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IMPLEMENTATION ANALYSIS OF THE NO SMOKING AREA POLICY: BRIDGING THE GAP BETWEEN NORMATIVE GOALS AND FIELD REALITIES IN URBAN AND RURAL CONTEXTS

[1]Wira Iqbal, [2]Alfan Miko, [3]Yevita Nurti, [4]Hendri Koeswara
[1]Faculty of Public Health, Andalas University
[234]Faculty of Social and Political Sciences, Andalas University.

Email:
wiraiqbal@ph.unand.ac.id

ABSTRACT

The No Smoking Area (KTR) policy is one of the efforts to control the health effects of exposure to cigarette smoke. Its implementation shows a gap between normative goals and reality in the field. Implementation disparities between urban and rural areas indicate that the local context plays an important role in the effectiveness of the policy. This study aims to evaluate the effectiveness of KTR implementation in Indonesia through a *Systematic Literature Review* approach with a focus on comparison between urban and rural contexts. The review procedure was conducted based on the PRISMA protocol by screening scientific literature from the Scopus database. KTR implementation faces multidimensional challenges ranging from weak cross-sectoral supervision and coordination, low public awareness, and social resistance to regulations. Compliance is higher in health facilities, but still low in other public spaces, especially in areas with limited institutional capacity. This paper emphasizes the importance of a policy implementation approach that is adaptive to local characteristics and actively involves community actors. This paper also offers practical implications for strengthening KTR policy governance in a more participatory and sustainable manner to support public health development goals.
Keywords: Implementation, Policy, Smokefree Areas, Inequality, Urban, Rural

Introduction

Smokefree Areas (KTR) have become a public health policy instrument that is globally adopted to reduce exposure to cigarette smoke and its impact on public health. In various countries, the implementation of this policy has been proven to reduce morbidity due to exposure to cigarette smoke, both directly and indirectly. (Sansone et al. 2019) . However, inequalities in the implementation and effectiveness of these policies are still found, especially between urban and rural areas. In the United States, for example, longitudinal studies show that households in rural areas have a lower tendency to establish indoor smoking policies compared to urban or suburban areas. (Mantey et al. 2022) . In the Indonesian context, although the KTR regulation has been stipulated in Law No. 36/2009 and strengthened by regional regulations in various regions, violations of this policy still occur frequently, indicating structural and socio-cultural challenges in its implementation in the field.

There is a significant gap between the normative objectives of the KTR policy, which is idealized as a form of protection of the right to public health, and the reality of

its implementation in various regions, especially between urban and rural areas. Previous studies highlight that rural areas often experience structural barriers in terms of supervision, education, and community support for KTR implementation. (Hahn et al. 2015) . In addition, community perceptions of individual rights and freedom to smoke are challenging, particularly in communities with high smoking prevalence and minimal health education interventions. (Rayens et al. 2016) . This suggests that a top-down approach that relies solely on formal policies is not sufficient to ensure the successful implementation of KTR. Therefore, systematic analysis of the barriers and supporters of KTR implementation in various regions is crucial in filling the gap between policy theory and field practice.

In understanding the dynamics of KTR policy implementation, a theoretical approach is important to explain how policies are formulated, implemented, and accepted by the community. This research adopts *policy implementation theory*, which views the success of implementation as largely determined by the interaction between implementing actors, the socio-political context, and the capacity of institutions that support it. (Kegler et al. 2019) . This approach also allows for the examination of contextual factors such as local culture, power structures, and social values that often influence the effectiveness of policy implementation at the local level. (Fallin et al. 2014) . Thus, the analysis of the KTR policy does not only talk about the existence of rules, but also how these rules are actually implemented in the community.

