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Publikasi di jurnal internasional bereputasi: *tips* dan *tricks*

ER

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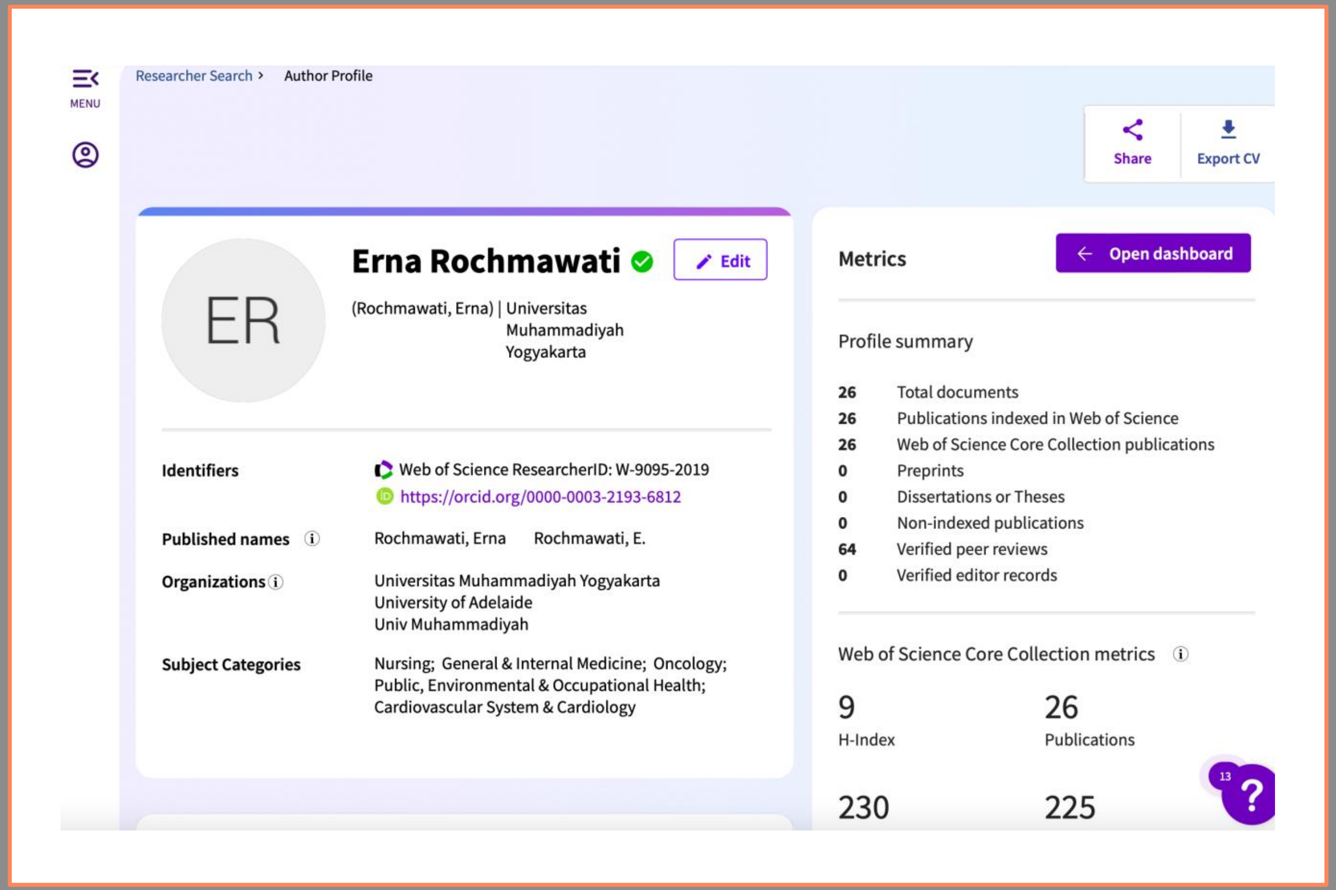

