dangers of smoking and how to help people give it up.[24] Additional research reveals that smoking ban promotion media will raise academic community awareness and knowledge of TFC applications on campus, which lends credence to this explanation.[21]

Another supporting factor discovered from the reviewed articles is knowledge and attitudes toward smoke-free area policies. Attitude plays a crucial role as it influences decisions regarding smoking behavior. Furthermore, attitude is the manifestation of an individual's conduct that arises from their understanding, expertise, drive, and surroundings, which impact their perception of the hazards associated with smoking. With the acquisition of accurate information and comprehension, an individual is capable of executing or manifesting conduct with precision and appropriateness.[33] Similar evidence was found in a study showing that

low education is an individual risk factor for smoking, which means that when someone has good knowledge about smoke-free areas, they will have the opportunity to implement smoke-free areas by 4,148 times compared to individuals who lack information.[25] In addition to knowledge in the community, owners or managers of public places who have good knowledge about the dangers of smoking for health are more willing to limit or prohibit smoking in their environments. The higher the level of knowledge a person has, the better the implementation of smoke-free areas in that place. Good knowledge will also determine the direction of no-smoking policies that can benefit, especially in efforts to prevent diseases caused by smoking, such as stroke, heart disease, diabetes, and others.[26]

Also, community support is required to improve compliance with the no-smoking area policy. This implies that smokers who exhibit positive behavior are 5.406 times more likely to support the establishment of no-smoking areas than those who exhibit less positive behavior. Furthermore, the better (positive) a person's attitude, the better their participation in the implementation of smoke-free areas. Individual attitudes will also be influenced by the social norms they adhere to. A similar thing was uncovered in research conducted by Crosby et al. (2018), revealing that in a hospital, these social norms were predicted by theory, namely by drawing attention to the fact that most patients, staff, and visitors report not smoking at the hospital entrance and that those who smoke there are more likely to follow the 'standard' and make the entrance smoke-free. Given that the majority of people support keeping the entrance free from smoke, this may inspire others to follow the "norm" and refrain from smoking or to smoke somewhere else. It may also give staff members the bravery to confront smokers at the door.[26]

Barriers to implementation of the smoke-free area policy in public places

The first factor identified as a factor inhibiting the implementation of the smoke-free area policy is personal characteristics, covering several factors. The first is gender, which is significantly associated with attitudes towards policy compliance and enforcement; this is related to the low use of tobacco among women compared to men, so non-compliance with the implementation of this policy is more likely to be among male respondents.[27] The prevalence of smoking was significantly higher in males compared to females, with males having a smoking rate that was 33 times higher than women. This could be attributed to the prohibition of tobacco consumption among women, in addition to the perception that smoking is socially acceptable among men.[33]

The next one is smoking status. This aligns with the results of other studies conducted in hospitals showing that smoking status in managers of public places has a relationship with participation in the implementation of smoke-free areas. The data clearly shows that staff who smoke exhibit much greater resistance to the implementation of measures to create a smoke-free environment in public places.[28] In addition, research conducted at universities unveils that students who use tobacco products are less in favor of school regulations that are completely smoke-, tobacco-, and vape-free. These results highlight the significance of expanding access to smoking cessation support services in order to assist existing tobacco users and more successfully direct them toward health education and counseling.[27] This point is reinforced by a study conducted by Riza et al. (2023), explaining that some public places such as restaurants,

cafes, bars, nightclubs, or other places show a higher level of non-compliance because managers may think the implementation of the no-smoking areas in restaurants or cafes will deter visitors and generate low income. Because the principle of restaurants and cafes is to seek maximum profit, they assume that the implementation of a no-smoking area will harm their businesses.[4]

Moreover, lack of awareness and sensitivity are interconnected. These factors can be associated with someone who has a low level of knowledge of the dangers of smoking and smoking ethics, which may lead to a lack of awareness of personal health, making it difficult for individuals to quit smoking so that it will result in difficulty in complying with the smoke-free policy that has been implemented.[21] There is a need to raise public awareness to comply with existing policies.[29] Gaining the cooperation of all parties involved requires first spreading awareness of the significance of smoke-free zones. School communities are more open to the adoption of the policy when they are given thorough and understandable information about the health benefits and the reasoning behind it. Campaigns to raise awareness, workshops, and educational programs can all aid in educating people about smoke-free zones and how they contribute to a safer and healthier atmosphere.[30]

The presence of tobacco sellers and smoking aids should also be identified. In Indonesia, pocket money, community use of branded tobacco products, and easy access to cigarettes near schools are the three key factors influencing tobacco use today.[30] On the other hand, most smokers, in fact, desire to give up smoking. Shutting down tobacco retail businesses would help these individuals and probably boost the incentive for those who are not yet considering quitting, particularly if this is accompanied by demand reduction strategies like public awareness campaigns and a greater number of people leaving support programs.[31]