This study aims to evaluate the effectiveness of the No Smoking Area policy in the context of urban and rural areas through a *Systematic Literature Review* (SLR) approach. The main questions raised are: *How does the difference in implementation of KTR between urban and rural areas create a gap between normative objectives and the reality of policy implementation?* To answer this, this study will synthesize the latest scientific findings related to factors that support and hinder the implementation of KTR in various regions and countries. Using the *PRISMA* framework, this study identifies relevant thematic patterns to provide a comprehensive understanding of the dynamics of policy implementation in different spatial contexts. (Lee et al. 2015) .

This article offers a significant scholarly contribution in two main aspects. First, it fills a knowledge gap by presenting a systematic synthesis of KTR implementation disparities between urban and rural areas, which has not been studied in a focused manner. (Jones et al. 2022) . Second, this study provides policy implications that can be used by policymakers, civil society organizations, and the public health sector to design intervention strategies that are more responsive to local contexts. The findings will also enrich the literature on community-based health policies and can be used as a basis for strengthening KTR policies to support the achievement of the Sustainable Development Goals (SDGs), particularly on aspects of health and well-being. (Riker et al. 2015) .

Policy implementation theory is the main conceptual foundation in this study. In general, this theory examines how a policy is carried out by field implementers and how responses from target groups affect the success of implementation. One of the widely used policy implementation models is the George C. Edwards III model, which emphasizes four main variables: communication, resources, implementer disposition, and bureaucratic structure (Kusumawati and Africia 2020). This model is relevant to analyze the No Smoking Area (KTR) policy because its implementation is strongly influenced by contextual factors such as political support, organizational culture, and the capacity of public institutions. On the other hand, the *collaborative governance*

approach has also begun to be used in KTR policy studies to assess the extent to which coordination between stakeholders strengthens policy effectiveness (Muazzinah et al. 2023).

Mapping of previous studies shows that the implementation of KTR policies in various regions shows a uniform pattern, namely weak law enforcement, low public awareness, and a lack of supporting resources. In Palu City, KTR implementation is considered ineffective due to weak cross-sector communication and low community compliance with existing regulations. (Syukur, Hattab, and Mangngasing 2024) . Similarly, in Jeneponto Regency, indicators such as communication, resources, disposition, and bureaucratic structure show suboptimal performance, so that the implementation of KTR policies has not been in line with its regulatory objectives. (Sakawati, Hamrah, and Halim 2023) . Another study conducted by Rosmayanti and Permana (2024) identified a number of barriers, such as a lack of law enforcement, the absence of smoking ban boards, and the unavailability of smoking cessation services, which collectively hinder the effectiveness of KTR policies in public spaces. (Rosmayanti and Permana 2024) .

However, from all these studies, it is clear that there are not many studies that specifically dissect implementation disparities between urban and rural areas. This gap is a concern because there are significant differences in the social, economic, and cultural contexts between the two areas that can affect the success of KTR policies. A study in a work environment in Palembang, for example, focused only on internal organizational barriers without looking at spatial or geographical factors. (Iriani 2018).

Research in schools in East Java also showed that most teachers and staff still smoke in the school environment, but did not link this phenomenon to the social structure of the local area. (Kusumawati and Africia 2020) . Thus, the theoretical and practical gaps in the literature related to spatial differences in the implementation of KTR policies are still wide open for in-depth research.

This article positions itself as an attempt to address this gap by presenting a systematic synthesis of the literature evaluating the implementation of KTR policies in urban and rural areas. The *Systematic Literature Review* approach used allows researchers to screen, compare, and classify relevant findings to identify differentiating factors in policy implementation based on regional context. This study also utilizes the PRISMA framework to ensure transparency and accountability in the literature selection process. By focusing on contextual aspects, this study contributes to the broadening of the theoretical and practical horizons of public policy implementation, particularly in public health and tobacco control issues.

In terms of methodological approach, previous studies are still dominated by descriptive qualitative approaches with case study designs in specific areas, such as Banda Aceh, Bekasi, and Langsa. (Maswita, Sudaryati, and Juanita 2020) ; (Sulistyo, Sutrisno, and Indraswari 2025) . While this approach provides a strong contextual picture, limitations on generalizability and external validity are still noted. In this regard, the use of SLR provides a more robust methodological alternative for answering research questions that are synthesized across studies and regions. In addition, this approach also provides an opportunity to identify consistent patterns and trends as well as anomalies that require further attention in public policy making.

