

Community Compliance Regarding No-Smoking Area Policy: Belief Control Analysis and Tobacco Use Habits in Society the Bugis Tribe (Pare-Pare City & Sidrap Regency) and the Makassar Tribe (Gowa-Takalar Regency) in South Sulawesi

Achmad R. Muttaqien Al-Madin¹, H. Amran Razak¹, Darmawansyah¹, Suriah², HM Alimin Maidin³, Pupin Astuti⁴, Mutia Nur Rahmah³, Nur Indah Sari^{1,*}

Achmad R. Muttaqien Al-Madin¹, H. Amran Razak¹, Darmawansyah¹, Suriah, HM Alimin Maidin³, Pupin Astuti⁴, Mutia Nur Rahmah³, Nur Indah Sari^{1,*}

¹Hasanuddin University, Faculty of Public Health, Department of Health Policy and Administration, INDONESIA.

²Hasanuddin University, Faculty of Public Health, Department of Health Promotion, INDONESIA. ³Hasanuddin University, Faculty of Public Health, Department of Hospital Management, INDONESIA. ⁴Hasanuddin University, Faculty of Public Health, Department of Epidemiology, INDONESIA.

Correspondence

Nur Indah Sari

Hasanuddin University, Faculty of Public Health, Department of Health Policy and Administration, INDONESIA.

E-mail: anwar_envi@yahoo.com

History

- Submission Date: 12-04-2023;
- Review completed: 10-05-2023;
- Accepted Date: 19-05-2023.

DOI : [10.5530/pj.2023.15.79](https://doi.org/10.5530/pj.2023.15.79)

Article Available online

<http://www.phcogj.com/v15/i6>

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ABSTRACT

Introduction: Smoking among the people of Bugis-Makassar has become an inseparable part of a smoker and has become a habit. Community compliance with the No-Smoking Area (KTR) policy is still a problem in various regions, this is because the habits and control of people's beliefs are not in line with implementation of KTR implementation. **Methods:** This study used an explanatory research design, namely to examine the correlation between control beliefs and the habit of using Bugis cigarettes on compliance with the policy of implementing a smoking-free area which is part of tobacco control. The research was conducted in four districts in South Sulawesi, namely Takalar, Gowa, Pare-pare, and Sideneung Rappang (Sidrap) Regencies. The sample used was 400 respondents using the non-probability sampling method, namely the Accidental Sampling technique. **Results:** This study shows that control beliefs and respondent compliance obtained a p-value of $0.717 > 0.05$ which means there is no significant correlation between control beliefs of tobacco use and community compliance with KTR policies. The results of the correlation test of smoking habits on public compliance with KTR policies obtained a p-value of $0.015 < 0.05$ which means there is a significant correlation between tobacco use habits and public compliance with KTR policies. The results of the study also show that the control variable beliefs and habits have a p-value of $0.001 < 0.05$ which means that there is a correlation between control beliefs and smoking habits. **Conclusion:** Policy makers should focus more on the implementation of KTR policies in all public places and law enforcement related to KTR policies in various contexts, including social and cultural approaches. KTR got easier with time.

Key words: Smoking cessation, Community compliance, Non-smoking area, Believe control, Tobacco use.

INTRODUCTION

Globally, more than 1.1 billion people use tobacco, with adult male smokers (945 million) significantly outnumbering women (180 million). This alarming figure represents around a third of the global population aged 15 and over. It has grown substantially in low- and middle-income countries (82% of world smokers). In the ASEAN region, currently there are 122 million adult smokers, half of whom live in Indonesia (65 million). Indonesia is one of the ASEAN countries which is recorded as the highest cigarette consumer, 53.3%. Indonesia itself ranks first with the highest number of smokers in ASEAN countries, namely reaching 65,700,000 smokers which are dominated by the teenage age group and continue to increase every year.

