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Embedded spiritual conversation in cancer communication: lived experiences of nurses and patients/relatives

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Aim: The study aimed to illuminate the experiences of patients, relatives and nurses in an oncology setting by exploring communication in cancer care.

Background: Like elsewhere in health settings, communication is a major component in cancer care and has an impact on patient's outcome. However, nurse–patient/relatives communication is still recognized as an ongoing challenge. Evidence is lacking on the nurse–patient communication in Indonesia particularly in oncology settings.

Design of study: The current study explored the lived experiences of patients, relatives and nursing regarding communication in an oncology setting at a private Islamic hospital. A phenomenological research design on the basis of the naturalistic paradigm was employed. The researchers purposely selected 16 participants and conducted semi-structured interviews using an interview guide. Colaizzi's naturalistic phenomenological approach was utilized to analyse the data.

Results: Three themes emerged from the data: B*uilding a compassionate relationship, Spiritual and religious discussion, Maintaining hope*. Developing trust and providing empathy as well as showing genuineness are elements in building the compassionate relationship. The religious and spiritual discussion includes reminders to pray and increase self-transcendence awareness. Patients and their relatives welcome such discussion. Maintaining hope is part of communication that can preserve positive feelings, goals and beliefs of patients and their families for their well-being.

Conclusion: Establishing compassionate relationship is the basis of communication in cancer care. Spiritual and religion, and hope are aspects that nurses and patients and their relatives discuss among themselves. These aspects may affect patient's outcome and quality of care and require further research.

Implication for nursing and health policy: Findings suggest that it is important to have communication during cancer care, which includes compassion, spiritual and religious aspect, and hope as it potentially enables patients and relatives to deal with their cancer journey. Our findings have implications for nursing practice, education and policy so that there is an integration of biopsychosocial, and spiritual and religious aspects in cancer communication.

Keywords: cancer care, nurse–patient communication, oncology nursing, palliative care, phenomenology, religious discussion, spirituality

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Background

Good communication and information are foundation to quality of nursing care wherever nursing operates in the world, especially when patients have been diagnosed with cancer. Throughout cancer diagnosis and treatment, patients and their families may feel angry, and anxious, and surrounded by uncertainty and despair. Additionally, psychological problems such as stress, unstable feelings, impaired self-concept and

decreased quality of life may emerge (Khoshnazar et al. 2016). In such circumstances, patients and their families need appropriate information and support to meet their needs. Communication is therefore crucial and plays a fundamental role in addressing the need of patients with cancer and their families particularly biopsychosocial and spiritual need (Khoshnazar et al. 2016), and nurses and other health professionals need to ensure the highest quality of communication in every healthcare system. Communication in cancer services has three main aims that are to develop effective interpersonal communication, exchange information, and facilitate appropriate decision-making related to treatment (Hasan & Rashid 2016).

Nurses can begin with communication by providing a passionate presence to develop rapport (Mojarad et al. 2019). Familiarity with nurses will encourage patients to raise questions and express their feelings and needs (Chan et al. 2018). The need of patients and relatives for information is dynamic throughout the cancer trajectory. Information is need at the time of first feeling ill, during diagnostic test, at the time of admission and during cancer treatment, for self-care and palliative care, and must focus on psychosocial and spiritual needs (Beernaert et al. 2017; Lam et al. 2020; Moosavi et al. 2019). These needs can be addressed in nurse–patient/relative communication (Fletcher et al. 2017).

Communication in cancer services influences the quality of cancer services, treatment adherence and patient outcomes (Prip et al. 2019). Researchers suggest many advantages of good communication between patient and healthcare professionals. For example, a study found that Thai women with breast cancer who underwent chemotherapy expressed that communication is one of their important supportive needs (Klungrit et al. 2019). Good communication between patient and health professionals is associated with decreased anxiety and increased adherence to treatment, and positively influences patients' health outcomes and well-being (Venetis et al. 2019).

