Current activities in smoke-free zone policy: a tobacco control care reviews in Indonesia

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Background

Indonesia is the only one of the six largest developing countries that has not ratified the World Health Organization’s Framework Convention on Tobacco Control (WHO FCTC) [1–3]. However, the Indonesian government has already recognized that the right to live without air pollution could be impacted by tobacco use [3, 4]. Secondhand smoke (SHS) is an established risk factor for several global health problems [5–8], particularly in Indonesia [4, 9]. The Tobacco Control Support Center of the Indonesian Association of Public Health Experts (TCSC-IAKMI) released a national report that ascertained the “non-smokers’ right to inhale fresh air is more important than the smokers’ right to pollute the air which is poisoned for others” [10].

Cigarette smoke that is inhaled into a smoker’s lungs is called mainstream smoke (MS), while cigarette smoke emitted from the burning cigarette is called side-stream smoke (SS) [11]. SS and air pollution are both indicated as environmental tobacco smoke (ETS), which is inhaled as secondhand smoke (SHS) by exposed people [11]. Several studies have assessed that the chemical content of SS is more damaging than that of MS, as the latter is produced by tobacco burned at a lower temperature and is exhaled [12, 13]. Indeed, the International Governmental Coalition Against Tobacco (INGCAT) has issued a recommendation supported by over 60 countries about the dangers of ETS, which totally affect both adults’ and children’s pulmonary and cardiovascular systems [14].

Smoking prevalence among men in Indonesia was 65.6% in 2007, 65.9% in 2010, and 6.8% in 2013. On the other hand, the prevalence of smoking among women was 5.2% in 2007, 4.2% in 2010, and 6.9% in 2013 [15, 16]. This smoking creates SHS exposure for 76.8 million people [15], and their number is likely to increase along with the increase in active smoking. In 2013, 81% of Indonesian children aged 13–15 years reported exposure to SHS in public places, which is the highest prevalence in the world [17].

In Indonesia, the total number of tobacco-related deaths in 2013 was estimated at 240,618, or 659 Indonesians per day [18]. The tobacco death toll falls disproportionately on men, as it is responsible for more than 21% of all male deaths. Even though fewer women die from tobacco in Indonesia (just over 7% of all female deaths), tobacco still kills 967 women every week [19]. Many of these women are mothers and wives taking care of families, and their deaths impose a huge burden on the families affected.

Otherwise, cigarette smoke is well-known to cause several abnormalities and diseases in most organs, such as stroke; changes in brain chemistry; cancers of the mouth, lip, throat, and larynx; arterial weakness; cardiac disease; chronic lung obstructive disease; lung cancer; asthma; liver cancer; stomach cancer; pancreatic and colon cancers; impotence; cervical cancer; and infertility [20].

In 2016, the WHO released an international report regarding the Republic of Indonesia’s policies on and achievements in tobacco control. This report profile indicated that there are incomplete SFZ laws in public places such as government facilities, indoor offices and workplaces, restaurants, and pubs [21]. Meanwhile, several public places have already SFZ laws, but with only moderate compliance, including healthcare facilities and educational facilities except universities, as well as with low compliance at universities and on public transport. However, national laws on SFZ exist supporting their national regulation [21].
Furthermore, in this report, the WHO assessed the MPOWER measures, including (1) monitor tobacco use and prevention policies; (2) protect people from tobacco smoke; (3) offer help to quit tobacco use; (4) warn about the dangers of tobacco; (5) enforce bans on tobacco advertising, promotion and sponsorship; and (6) raise taxes on tobacco.

In the current study, a rapid assessment procedure (RAP) was undertaken to describe the implementation of SFZ in Indonesia by reviewing several documents on the current activities and programs related to SFZ implementation policy. These files comprised government acts and regulations towards SFZ application in Indonesia. Ethical approval of the study was obtained from the Expert Commission on Research and Research Ethics of the Public Health Faculty of Universitas Indonesia, No. 2901/UN2.F10/PDP.04.00.2015.