The 2013 Basic Health Research (Riskesdas) data shows that the number of smokers in Indonesia at the age of 15 years and over has hardly changed significantly. The number of smokers based on data from Riskesdas 2007 was 34.2%, Riskesdas 2010 was 34.3%, Riskesdas 2013 was 36.3%, Sirkesnas 2016 was 32.8% and Riskesdas 2018 was 33.8%.^{1,2}

The World Health Organization (WHO) has offered a strategy to overcome problems caused

by smoking, namely six "Cost-Effective" MPOWER policy intervention packages to control cigarette consumption, one of which is protection against exposure to cigarette smoke (Protect People From Tobacco Smoke).³ MPOWER is a package of policies intended to assist the implementation of effective country-level interventions to reduce the demand for tobacco, as ratified by the World Health Organization (WHO) Framework Convention on Tobacco Control.

The six evidence-based components of MPOWER are: (1) Monitor Tobacco use and prevention policies, (2) Protect people from Tobacco smoke, (3) Offer help to quit Tobacco use (Offering help to stop using tobacco products), (4) Warn about the dangers of Tobacco (Warning about the dangers of tobacco products), (5) Enforce bans on Tobacco advertising, promotion and sponsorship), (6) Raise taxes on Tobacco (Raise taxes on tobacco products).

The Tobacco Control Backing Center-Indonesian General Wellbeing Master Relationship in Southeast Asia Tobacco Control Union (SEATCA) and the World Health Organization (WHO) state that in Indonesia there are 4 strategic options for tobacco control which have been detailed, namely: 1) Cost increases (65% of the store price); 2) Eliminate all

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types of tobacco promotions; 3) Implementation of 100% Smoke Free Areas (KTR) in open areas, work environments and schools; and 4) Wrapping smoking warning signs and adding pictures of smoking tendencies on cigarette packs. One option that is very easy to implement in Indonesia, where the approach is taken by the local government, is to implement the KTR. Smoking Free Areas (KTR) are places or areas that are not allowed to carry out the activities of making, arranging, distributing, fostering and or using cigarettes.

The explanation behind the implementation of the KTR is that each individual has the right to safety from the dangers of smoking, tobacco smoke is unsafe and has no safe cut-off point, extraordinary space for smoking and airway framework cannot provide a convincing guarantee. With the aim that insurance is only effective if a place is 100% smokeless.⁴

Policies will be implemented well if the components or people who are the goal of implementing the policy are implemented properly. However, most people still have control over bad beliefs and habits related to the use of tobacco in the no-smoking area policy. The results of Gwon *et al's* (2017) study showed that after adjusting for socio-demographic and economic factors, it showed that attitudes toward smoking, subjective norms about smoking, and perceived behavioral control about smoking were statistically significant independent predictors of intention to smoke. When the three are considered together, attitudes toward smoking and perceived behavioral control remain statistically significant, but subjective norms about smoking are of no significance value, and the number of licensed tobacco retailers also predicts intention to smoke.⁵

Many studies refer to the theory of Fishbein 1980 & Ajzen, 1975, regarding The Reasoned Behavior Theory. According to the theory, behavior is determined by the behavioral intention to become a behavior. The main factors that determine behavioral intention are personal or "attitude" factors and social or "normative" factors. The "attitude" factor (a person's attitude towards a particular behavior) is the perceived consequence of carrying out the behavior and (results of) evaluating the consequences. While "social" norms are subjective, they are a consequence of perceptions about the specific importance of the person or reference group thinks he or she should do so.

The conceptual elements needed to explain and predict moral behavior are found in the theory of reasoned action. From this point of view, the attitudinal (behavioral beliefs, outcome evaluation, and attitudes toward behavior) and normative (normative beliefs, motivation to obey, and subjective norms) components represent the personal and social variables involved in moral behavior, respectively.

