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Thank you for your helpful comments (**black**). Our responses are written in blue.

Introduction:

Please add the population of Indonesia - it is unclear from the figure for current smokers as to what the smoking prevalence is and how this is a high rate compared to other countries worldwide, particularly among men.

Please provide further clarification about the Smoke Free Policy (SFP). It is unclear if these restrictions are indoor only at selected facilities. Further, it requires clarification as to whether vaping products are included in this definition.

It would also be helpful to add a reference to the WHO Framework for Convention on Tobacco Control - Indonesia is notable as one of the countries which has not signed.

There are inconsistencies and errors in grammar throughout the manuscript including the introduction. "An SFP" should be "A SFP".

It is unclear then the SFP bill passed through parliament - please clarify this.

Thank you. We have revised/added as suggested, each was shown in yellow below. We have also re-checked the grammar for any errors.

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Indonesia, with a total of 264 million population, had an estimated 61.4 million current smokers in 2018.[1] The latest Basic Health Research, a nationally representative survey, showed a persistently high smoking prevalence among adults and an increasing prevalence among 10-18 years old in 2018.[2] The latest Global Adult Tobacco Survey also showed that 59 million adults were exposed to secondhand smoke at workplaces or restaurants in 2011.[3] All this indicates the need for an effective smoke-free policy (SFP). Studies from high-income countries have shown that SFP is associated with reductions of smoking rates in the United States,[4] indoor smoking in the United Kingdom,[5] indoor air pollution in North America and Europe,[6] secondhand smoke exposure in New Zealand,[7] and population rate of myocardial mortality in Belgium.[8]

However, the national tobacco control efforts are not comprehensive in Indonesia, due partly to the lack of the Framework Convention on Tobacco Control (FCTC).[9] There are two national laws related to SFP: Health Act 36/2009 and Presidential Decree 109/2012. The Act provided a recommendation for local governments to implement SFP, and the Decree stipulated that producing, selling, advertising, promoting, and smoking of tobacco products (vaping excluded) are prohibited indoor and within the fence/gate of selected facilities.[10,11] However, only 67% of districts (345 of 514 total) have adopted some form of SFP regulation (with and without approval from local parliament) by December 2018, ten years after the Act.[12] This is because, due to the decentralization policy, the adoption of SFP relies on local governments (city/district). Also, depending on various local factors, the compliance varies from Jayapura city 17% (2018) to 78% in Bogor city (2011).[13,14]

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Methods:

It is appreciated that a purposive sampling strategy was necessary for logistical reasons but was any stratification used to identity how many of each facility should be selected? What are the total number of each of these facilities (e.g. hospitals) and therefore what was the coverage of the sample?

Thank you. Unfortunately, there was no stratification in our sampling process, also because no data on the sampling frame for each facility type.

Further information is required to describe how the quantitative data were collected - was this done by questionnaire? In-person or online?

Thank you. We have provided further information as suggested, now included in the first para of the Methods section.

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We visited the facilities and conducted da collection using a paper-based observation checklist, which later entered into Excel.
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What approaches were used to minimize risk of bias? Were observations undertaken at each site and by whom? How were data gathered and entered? Please provide further clarification of the selection of 1-kilometre buffers for the spatial analyses.

Thank you. We conducted observations at each site by trained data collectors using a paper-based observation checklist. The data then entered into Excel and STATA for analysis. Yes, we have added a reference to clarify using a 1-kilometer buffer. All this has been added in the revised version of Methods, the first and second paragraphs.

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We used a mixed-methods study comprising of quantitative and qualitative methods. First, the quantitative approach assessed the compliance with six SFP criteria: "no smoking" signage, no active smoking, no selling, no adverts, no cigarette smoke, and no ashtray. Sample facilities included health facilities (e.g. hospitals, clinics, and pharmacies), educational facilities (e.g. kindergarten, high schools, university, and tuition), places of worship (e.g. mosques, churches), workplaces (e.g. government offices, banks), indoor public facilities (e.g. public transport vehicles, malls, hotels, restaurants, child play stations), and outdoor public facilities (e.g. bus stations, traditional markets, and parks). Due to limited resources, we employed a purposive sampling of 144 facilities, including 24 health facilities, 26 educational facilities, 23 places of worship, 34 workplaces, 31 indoor public facilities, and 16 outdoor public facilities (see Table 1). We visited the facilities and conducted da collection using a paper-based observation checklist, which later entered into Excel. Second, the qualitative method aimed to explore challenges in implementing SFP. We conducted face-to-face in-depth interviews with six key informants with good understanding of the SFP and local context. They included two religious leaders, two community leaders, and two health practitioners. Seven trained enumerators and interviewers conducted data collection during October to November 2019.