Based on the conceptual synthesis of the discussed literature, it can be concluded that the implementation of KTR policies cannot be separated from the complex interactions between policy structure, institutional capacity, socio-cultural

context, and spatial characteristics of the implementation area. In this case, policy implementation theory is an adequate framework to analyze these complexities. This article will use this framework as a basis for developing a systematic analysis of the effectiveness of KTR policies in urban and rural areas, by highlighting how the local context affects the success or failure of the implementation of policies that have been formulated nationally.

Methods

This research uses the *Systematic Literature Review (SLR)* approach as the main strategy. PRISMA's structured approach assists in identifying gaps in the literature and provides a basis for future research, thus contributing to the advancement of evidence-based practice. (Kaiser, Schuhmacher, and B s n.d.) , which allows the synthesis of scientific findings from various previous studies in a systematic, transparent, and replicable manner. This approach was chosen to evaluate the implementation of Smokefree Area (KTR) policies in urban and rural contexts through an in-depth review of studies that have been published in reputable scientific journals. This systematic model is in accordance with the PRISMA (*Preferred Reporting Items for Systematic Reviews and Meta-Analyses*) methodological framework, which has been widely recognized as a standard for systematic reporting in policy and public health studies. (Verboom and Baumann 2022) .

Data sources in this study are secondary and obtained from scientific literature published in the last five years. The databases used include Scopus, PubMed, and SINTA. The types of data reviewed included peer-reviewed journal articles that discussed the implementation of KTR policies or health policies related to tobacco control in urban and rural areas. The selected literature consisted of empirical and theoretical studies that met the criteria of methodological and substantive relevance to the research topic. (McLeroy et al. 2012) . This approach allowed for a broad exploration of the available scientific evidence to answer the research questions within an established conceptual framework. (Glor 2022) .

The literature data collection process was conducted through a systematic search protocol using combinations of English keywords such as *"smoke free""policy""implementation" "urban""rural."* The search strategy followed the PRISMA-S format, an extension of PRISMA that specifically emphasizes transparency in reporting the literature search process (Rethlefsen et al. 2021). The search was conducted between 2018 and 2024 to ensure the currency of information, and only open-access articles with abstracts and full text were included in the initial selection process.

The unit of analysis in this study is not individuals or field populations, but scientific articles as units of information that are analyzed thematically. Each article was examined based on the study location, methodological design, policy focus, and factors affecting implementation success or failure. In addition, each publication is also analyzed for the use of theory, implementing actors, and the socio-cultural context underlying the implementation of the KTR policy. (Sina and Nazemi 2022) .