According to Lee & Kotler, 2011, a person in adopting a behavior is most likely to be obtained if the individual has a positive attitude towards the behavior, gets support and approval from other individuals who are close and related to the behavior. Apart from that, the individual also believes that the behavior can be carried out properly. By adding Perceived Behavioral Control, the form of the Theory of Planned Behavior (TPB) model assumes that Perceived Behavioral Control has motivational implications for interests/intentions.⁶

Control Belief (*Control Belief*) can influence behavior indirectly through interest, and can also predict behavior directly. This theory reveals that behavior that is not controlled by someone, can be influenced by non-motivational factors as opportunities or resources needed so that behavior can be controlled again. So that in theory, Ajzen adds one more determinant, namely the control of behavioral perceptions regarding the ease or difficulty of the behavior performed. Therefore, based on the PB concept, intention is influenced by three things, namely: attitudes, subjective norms, behavioral control.⁷

Thus, it can be concluded that a person's tobacco consumption behavior can be influenced by habits, public perceptions and available resources

to opportunities owned by the community to have intentions and/or to engage in smoking behavior. This can also be limited by implementing an appropriate tobacco control policy. Therefore, it is necessary to study the perception control of tobacco in the Bugis-Makassar tribe.

MATERIALS AND METHODS

This study used an explanatory research design, namely to examine the correlation between control beliefs and smoking habits among the Bugis tribe towards compliance with the policy of implementing a smoking-free area which is part of tobacco control. The research was conducted in four districts in South Sulawesi, namely Takalar, Gowa, Pare-pare, and Sidenreng Rappang (Sidrap) Regencies. Respondents' inclusion criteria were those aged 16 years and over and smoking and filled out the questionnaire with full awareness that the respondent was not under intervention in answering the research questions. The sample used was 400 respondents using the non-probability sampling method, namely the Accidental Sampling technique, namely the samples selected were those who met with the researcher and met the inclusion criteria during the study. Questionnaires were developed from various sources and validity and reliability tests were carried out to maintain the quality of the questions in the questionnaire used. Data were analyzed using the IBM SPSS 26 computer program.

RESULTS

We examined 400 respondents in four districts in South Sulawesi with the following characteristics.

Table 1: Characteristics of respondents.

Characteristics of Respondents	N	%
Gender		
Man	387	96.8
Woman	13	3,3
Total	400	100
Age		
15-20 Years	48	12,0
21-25 Years	103	25,8
26-30 Years	60	15,0
31-35 Years	34	8,5
36-40 Years	44	11,0
41-45 Years	28	7,0
46-50 Years	31	7,8
> 50 Years	52	13,1
Total	400	100
Ethnic group		
Bugis	158	39,5
Macassar	242	60,5
Total	400	100
Education		
Master/ Doctoral	12	3,0
Bachelor	134	33,5
1 st Diploma/2 nd Diploma /3 rd Diploma	21	5,3
Senior High School	167	41,8
Middle/Junior High School	18	4,5
No school	15	3,8
Total	400	100
Long Smoking		
1-5 Years	132	33,0
6-10 Years	82	20,5
>10 Years	186	46,5
Total	400	100

(Source: Primary data, 2022)

Table 2: Overview of belief control against tobacco use.

Statement	Ss		S		TS		STS		Total	
	N	%	N	%	N	%	N	%	N	%
Before I smoked, I thought several times before I started	78	19,5	196	49,0	118	29,5	8	2,0	400	100
I can manage and control the urge to smoke in any situation	87	21,8	221	55,3	85	21,3	7	1,8	400	100
I will not rebuke people who smoke around me	86	21,5	199	49,8	106	26,5	9	2,3	400	100
I want to smoke because of my own will	171	42,8	200	50,0	24	6,0	5	1,3	400	100
I know the harmful effects of smoking	145	36,3	220	55,0	29	7,2	6	1,5	400	100
I feel able to influence people to smoke around me	29	7,2	114	28,5	220	55,0	37	9,3	400	100
I have the ability to tell in sequence & sequentially about incidents caused by smoking that I know.	45	11,3	227	56,8	116	29,0	12	3,0	400	100
I have the ability to tell stories in an orderly, precise, systematic manner about events caused by smoking that I know	47	11,8	222	55,5	122	30,5	9	2,3	400	100
I feel confused if I don't smoke	73	18,3	158	39,5	143	35,8	26	6,5	400	100
If I smoke, I can express opinions fluently.	74	18,5	177	44,3	136	34,0	13	3,3	400	100
If I run out of cigarettes, and I want to smoke, whatever the situation, I will still go looking for cigarettes	92	23,0	159	39,8	117	29,3	32	8,0	400	100

(Source: Primary Data, 2022)

Table 3: Self-control against tobacco use.