Communication is one of the compulsory competencies for nurses according to the standard for the professional nurse in Indonesia (Ministry of Health 2020). Further, the Association of Indonesian Nursing Education Institution (AINEC) decided that communication is a compulsory subject for undergraduate nursing education and suggested at least five credits for the communication subject that includes lectures and practical sessions (Harjanti et al. 2016). The decision has been implemented by higher education nursing institutions in Indonesia since then. Topics related to communication that should be taught to undergraduate nursing students include the principles of communication, verbal and non-verbal communication, therapeutic communication in various settings and cultural contexts, and interprofessional communication. Other topics related to communication are integrated in other nursing subjects for example communication in palliative care and breaking bad news (Harjanti et al. 2016). The Indonesian of Ministry of Health has developed a module on nursing communication (Anjaswarni 2016); however, the topics on the module are still for 'general' nursing communication. There are only few studies related to communication in nursing practice and education that have been conducted in Indonesia and none related to communication in cancer care (Anwar et al. 2020; Ardita et al. 2019; Claramita et al. 2016; Karmila et al. 2019).

The number of new cancer cases and cancer-related deaths has increased in Indonesia in recent years (IARC 2019). However, no Indonesian studies focusing on communication in cancer care could be found. Thus, we report here the findings of a first-time phenomenological study exploring experiences of communication from the perspectives of patients, relatives and nurses in cancer care.

Methods

Research design

The study employed a qualitative phenomenological design within the naturalistic paradigm (Lincoln & Guba 1985). The naturalistic paradigm is based on humanistic and holistic philosophy that is closely aligned with nursing. According to Husserl (1970), phenomenology is an approach that explores the understandings of those who have had particular experiences of a phenomena.

Sample and settings

We conducted the study in an oncology setting at a private Islamic Hospital in Indonesia March to April 2019, involving nurses, patients and their relatives. Participants willing to be included in the study were recruited through purposive sampling. The inclusion criteria for the patients were as follows: aged 18–70 years, had stage II-IV cancer and undergoing chemotherapy. The inclusion criteria for the relatives were as follows: aged 18–80 years and primary caregivers of patient with cancer, while the inclusion criteria for the nurses were as follows: working experience in cancer setting ≥1 year and minimum degree of bachelor in nursing.

Ethical consideration

Appropriate ethical research approval was obtained from the Institutional Review Board of the Universitas Aisyiah (no.430/I/UNISA/2019) as well as approval from the management of

the private hospital. The researchers provided a detailed description of the study and explained the associated procedures to each potential participant prior to signing the informed consent form. Researchers maintained ethical principles of participant's autonomy, voluntariness, anonymity and confidentiality throughout the study.

Data collection

After informed consents were obtained, face-to-face semi-structured interviews were conducted in a private setting around the hospital, chosen by each participant. The interviews were conducted in Bahasa, the mother tongue of the researchers and participants, using the interview guide with several broad questions. Participants were invited to share their experiences in relation to communication in cancer care, respectively. All participants were probed about their experiences of nurse–patient communication and its elements. The interviews were commenced by the researchers asking: 'Please tell your experiences in relation to nurse-patient communication?'. Other questions for patients and relatives included 'How do you feel about nurse-patient communication?', 'What do you think about detailed information that nurses give you?', 'How do you think about elements in nurse-patients communication?'. Additional questions for nurses were as follows: 'How do you start communication with patients and relatives?', 'What information do you provide to patients or relative about their illness and how do you do it?'

The duration of interviews was 19–46 min, with 30 min being the average. We listened and checked for each recording for the audibility after the interview was completed. The researchers digitally recorded all interviews, and reflective memos and notes taken during the interviews and written by the researcher were used for data analysis.

Data analysis

First, the recordings of interviews were transcribed verbatim, and we then used Colaizzi's phenomenological analysis, which was developed on the basis of Husserl's descriptive phenomenology, because it provides a clear structure for data analysis (Colaizzi 1978). The method consists of seven steps (Polit & Beck 2012). Figure 1 shows details of Colaizzi's seven-step data analysis that we performed in the study.