The third inhibiting factor found is the lack of enforcement management. Respondents often cited a lack of enforcement as a deterrent to the establishment of smoke-free properties. According to earlier studies, the majority of hospital employees found it awkward to confront smokers and enforce a smoke-free policy; some believed that security services should be in charge of doing so. There may also be contributing factors, such as the unwillingness to contact smokers directly and the belief that security should be a part of this.[20] Employees believed that enforcing the policy strongly and consistently was crucial for achieving compliance; however, there were obstacles to enforcement, such as staff members acting as policy enforcers, the inability to enforce the policy at all times, and reliance on maintenance personnel and conflicted residents to report infractions.[23]

The availability of resources is another requirement for the smoke-free policy's implementation. The facilities and infrastructure needed to implement the no-smoking area law are the resources in question, as well as human resources to execute the policy. Qualified human resources both in the agency implementing the activity and the community as the target of the regulation will further support the implementation of the regulation. The ability of resources to implement policies, sources of funds, and the availability of facilities and infrastructure to support the successful implementation of smoke-free area policies is such as forming a special team of task forces enforcing and supervising smoke-free areas. Furthermore, in order to facilitate the successful implementation of the policy, it is necessary to implement additional resources, including budget funds and facilities that support non-smoking zones, such as special smoking areas, information boards on smoking restrictions, posters on

smoking restrictions, and circulars on smoking restrictions.

Lack of support and collaboration with the local government was identified as one of the factors inhibiting the implementation of the smoke-free policy. Policy implementation must be supported by the government, the private sector, and the community. The community acts as a target group that must also support the implementation of the smoke-free area policy. To achieve successful implementation of public policy, good communication is required between the implementor and the target group. With good communication between the two parties, the information will be clearer. As a result, there will be consistency from the implementors in carrying out every policy to be applied in the community. Several strategies exist to increase government leaders' commitment to enforcing smoke-free area regulations, including strong public support for smoke-free area policies, the public standing of tobacco control advocates, and fostering greater familiarity and trust between civil society, government leaders, and citizens. Top-down directive orders are one such strategy that can increase political commitment for lower-level law enforcement actors. It is also critical to provide a neutral forum for stakeholders to debate smoke-free area policies and how best to implement them in order to exchange ideas on successful enforcement tactics.[24]

The lack of examples of policy implementation by local governments is a further inhibiting factor. The majority of workers thought that they should not smoke in front of patients since they are role models for them. The data clearly indicates that the management system influences the behavior of smokers; when the manager is compliant with the smoke-free policy, smokers will also comply with the policy, and vice versa; if in public places, the level of compliance of the manager is not good, it will affect the level of smokers in the place.[32]

The last inhibiting factor is the unavailability of no-smoking signs or smoke-free policy signs. In a study conducted by Al-Jayyousi et al. (2021), the absence of resources, such as no smoking signage, was cited by over 50% of respondents as a hindrance to the implementation of the smoke-free policy. These signs encourage law enforcement, warn people of the smoke-free regulations, and influence people's decision to smoke indoors.[27] After the no-smoking area policy law, more places should put up no-smoking signs and cancel the provision of ashtrays and other items. When managers implement these three measures in public places, the level of compliance will also increase.[32] Empirical studies have also indicated a correlation between the placement of smoking ban signs in key locations and the observance of smoke-free areas.[21]

RECOMMENDATIONS

Implementing a smoke-free area policy in public places is increasingly recognized. However, the implementation of this SFP in public places settings has faced some barriers such as personal characteristics, the presence of tobacco sellers and smoking aids, lack of enforcement management, lack of support and collaboration with local government, lack of examples of policy implementation by local government, and no smoking sign/SFP signs. The facilitators for the implementation of a smoke-free area policy in public places include knowledge and attitudes toward a smoke-free area policy, the presence of access to tobacco cessation services, fines and penalties, and implementing a smoke-free campaign via social media. The reviewed articles had

more elements that inhibited than those that supported smoke-free policy regulations. The findings of this research are crucial for stakeholders and policy makers to assess and promote the effectiveness of implementing smoke-free area regulations in public settings. In the future, policymakers can employ various strategies to enhance compliance rates. These may include intensifying socialization activities to augment public awareness regarding the implementation of SFP policies, offering smoking cessation therapy, and fortifying regulations or legal frameworks by imposing more stringent sanctions on individuals who contravene them. Additionally, additional research is required to thoroughly investigate the application of SFP rules in public spaces.

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