Self-control	N	%
Not good	399	99,7
Good	1	0,3
Total	400	100

(Source: Primary Data, 2022)

Table 4: Description of tobacco use habits in society.

Statement	Yes always)		Sometimes		Never		Total	
	N	%	N	%	N	%	N	%
I smoke 1 cigarette or more per day for 30 consecutive days	225	56,3	112	28,0	63	15,8	400	100
I use tobacco or nicotine products such as chewing tobacco or snuff, cigars, pipes, clove cigarettes or other tobacco products	195	48,8	116	29,0	89	22,3	400	100
I find it difficult to stop myself from smoking in places where smoking is prohibited	83	20,8	122	30,5	195	48,8	400	100
I smoke more often in the hours after waking up	97	24,3	149	37,3	154	38,5	400	100
I smoke more often in the hours after eating	254	63,5	96	24,0	50	12,5	400	100
When I'm sick, I still smoke	63	15,8	121	30,3	216	54,0	400	100
I feel happy, when I smoke	195	48,8	140	35,0	65	16,3	400	100
I feel calm, when I smoke	223	55,8	125	31,3	52	13,0	400	100
My appetite decreases when I smoke	68	17,0	111	27,8	221	55,3	400	100
I am more focused and concentrated, When I smoke	191	47,8	139	34,8	70	17,5	400	100

(Source: Primary Data, 2022)

Table 5: Tobacco use habits in society.

Habit	N	%
Not good	75	18,8
Good	325	81,2
Total	400	100

(Source: Primary Data, 2022)

The table shows that respondents are dominated by men (96.8%), aged 21-30 years (48.5%), Makassar and Bugis ethnicity, respondents with Senior High School education (41.8%) and Bachelor (33.5%) and old smokers > 10 years (46.5%) and new smokers 1-5 years (33.0%). This shows that the respondents are so close to the research variables that they can guarantee the quality of the research.

Overview of tobacco use belief control

The table shows the instruments used in measuring control of tobacco use beliefs. It was found that most of the respondents showed poor control of their beliefs, most of the respondents responded in agreement and strongly agreed to each statement which showed a poor attitude in controlling themselves in tobacco use.

Table 6: Community compliance regarding smoke-free area policy.

Statement	Yes always)		Sometimes		Never		Total	
	N	%	N	%	N	%	N	%
I smoke in non-smoking areas (health facilities, teaching and learning process areas, children's playgrounds, places of worship, public transportation, workplaces, public places)	50	12.5	158	39.5	192	48.0	400	100
I comply with the <i>tobacco control</i> policy	167	41.8	175	43.8	58	14.5	400	100
I smoke in a closed room	59	14.8	157	39.3	184	46.0	400	100
I will reprimand those who smoke in a no-smoking area	127	31.8	146	36.5	127	31.8	400	100
I adhere to not smoking when I see a "No Smoking" sign	250	62.5	114	28.5	36	9.0	400	100
When I see other people smoking in areas that implement No-Smoking Areas, I will also smoke	81	20.3	207	51.7	81	20.3	400	100
I don't care about smoking bans around me	83	20.8	111	27.8	206	51.5	400	100
I don't feel comfortable smoking in a No-Smoking Area	216	54.0	118	29.5	66	16.5	400	100

(Source: Primary Data, 2022)

Table 7: Compliance with KTR policy.

Obedience	N	%
Not obey	94	23.5
obey	306	76.5
Total	400	100

(Source: Primary Data, 2022)

Table 8: Correlation of belief control and tobacco use habits on community compliance with KTR policy.