The process of transcribing and analysing was conducted in Bahasa. The use of Bahasa facilitated the researchers to understand the real meaning of the words by considering the use of language and the context. The researchers had regular and continuing discussion to verify the appropriateness and gain equivalence of the conceptual meanings and terminology. This process also enabled clarification of information from the data and ensured accurate meaning of the data from the transcripts. The quotations that we provided in English may appear grammatically incorrect since we made minimal grammatical corrections when necessary to keep the natural essence of the data. The consolidated criteria for reporting qualitative research (COREQ) checklist that is developed by Tong et al. (2007) was followed to report this study.

Trustworthiness of the data

In a qualitative study, rigour is established and maintained by considering the trustworthiness of the study. The criteria to maintain trustworthiness include credibility, transferability, dependability and confirmability (Lincoln & Guba 1985). Credibility and confirmability in the study were strengthened by spending ample time on data collection and analysis, by keeping field notes during the data collection and analysis stages, and by recording the interviews and transcribing them verbatim. Dependability was enhanced by keeping an audit trail to enable in exhibiting the evidences of thematic sources. In addition, all researchers reviewed the descriptions and experiences and agreed with the findings of the study. To ensure the data transferability, a complete description of the findings to allow readers to assess the application of data to other contexts is provided (Chesnay 2014).

Results

Sixteen participants comprising four nurses, seven patients and five relatives were interviewed in-depth. Table 1 shows the demographic characteristics. All of the nurses and the patients were female, and the nurses have worked for >7 years. Most of the patients had breast cancer. All participants were Muslim. Three themes construct communication in cancer care, namely B*uilding a compassionate relationship, Spiritual and religious discussion and Maintaining hope* (Table 2).

Building a compassionate relationship

This is a deliberate process, with most participants describing that such relationships were established in the first meeting between nurses–patient/relatives by developing mutual trust and familiarization. Two patients stated:

> At the beginning, we know nurses who will take care of me, we introduce our self each other to get more familiar. I will know the nurses and the nurses will know about me. (Patient 3)
>
> The nurse who met me at the first time, she greeted me and introduced herself. . .'Assalamu'alaikum (Islamic greeting), my name is nurse X and I am the nurse who take care of you today'. . .. This makes me happy and comfort. (Patient 1)