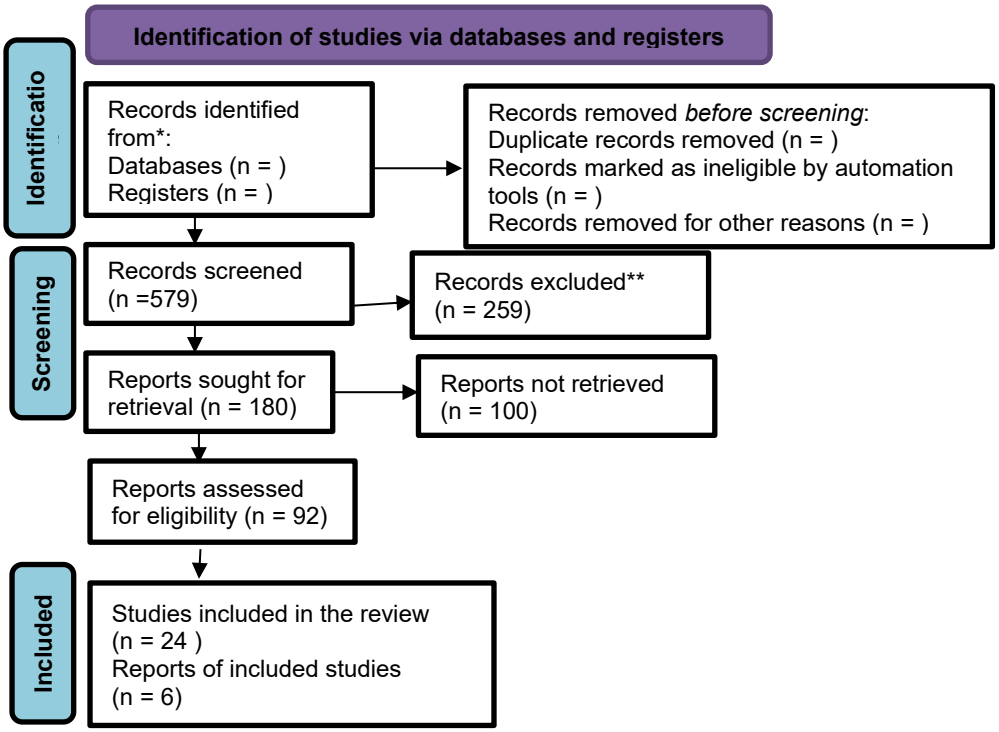

Figure 1. Diagram of the study flow

To assist with the data organization and systematic documentation process, the researcher used the PRISMA category-based *spreadsheet* as a manual tool. Although not using qualitative analysis software such as NVivo or Atlas. The analysis structure followed the *transparent reporting* workflow as recommended in PRISMA-Ethics for policy-based literature research. (Kahrass et al. 2021) .

Results

The results of this study were compiled based on a *Systematic Literature Review* process of 20 scientific publications related to the implementation of the No Smoking Area (KTR) policy in Indonesia, with a focus on the context of urban and rural areas. The synthesis was conducted using a narrative-thematic approach that summarizes the publication characteristics, trends in findings, methodologies used, as well as the main themes that emerged from the analyzed literature.

Publication characteristics showed that the majority of studies were from the 2019-2024 period and published in reputable national and international public health journals. Most of the studies used qualitative or *mixed-methods* approaches, with a regional focus on large cities such as Yogyakarta, Medan, Bandung, and Jayapura, as well as several rural districts such as Blitar and Bantul. Common themes in this publication include the level of compliance with KTR, barriers to implementation, and the role of community participation and local institutions.

In general, the level of compliance with KTR in various regions is still relatively low. A study in Medan City found that only 44% of public facilities met the six criteria of the KTR policy, with the highest level of compliance in health facilities (83%) and the lowest in outdoor public facilities (0%) (Nasution et al. 2022) . Similar findings were also found in Jayapura, with an average compliance rate of only 17%, which also showed no significant spatial pattern between the city center and peripheral areas.

(Wahyuti et al. 2019) . Meanwhile, a study in Blitar showed high community support for the KTR policy (94.5%), but policy implementation still faces challenges in monitoring and coordination between related parties. (Widati et al. 2024) .