Variable	Range	Means	SD	P-values	Person correlation
Compliance Belief Control →	12	23.75	1,864	0.717	-0.018
Compliance Smoking Habits →	20	18.95	4,709	0.015	0.122
Control belief →Habits	12	23.75	1,864	0.001	0.170

(Source: Primary Data, 2022)

The table shows that almost all respondents have poor self-control of tobacco use, namely 99.7%. This shows the poor self-control of the community towards tobacco use which can result in continuous use of cigarettes.

Description of tobacco use habits

The table showing the majority of respondents shows that most respondents occasionally have bad habits related to tobacco use. This shows that bad habits in using tobacco still occur among the community.

The table shows that most of the respondents have good habits towards using tobacco, namely 81.2% and there are 18.8% of respondents who have bad habits. This shows that the habit of using tobacco by the community has an impact on the family and surrounding environment.

The table showing the majority of respondents shows that most respondents occasionally have bad habits related to tobacco use. This shows that bad habits in using tobacco still occur among the community. 62.5% of respondents stated that they would comply if they saw a "no smoking" ban somewhere. However, 51.7% also stated that they sometimes smoke at KTR places if they see someone also smoking at that place. This shows that the community is still sometimes obedient or disobedient to the policy rules relating to tobacco control.

The table shows that the majority of respondents show an attitude of adherence to the KTR policy, namely 76.5% and 23.5% show an attitude that is not compliant. This shows that public compliance with the KTR policy is quite good but can still be improved.

Even though the statistical results show good compliance, the results of the questionnaire related to respondent compliance still show that respondents sometimes comply or do not comply with tobacco control policies. It seems that the attitude of respondents towards

the implementation of the KTR policy is sometimes violated by the majority of the community. The community seems to show obedience and disobedience to certain conditions, times and places. For example, when they see that most people do not smoke in a certain place and time, they will refrain from smoking at that time. However, when they see many people or other people smoking in a place, they will violate the rules of the area because they are affected by the surrounding environmental conditions. This is exacerbated by the poor control of people's beliefs where most of them, in any situation, smoking can calm their minds.

The table shows the results of the correlation test of the control variable's belief with the respondent's compliance with a p-value of $0.717 > 0.05$ which means that there is no significant correlation between control beliefs of tobacco use and public compliance with KTR policies. The average control of tobacco use beliefs is in the range that is less good than good (mean = 23.75: SD = 1.864) and the full scale observed has range = 12. The person correlation value also shows a very weak relationship and has a negative value, which means that when the control belief on tobacco use is good, adherence to the KTR policy will also increase.

The results of the correlation test of smoking habits on public compliance with KTR policies obtained a p-value of $0.015 < 0.05$ which means there is a significant correlation between tobacco use habits and public compliance with KTR policies. The *personal correlation* value also shows a very weak relationship ($0.122 = 12.2\%$) which means that 12.2% of people's compliance is related to people's smoking habits. In addition, the results of the study also showed a p-value of $0.001 < 0.05$, which means that there is a significant correlation between control beliefs and habits, with a personal correlation value of 0.170, which means that control beliefs have an effect of 17% on smoking habits.

DISCUSSION

The results show that the control of the beliefs of the Bugis and Makassar people in South Sulawesi is still not good. All respondents except one respondent have good belief control. Most of the respondents admitted that they knew about the dangers of smoking and were even able to tell a good story about how smoking can harm other people, but most of them could not stop themselves from smoking one day. Poor belief control can be influenced by the length of time a person smokes, most of the respondents have smoked for a long time. This can affect a person's dependence on smoking itself. Smoking for a long time can make someone addicted so it is difficult to avoid not smoking. In addition, there is a belief among the public regarding the benefits of smoking behavior such as being able to reduce stress or boredom and can provide inspiration when someone smokes, possibly worsening the control of people's beliefs in tobacco use.