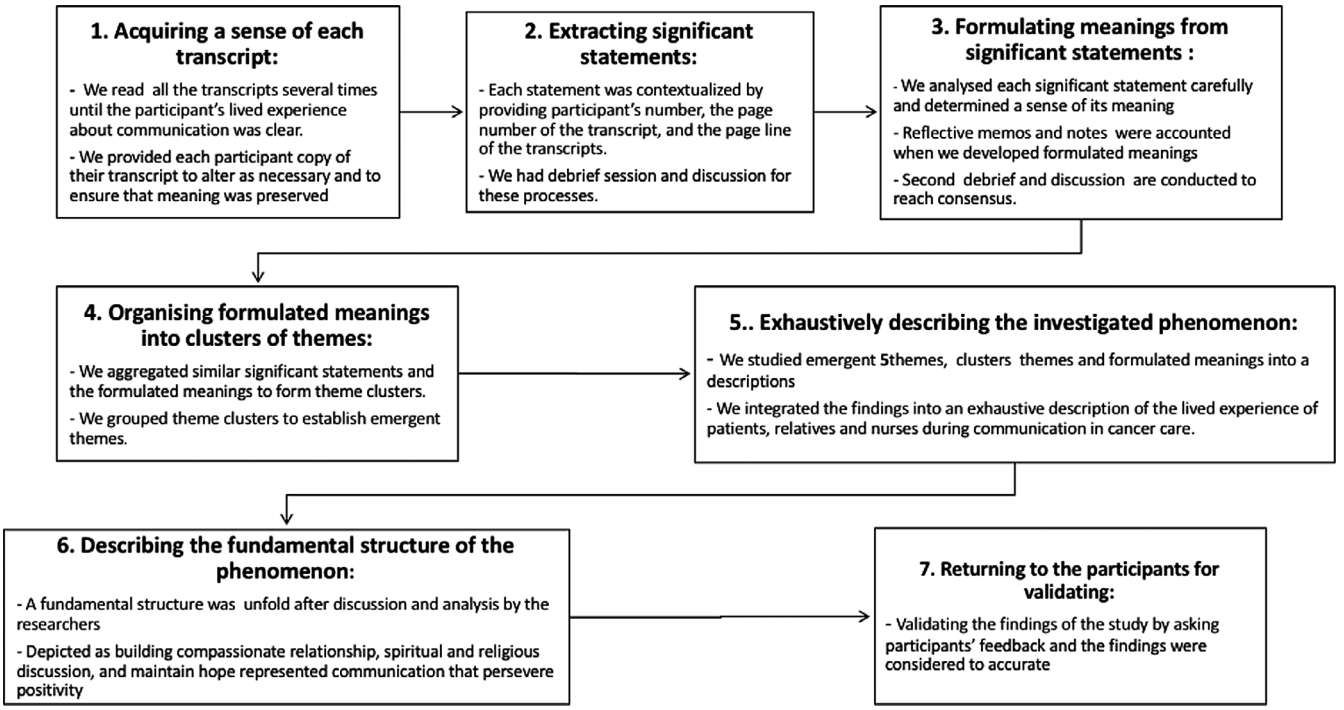

Fig. 1 Colaizzi's seven-step data analysis method performed in our study.

The participants reflected on characteristics of nurses that were fundamental to developing compassionate relationships, including showing empathy and genuineness, being sensitive to patient's need, providing required information and being therapeutically present. These three exemplars capture the compassionate relationship attributes from the perspectives of patients, relatives and nurses:

> When a patient says of having headache, we have to know the causes. For example, like what just happened when one patient has nausea, one has headache, we help them. The one who experience headache could be due to impaired oxygenation so we give her oxygen. We also report to the physician so that the patient can get medicine to control her pain. (Nurse 4)
>
> We can see and feel that the nurses genuinely take care of us from their words and attitude. It shows their affection. (Patient 5)
>
> The nurses often greet us. We (patient and relatives) can get closer with the nurses, so we do not feel scared. We also do not feel bad if we have questions or comments, we can ask to the nurses... We always get reminder the time to follow-up visit because sometime the schedule change, so we do not need to be worried (and) we feel good so we do not need to be worried. (Relative 1)

Spiritual and religious discussion

Religion in Indonesian culture is perceived as an inseparable part of life. In our study, we found that discussion about spirituality and religious practices is a common aspect during nurse–patient-relative communication in cancer care. Patients and their families welcome the spiritual and religious discussion with the nurses during their encounter, and two subthemes emerged: spiritual and religious conversation, and self-transcendence awareness.

Nurses incorporated spirituality and religious conversation in their daily communication with patients/relatives. As all of the participants were Muslim, the spiritual conversations were specific to values and practices in Islam. Two nurses said:

> We do it for all patients. The majority of the patients are Muslim, so we encourage them to make prayers, to always get closer to God. (Nurse 4)
>
> We encourage patients to perform their five daily compulsory worship (salat) on time and... also sunnah (non-compulsory) prayers like *dhuha* (morning worship) and *tahajud* (midnight worship). Salat (worship) is a media for the patients to communicate with his/her God to ask everything including the best solution. (Nurse 1)

Another nurse added that.

Table 1 Demographic characteristics of the participants

Nurses	*F (%) Min-Max*
Age	36–47 years old
Sex	
Male	0 (0)
Female	4 (100%)
Education	
Diploma	2 (50%)
Bachelor	2 (50%)
Working Experience	7–10 years
Total	4 (100%)
Patients	
Age	28–60 years old
Sex	
Male	0 (0%)
Female	7 (100%)
Education	
Elementary	1 (14.3%)
High School	3 (42.85%)
Bachelor	3 (42.85%
Cancer type	
Breast	5 (71.4%)
Skin	1 (14.3%)
Lung	1 (14.3%)
Stage	2–4
Total	7 (100%)
Families	
Age	42–64 years old
Sex	
Male	3(60%)
Female	2 (40%)
Education	
Elementary	1(20%)
High	2 (40%)
Bachelor	2 (40%)
Family ties	
Children	2 (40%)
Sister	1 (20%)
Spouse	2 (40%)
Total	5 (100%)

Because all of patients are Muslim, we often perform prayer (dua) together and remind them to get closer to God. (Nurse 2)

The patient and their relatives expressed that such spiritual and religious conversation help them psychologically.