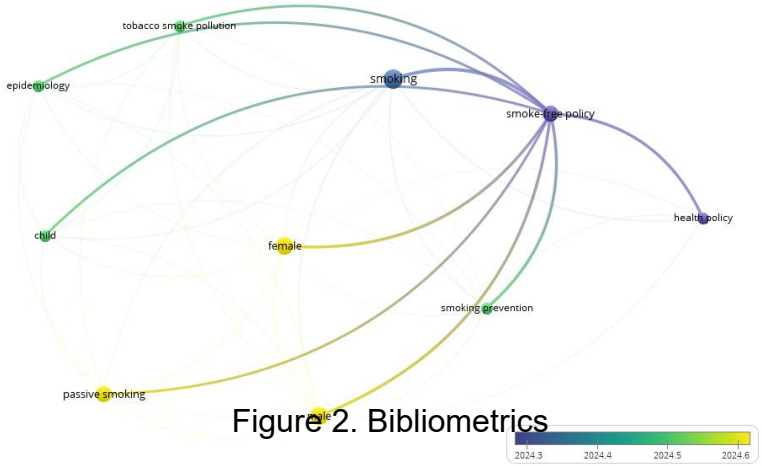

Figure 2. Bibliometrics

Several publications present the challenges of consistent KTR policy implementation between urban and rural areas. These challenges include low public awareness, a lack of monitoring budget, weak legal sanctions, and resistance from the community or businesses. A study in Yogyakarta found that although many hoteliers have implemented KTR, consumer resistance and unclear government sanctions are the main obstacles. (Sutantri et al. 2024) . Meanwhile, a similar study in Bekasi showed that limited supporting facilities and low public knowledge weakened policy effectiveness. (Sulistyo, Sutrisno, and Indraswari 2025) .

A synthesis of methodological trends shows that the majority of studies use observational and *cross-sectional* approaches, both with field surveys and in-depth interviews. For example, a study in Bengkulu that evaluated compliance in 105 public facilities showed that only 38% met the six KTR criteria, with significant variation between facility types and locations. (Yunarman et al. 2020) . On the other hand, a community-based study in Bantul used a linear regression approach to evaluate the effect of the "Smoke-Free House" policy and found an increase in awareness of protection of women and children by more than 50% among smokers. (Trisnowati et al. 2019) .

Thematically, there are four main categories in the literature findings: (1) the level of compliance with KTR policies; (2) structural and cultural barriers to implementation; (3) differences in urban vs rural contexts; and (4) the role of local and community actors in driving policy success. A study in Bandung that utilized a *netnography* approach emphasized the importance of the digital community's response to KTR expansion and showed that distrust of the policy was the main barrier to implementation in public spaces. (Karolina and Zarkasi 2023) . In addition, a study on household-based KTR policies in Yogyakarta highlighted the importance of social norms and women's involvement in driving community compliance with the indoor smoking ban. (Padmawati et al. 2018) .

A quasi-experimental study analyzing national data from 2007-2018 shows that district-level KTR policies have varying impacts on smoking intensity. Some district-level policies were strongly associated with reduced smoking intensity (OR=0.95, CI:

0.92-0.98), but did not always correlate with reduced prevalence of active smokers, suggesting inconsistency in effectiveness between regions. (Septiono 2024) .
Overall, the results of this systematic review show that KTR policies in Indonesia face complex challenges, which include structural, socio-cultural, and spatial aspects, as well as weak monitoring and law enforcement systems in the field. Variations in findings between urban and rural areas reinforce the importance of contextual analysis in designing policy interventions that are more effective and adaptive to local needs.

The main findings in this study indicate that the implementation of the No Smoking Area (KTR) policy in Indonesia still faces various structural and cultural barriers, both in urban and rural areas. This finding directly confirms the problem formulation in the study, namely, the gap between the normative objectives of the policy and the reality of implementation in the field. Compliance with the policy remains low, especially in outdoor public spaces and non-health facilities, while community participation and institutional support are often limited or inconsistent. This reality indicates that policy effectiveness is not only determined by the existence of formal regulations, but by a more complex social, economic, and institutional constellation. (Nasution et al. 2022).

Within the framework of policy implementation theory, this result reflects that the successful implementation of a policy is strongly influenced by four main elements: communication, resources, implementer disposition, and bureaucratic structure. (Yunarman et al. 2020) . Weaknesses in cross-sector coordination, lack of socialization, and unclear legal sanctions are the dominant obstacles in the implementation of KTR at the local level. For example, in Yogyakarta, consumer resistance to KTR policies in the hospitality industry was exacerbated by weak law enforcement and the absence of strict technical guidelines from the local government. (Sutantri et al. 2024) .