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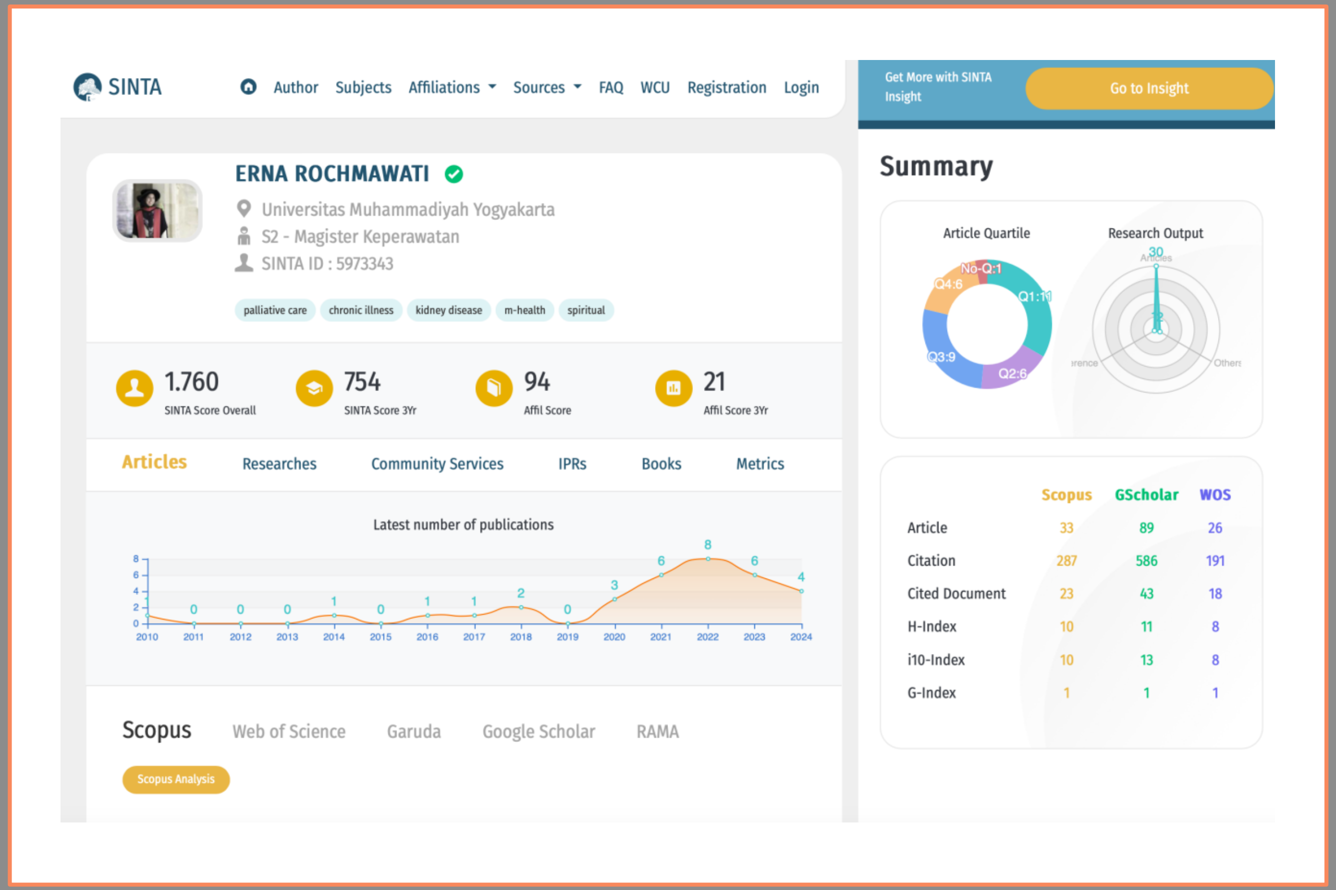