We employed both quantitative analysis (e.g. descriptive and spatial analyses) and qualitative analysis (e.g. thematic content analysis). Descriptive analysis, using in STATA 15.1, provided the compliance rates overall and by facility groups. Spatial analysis, using ArcMap 10.6, explored any spatial patterning in the compliance. We used the geoprocessing buffer tool to generate 1-kilometer buffers (approximately 15-minute walk) from the main SFP supporters such as the governor, mayor, and health offices.[13] The

compliance rates among facilities within and outside the buffer were compared, as shown in Figure 1. Using Google MyMaps, we obtained geolocation data of each facility (post survey). For qualitative data, we used content analysis in exploring the challenges to SFP implementation.[13]
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13. Wahyuti et al. Monitoring compliance and examining challenges of a smoke-free policy in Jayapura, Indonesia. J Prev Med Public Health 2019; 52:427-432

Please also describe how key respondents were identified and what was the analytical approach for qualitative data analyses? To address all the above queries, it would be beneficial to complete a STROBE checklist for observational studies.

Thank you. We have revised as suggested – see below. For the qualitative data, we applied content analysis and used themes on SFP challenges in the literature.

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We conducted face-to-face in-depth interviews with six key informants with good understanding of the SFP and local context. They included two religious leaders, two community leaders, and two health practitioners.

For qualitative data, we used content analysis in exploring the challenges to implementation.[13]
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RESULTS:

Please add confidence intervals for the overall percentages reported.

Thank you. We have added the Cis for the overall percentages in the Note section of Table 1.

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Note: N=sample (purposive), % = proportion, Govt=government; No smoking=no active smoking, no smoke=no cigarette smoke. Places of worship include mosques and churches. Tuitions include extracurriculars on math and English. Public transport vehicles include bus and taxis. Bus stations include bus and taxis terminals. Public parks include one swimming pool. Compliance with all 6 = signage, no active smoking, no selling, no advert, no smoke, and no ashtray. For the overall (panel a), the rates with confidence intervals: signage 61% (CI: 53%, 69%), no smoking 81% (75%, 88%), no sale 81% (74%, 87%), no advert 94% (90%, 98%), no smoke 91% (86%, 96%), no ashtrays 96% (93%, 99%), compliance with all 6 44% (36%, 53%).
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The final paragraph in the results section should be in the discussion.

Thank you. We argue that the first three paragraphs of the Results section are for quantitative results, while that final paragraph is reading the qualitative results (from in-depth interviews). However, if the reviewer strongly prefers to move it to the discussion section, we would follow.

DISCUSSION:

What was the baseline referred to in the first two sentences when the SPF compliance is described as "lower"?

Thank you. We have revised to improve clarity, as shown below.

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Our results showed that the overall SFP compliance of 44% in Medan city, the capital of North Sumatera province. While that compliance rate was higher than that in Jayapura city (17% in 2018), it was lower than that in Bogor city (78% in 2011).[13,14] Similar evidence in other low- and middle-income countries is limited to a study in Punjab, India, showing high compliance of 84%.[17]

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It would also strengthen the discussion if strengths and limitations of the cross-sectional study design could be considered. Further, the strengths and limitations of this approach require further detail.

Thank you. We have revised as suggested, shown below.

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Our study has at least two limitations. First, we used purposive sampling and had relatively limited number of sample/facilities. Further studies should consider using random sampling and including more facilities including rural areas where the current evidence is lacking. Second, using a cross sectional study design is appropriate to provide a snapshot of SFP compliance but may be limited in correlates of compliance. Nonetheless, our findings have important policy implications for Indonesia and beyond.

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