I listened to the tausiyah (religious advices) from the nurse, I am happier...and I also received a lot of *dua* (prayers) from nurses... If there are spare time, we will talk with nurses because it increases my motivation. The one who are more knowledgeable in Islam can share it, and the nurses have done it. That is really good point from nurses. (Patient 1)

It is important... tausiyah (religious advices) helps me psychologically. (Patient 7)

The patients and relatives felt that every part of their life is connected with God, including during the illness, and this could be referred as self-transcendence awareness. Self-transcendence awareness has several benefits, including to keep patients of being optimistic, to increase adherence to treatment, and to have a belief that God will give the best result. From nurses reported that they always remind patients and relatives about this.

The important thing is we realize that all of everything come from God..., we have tried to seek treatment as much as we can. We hope that the treatments have good result. (Patient 5)

I told patients and relatives to see that the illness is to purify their sins, it could be also a form of test from God as well as to a way to improve their well-being. (Nurse 4)

Maintaining Hope

This consisted of efforts to conserve patients' and relatives' optimism, positive goals and beliefs about their illness or their future. Strategies to improve patients' and relatives' positive feelings and thoughts were described by the nurses in the following instances:

There are many cancer cases that can be cured, so we tell patients and relatives about this. We asked them not to think that cancer cannot be cured, or a patient died after chemotherapy. We asked to focus on the success stories. We try to a create comfortable atmosphere for the patient, we make the patients to feel as comfort as we can, to be more relaxed so that chemotherapy will not scared the patient. (Nurse 2)

We try to assure the patients that we help them during the treatment. ..... When a patient was diagnosed, she/he may feel scared of death and worry about the families, so we help them, we teach them some tips to avoid the complications. (Nurse 4)

The nurses created an atmosphere wherein patients could be optimistic and think about the treatment in a positive way. Such encouragement was considered an important aspect for patients and relatives to comply with cancer treatments and have hope for the recovery, for example:

The patient needs to be motivated by nurses such as 'keep your spirit, you can do it', it is important. It can help the patient not to overthink with his/her illness, it also can make him/her happy. (Relative 2)

Table 2 Analysis of Data

Statement	*Formulated meaning*	*Thematic cluster*	*Theme*
'At first, we know the nurses who will take care of us, and the nurses also know us, we know each other, and then here like what' (PP3)	Initial meeting	Trust development	Building a compassionate relationship
	Introducing each other		
	Physical presence	Therapeutic presence	
	Psychological presence		
	Helping to make patient comfort	Sincerity	
	Showing good intention		
'When the patients look anxious, depressed or denial, we provide physical comfort such as touch them to make them feel calm' (NP4)	Non-verbal immediacy	Immediacy behaviour	
	Verbal immediacy		
	Understanding patients	Responsiveness,	
	Tailoring during explanation	Respect	
	Providing fast response for the patient's need		
	Maintaining patient's privacy	Apologize culture	
	Respecting each other		
'. . . we are honest, if we have mistakes, we admit the mistakes, so we could keep relationship well' (NP3)	Asking apologize		
	Admitting mistake		
'we encourage patients to perform their five daily prayers (salat) on time and. . .also sunnah prayers like dhuha and tahajud. Salat is a media for the patients to communicate with his/her God to ask everything including the best solution' (NP1)	Encourage patients to pray	Communication with God	
	Remind patients that illness is part of life		
	Encourage patients and families to get closer to God		
'it's important, religious reminder (tausiyah) helps me psychologically' (PP7)	Being surrender to the Al Mighty	Self-transcendence awareness	Spiritual/Religious discussion
	Endeavour (Ikhtiar)		
	Believe that the Al Mighty will heal		
'I will follow the chemotherapy program, Bismillah, I will be healthy again' (PP7)	Creating comfort	Creating positive feelings and thoughts,	Maintaining hope
	Positive thinking		
	Avoiding negative thinking	Giving motivation	
	Being patient		
	Motivating patients to adhere the treatment		
'. . . the patient who is motivated by nurses or his family, is necessary, that can help the patient so that he does not overthinking negatively, as well get nice atmosphere' (FP2)	Pharmacologic treatment	Managing symptoms	
	Non-pharmacologic management		
'. . .we demonstrate how to reduce pain by non-pharmacological. . . and. . .after chemotherapy, we also give some medicines, as anticipate side effects' (NP4)			