**Indonesian tobacco control care systems**

Indonesia has already introduced regulation related to smoke-free zones (SFZs), as stipulated by Governmental Act No. 36/2009, article 115, paragraph 1. It introduced seven SFZs, including healthcare facilities, educational settings, children playground or gathering places for children, worship places, public transportation, workplaces, and public places (Table 1).

The second paragraph of this act also obligated local governments to set SFZs in each of their territories. One of the important steps in this regulation was the memorandum of understanding (MoU) between the Ministry of Health (MoH) and the Ministry of Home Affairs, which resulted in both Ministers’ Decision No. 188/MENKES/PB/I/2011 and No. 7/20111 about the guidelines for SFZs.

**SFZs in developed countries**

In most developed countries, smoking bans are well implemented. For instance, New York City, USA, has banned smoking in public places, particularly in pubs, restaurants, and cafeterias.

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<th>Objectives</th>
<th>Targets</th>
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<td>1. Decrease morbidity and mortality rate while changing society’s behavior for a healthy life.</td>
<td>Public transportation</td>
<td>Management of transportation supporting facilities such as cafeterias, entertainment facilities, etc.</td>
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<td>2. Increase the optimal productivity.</td>
<td>Public transportation</td>
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<td>3. Realize fresh and healthy air quality free of cigarette smoke.</td>
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<td>4. Decrease smoking rate and prevent early smoking adoption.</td>
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<td>5. Realize a healthy youth generation.</td>
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<td>Places of worship</td>
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Furthermore, these findings were discussed in MoH’s report, which mentioned that successful terms of implementation of the regulation included that everyone involved should know and support who guarded, protected, made, supervised, and enforced the rules. It should also be well packaged and well delivered for effective socialization [24]. These national guidelines recognized that smoking not only impacts diseases but also influences health expenditures, which are not worth it [25, 26].

Moreover, both the Netherlands and the United Kingdom have regulated tobacco consumption with an expensive excise rate, calculating the cost of tobacco products in detail. The Dutch government set the excise rate of cigarettes using the ad-volarem system and that of chewing tobacco based on weight, as with cigars [29]. The ad-volarem system enables the government to escalate the tobacco excise percentage along with its increasing consumption without any upper limit, while in Indonesia, the excise rate has been set not to exceed 57% excise escalation. Although tobacco consumption in Indonesia has es-
Role of Family Practitioners in the prevention of tobacco smoking

practitioners’ role in recent days is to adequately impress on their patients, particularly those families with smokers in their households, the importance of community well-being with fresh air for a healthier environment [33, 34]. In many ways, patients may be influenced to improve their health conditions by communication with proactive practitioners [35], including doctors and nurses giving information about smoking cessation.

Table 2. Tobacco excise policies in the Netherlands and the UK [29, 31, 32]

| Netherlands | In the Netherlands, the excise rates are applied at a minimum amount of customs at least €181.59; the minimum amount of customs is at least €181.59; the rate for tobacco is €99.25 per kilogram. |
| UK | Tobacco Products (Finance Act 2017, Article 22 Paragraph 2): The following rate changes took effect March 8, 2017: a) cigarettes of the same amount as 16.5% of the retail price plus £207.99 per thousand cigarettes, b) cigars of £259.44 per kg, c) hand-packed cigarettes of £209.77 per kg. Other types of tobacco cigarettes and chewing tobacco have a rate equal to £114.06 per kg. |

Future of tobacco control care in Indonesia

MoH’s SFZ guidelines are part of the national effort to protect non-smokers from exposure to cigarette smoke. SFZ implementation policies have been identified as a primary intervention strategy not only to control tobacco itself but also to restrain communicable diseases [40]. Fortunately, SFZ implementation in Indonesia was followed by 49 local regulations in December 2014 that comprised 102 municipalities and 13 provinces [10].

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