Compared to previous studies, the results of this study reinforce previous findings that KTR compliance is higher in healthcare facilities than in other public spaces. However, this study expands on this by showing that inequities in policy implementation occur not only between sectors but also between geographical areas. In Jayapura, for example, despite the existence of a local regulation on KTR since 2015, compliance rates are still very low (17%) and do not show a clear spatial pattern between the city center and periphery. (Wahyuti et al. 2019) . In contrast, community-based initiatives in Yogyakarta through the *smoke-free home* movement show higher effectiveness due to their participatory approach and rootedness in local social norms. (Padmawati et al. 2018) .

The scientific contribution of this article lies in the integration of empirical evidence across regions in the Indonesian context, as well as a theoretical approach that emphasizes the importance of *context-sensitive policy implementation*. By systematically dissecting the dynamics of KTR policies based on geographic location, this article enriches the public policy literature in the health sector and offers a new perspective that policy effectiveness is strongly influenced by local factors such as community leadership, value systems, and social cohesion. (Sugiyo 2020) . Furthermore, the use of the *Systematic Literature Review* approach in the context of local health policy is a method that is still relatively rarely used explicitly in Indonesia and therefore strengthens the novelty of this research.

However, this study has a number of limitations. Firstly, the SLR approach limits the scope to published studies, so information from field practices that are not formally

documented may not be captured. Secondly, the inclusion criteria emphasizing the last five years of publication may have excluded important previously published studies. Third, methodological heterogeneity among the reviewed studies - such as differences in observational, qualitative, or quantitative designs - limited the ability to conduct advanced quantitative analyses such as meta-analysis. (Ismaniar, Wahyudin, and Paratama 2025) .

The implications of these findings are important for policy designers, public health practitioners, and researchers. First, a *responsive policy implementation* approach is needed that adapts implementation strategies to local characteristics, including optimizing the role of community leaders, religious institutions, and civil organizations. (Made et al. 2024). Second, health education interventions must be designed contextually and community-based to raise awareness and change social norms related to smoking behavior in public spaces. Third, policies need to be supported by an adequate monitoring system, including budget allocation, reporting mechanisms, and sanctions that can be fairly enforced. Finally, further research can be conducted with a *mixed methods* design that combines SLR approaches and in-depth interviews to explore non-documentary factors that influence the success of KTR policies. (Trirasetya et al. 2024).

Conclusion

The results of this systematic review show that the implementation of the No Smoking Area (KTR) policy in Indonesia still faces a variety of complex challenges, especially in the context of differences between urban and rural areas. Compliance with KTR provisions tends to be higher in health facilities and areas close to administrative centers, but remains generally low in public facilities and open spaces. The main barriers identified include a lack of inter-agency coordination, budget constraints, weak supervision, and social resistance to regulations. The findings confirm the apparent gap between the normative objectives of the policy and the reality of implementation on the ground, which is reinforced by structural and cultural factors that vary across regions.

Theoretically, this article contributes to the strengthening of the public policy implementation framework by emphasizing the importance of a contextual approach that is adaptive to local characteristics. The *Systematic Literature Review* approach used enriches understanding of the dynamics of KTR policy implementation by presenting a synthesis of evidence from various regions and study designs, resulting in a comprehensive picture of implementation successes and failures. In addition, this article also offers a conceptual basis for formulating policy strategies that are more responsive, participatory, and community-based as a step towards strengthening the effectiveness of regulations in the field of public health.

As an implication, it is suggested that further research integrate qualitative field approaches to dig deeper into sociocultural and institutional factors that have not been covered in the literature study. For policymakers, the results of this study emphasize the urgency of strengthening monitoring systems and developing locally-based intervention models that consider social norms and community leadership. The practice of implementing KTR policies also needs to be supported by cross-sector training, continuous socialization, and multi-sector collaboration so that policies do not only become formal documents, but are truly internalized in community behavior.

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