This is why, chemotherapy is compulsory for me because I had skin cancer, yaa. . . chemotherapy is a must, that is the risk. (Patient 4)

The important thing is just to comply with the treatment, Bismillah (in the name of God) I will be recovered. (Patient 7)

In addition to the encouragement and hope, the nurses expressed that they need to manage side effects and symptoms that occurred due to chemotherapy or the illness. Symptom management consists of interventions to minimize the deterioration of patients' condition by implementing non-pharmacology and pharmacology interventions.

We demonstrate to patients how to reduce pain using non-pharmacological techniques. And. . . after chemotherapy we give some medicines to reduce its side effect. (Nurse 4)

Discussion

The findings illustrate important elements about nurse–patient–relatives communication experiences in cancer care. In addition, communication in this setting is often conducted triadic, so that all are involved. The qualitative approach used in this study provided rich data to explore explicitly the understanding of communication not only from nurses, but also from the perspective of patients and their relatives. We found that all participants concurred that communication is an essential component in cancer care. Three themes emerged in the study that include *Building a compassionate relationship, Spiritual and religious discussion, and Maintaining hope*.

For a patient to know the person is a crucial element of communication and compassionate health care (Benevenuto Reis et al. 2018; Sinclair et al. 2016). Our study demonstrated that the compassionate relationship between nurses–patients–relatives was initiated when nurses implemented the most important factor in communication, that is developing trust. During this stage, the three groups stated that they introduce themselves to one another and also explored the goals and roles of each other. A good relationship leads nurses, patients and their families to understand one another which helps nurses meet the patients' and their families' need (Smith-MacDonald et al. 2019). In addition, our study revealed that patients and relatives increased their trust when the nurses showed their competencies and when their needs were addressed by the nurses. This finding supports previous studies that found nurses' personal quality can encourage patients to trust nurses (Dinc & Gatsmans 2013; Tehranineshat et al. 2018). The authors add that mutual trust enables nurses to meet patients' need effectively.

The nurse participants felt of being responsible to provide information about follow-up visit, side effects of chemotherapy and cancer management, similar to another study where nurses were found to be responsible to develop and coordinate patient care programmes while monitor medication side effects (Khoshnazar et al. 2016). The patients and relatives reported on being well-informed about scheduling follow-up visit which gave them comfort. Such finding was different in a study among patients with cancer in Poland, where they reported not knowing about follow-up visit schedule (Godlewski et al. 2017).

The provision of spiritual communication to cancer patients and their families is important throughout cancer care (Ellington et al. 2017), and we argue not only in Indonesia, but around the world. A notable finding from our study was *Spiritual and religious discussion*. Interview data revealed a strong emphasis on this, and this is not surprising as a previous study found that spirituality and religion is a central part in Indonesian daily life and increasingly crucial in times of illness (Rochmawati et al. 2018). Patients and relatives expressed that they obtain religious advice from the nurses which helps them psychologically. This confirms findings of nurses becoming a resource of spiritual and religious information for patients and relatives (Ramezani et al. 2014; Reblin et al. 2014; Wittenberg et al. 2017). In addition, spiritual conversation positively affects quality patient care (Wittenberg et al. 2017), and we found that spiritual and religious conversation helps patients and relatives find ease from the psychological impact of cancer.

Although previous studies have claimed that spiritual and religious discussion is considered advanced skills (Ford et al. 2012), in the current study, the nurses reflected such discussion becomes a part of their daily communication. This occurrence is likely because all of the participants in the study including patients, relatives and nurses were affiliated to similar religion and this helped them to be more openly talking about spiritual and religion. Nurses and patients from similar culture or religion background have higher opportunity and possibility to share the set of beliefs (Lee 2019).