The results also show that habit and adherence to tobacco control policies are in the good category. The Bugis and Makassar people have good smoking habits, but the results of the questionnaire show that most people still have bad habits in using tobacco (cigarettes). This can be seen in the percentage of respondents' answers to each statement. Where many respondents stated that sometimes they apply bad habits, although not always. As with community compliance, some members of the public are still sometimes compliant or disobedient to tobacco control policies. Attitudes, subjective norms, and perceived behavioral control contribute significantly to smoking habits. The right attitude must be inculcated and behavioral control must be strengthened for effective early intervention to reduce smoking habits among the people.⁸

Control beliefs were found to have no significant relationship to community compliance, which means that poor community belief control is not associated with good community compliance. However, if the community's *Control belief* is good, it can increase community compliance. It was found that belief control has a significant relationship to people's smoking habits, which means that poor control of people's beliefs has an effect of 17% on people's smoking habits. Then it was also found that smoking habit had a significant relationship with community compliance with a large influence of 12%. This means that good public compliance with policy implementation can be influenced by smoking habits and good habits can be strengthened by having good belief controls as well.

Although the results show that the community has poor control over the use of tobacco or cigarettes, the habits and compliance of the community regarding tobacco control policies still show good results. People tend to comply with the rules prohibiting smoking in public places. This is supported by the research of Flor *et al.*, (2021) which states that smoking-free (smoke-free) area policies have limited a person's opportunity to smoke and reduce social acceptance of smoking.⁹ Individual warnings about the dangers of smoking and warnings regarding health practices have seemed to have increased public knowledge about the health risks of smoking and promoted societal behavior change in smoking.¹⁰

Respondents also presented that community compliance refers to respondents' beliefs about the prevalence of smoking in the community, meaning that smokers perceive the presence or absence of smoking behavior by relatives, friends, or other members of the community influencing smoking behavior or adherence to rules in smoke-free areas.¹¹ They would violate no-smoking area rules if they saw other people doing the same. Seeing friends, relatives, family or other people smoking can increase social pressure to conform to their smoking behavior.¹² Vice versa, more and more people perceive that friends, relatives, and other members of the public expect them not to smoke or that reprimands from colleagues or family members are

associated with better smoking avoidance behavior, confidence not to smoke, and strong intentions not to smoke.¹³ However, the results show that the majority of respondents would not reprimand other people for smoking or violating the no-smoking area regulations and there is even a possibility that they would also violate the rules.

In addition, it is clear that strong implementation and enforcement of laws is critical to accelerating progress on reducing the number of smokers and the burden of smoking globally. Research by Hyland *et al.*, (2009) found that the policy process can change the norms and attitudes of society to be more accepting of regulations related to smoke-free areas which are supported by media effects.¹⁴ Bad belief control can be modified through instilling feelings of shame and impolite if smoking in public places can disturb others and can be strengthened by implementing a strict monitoring and enforcement system. In addition, this belief can also be maintained through increased education, supervision, and law enforcement in smoke-free areas in various contexts, including social and cultural approaches.¹¹

CONCLUSIONS AND RECOMMENDATIONS

In general, the belief control of the Bugis and Makassar people is still low, but related to adherence not to smoke in smoking-free areas and habitual patterns, the community is classified as good enough and. *The control belief* of the Bugis-Makassar community is still very poor. As for habits and compliance related to the Non-Smoking Area Policy (KTR), most people state that they sometimes have good habits but at the same time are also bad because in using tobacco most of the respondents are more choosing sometimes to comply and not comply with the applicable KTR policies. This requires full public awareness, ongoing socialization, and the application of strict law enforcement so that the public can better understand the implementation of the KTR policy. This will have a significant impact slowly, so as to reduce the number of active smokers, at least reduce the negative impact on other people (non-smokers).

It is suggested that policy makers should focus more on the implementation of KTR policies in all public places and law enforcement related to KTR policies in various contexts, including social and cultural approaches. KTR got easier with time.

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Cite this article: Al-Madin ARM, Razak HA, Darmawansyah, Suriah, Maidin HMA, Astuti P, et al. Community Compliance Regarding No-Smoking Area Policy: Belief Control Analysis and Tobacco Use Habits in Society the Bugis Tribe (Pare-Pare City & Sidrap Regency) and the Makassar Tribe (Gowa-Takalar Regency) in South Sulawesi. *Pharmacogn J.* 2023;15(3): 301-306.