A further theme that emerged is *Maintaining hope*. A previous study found that interventions to promote hope tended to be made at an advanced phase or end-of-life conditions (Nierop-van Baalen et al. 2019). This contrasts with the present findings that maintaining hope was conducted since the early trajectory of the cancer care. Actions to maintain hope was part of daily communication in the oncology setting and a valuable and necessary role for oncology nurses. This is in line with findings from a systematic review in oncology outpatient settings where healthcare professionals play a central role in enhancing hope and positivity for the patients (Prip et al. 2018). The nurse participants expressed that they asked patients and relatives to focus on success stories of other patients and offered supports to patients to maintain patients' and relatives' hope. These activities have been identified in other qualitative studies, where healthcare providers can improve and maintain patients' hope through their attitude, behaviour and ways of communicating (Nierop-van Baalen et al. 2019).

Hope and optimisms are important to maintain patient's psychological well-being as well as to increase their ability to recognize, accept and fight the terminal illness (Collins et al. 2018; Wolf et al. 2018). Nurses in our study stated that symptom management was important to maintain the hope of patient and relatives. This is similar to Seibaek et al. (2018) who described that sufficient symptom management combined with sensitive attention of the patients with ovarian cancer can sustain their hope. In addition, patients who

display themselves as strong individuals express that they can fight the illness (Lannie & Peelo-Kilroe 2019), while poor control of symptoms can prolong patients' ability to accept the illness, and this can be detrimental to the patient's well-being (Wolf et al. 2018). Such benefits were reflected in our study that patients felt that such motivation can make them happier, being optimistic with the future and increasing their adherence to the treatment.

Limitations of the study

We conducted this study only in the oncology setting of an Islamic private hospital in the central part of Indonesia, and all participants are affiliated to a similar religion. Therefore, these factors may not be fairly representative of the nature of nurse–patient–relatives communication in other oncology units located in different regions of Indonesia or the world. Additionally, all patients and nurses were female and therefore may not applicable for male patients and male nurses.

Conclusion

This study offers an understanding of nurse–patient–relative communication in cancer care in Indonesia, and such communication was initiated with the development of a compassionate relationship. For participants, this aspect is about building mutual trust and nurses must demonstrate their authenticity, empathy and sensitivity towards patients and relatives' needs. Important aspects in cancer care, such as spirituality and religion, are often expressed in the communication between nurses, patients and relatives in this setting that might be influenced by culture. Our study also demonstrates that maintaining hope is emphasized during communication. Further study is recommended to examine the impact of the aspects in communication, such as spiritual and religious discussion and maintaining hope for the well-being of patients and their relatives.

Implications for nursing and health policy

For healthcare systems to provide quality care, all patients and their families need to perceive that they have good communication with nurses and other healthcare professionals. Similarly, nurses must feel that they are properly trained to communicate well in their care of patients and their families in oncology setting. For this to happen, health and education leaders and policymakers need to provide opportunities to enhance nurses' competencies in communication and the spiritual aspects of patient care. Nurses need to take up such opportunities to improve their communication skills and join in conversations about how to enable communication training in cancer care settings, as well learning techniques to integrate spiritual and religious conversations in practice, as well as those that focus on communication skills.

Healthcare and nursing education institutions are fundamental platforms to improve healthcare professional–patient/relative communication in cancer care. Strategies to promote communication skills in cancer care should be included in educational and healthcare policies. For example, the Association of Nursing Education Institution and the nurse association in Indonesia can provide a clear guideline on topics related to communication in cancer care. In addition, the Indonesian Ministry of Health can develop modules for that can be utilized to teach communication in nursing in cancer care. The healthcare institutions are encouraged to conduct refresher workshops and courses so that nurses and other healthcare professionals can be more knowledgeable and confident when communicating with patients and their families in an oncology setting. In addition, the standards of practice in the cancer care that include the integration of spirituality and religiosity in communication should be developed and used in settings where they do not currently exist.

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Authors' contribution

Study design: MM, ER
Data collection: MM
Data analysis: MM, ER
Study supervision: ER
Manuscript writing: MM, ER
Critical revisions for important intellectual content: MM, ER

Ethical approval

Ethical approval was obtained prior to the commencement of the study through the Human Research Ethics Committee of the Universitas Aisyiah (430/KEP-UNISA/I/2019).

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