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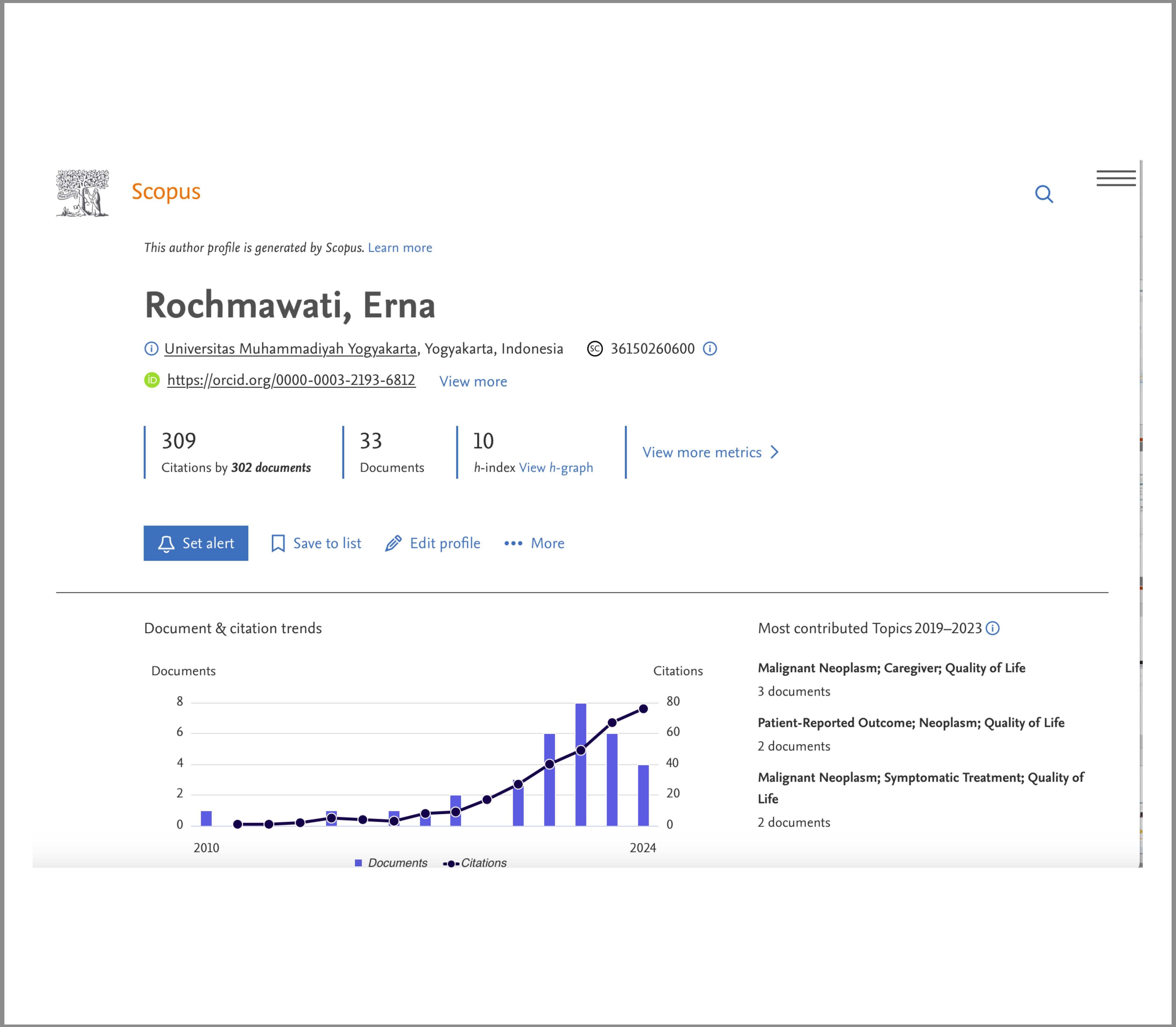
Summary

Article Quartile

Research Output

	Scopus	GScholar	WOS
Article	33	89	26
Citation	287	586	191
Cited Document	23	43	18
H-Index	10	11	8
i10-Index	10	13	8
G-Index	1	1	1



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Document & citation trends

Most contributed Topics 2019–2023

Malignant Neoplasm; Caregiver; Quality of Life
3 documents

Patient-Reported Outcome; Neoplasm; Quality of Life
2 documents

Malignant Neoplasm; Symptomatic Treatment; Quality of Life
2 documents

Overview

01

Bagaimana menyusun manuskrip dari hasil penelitian?

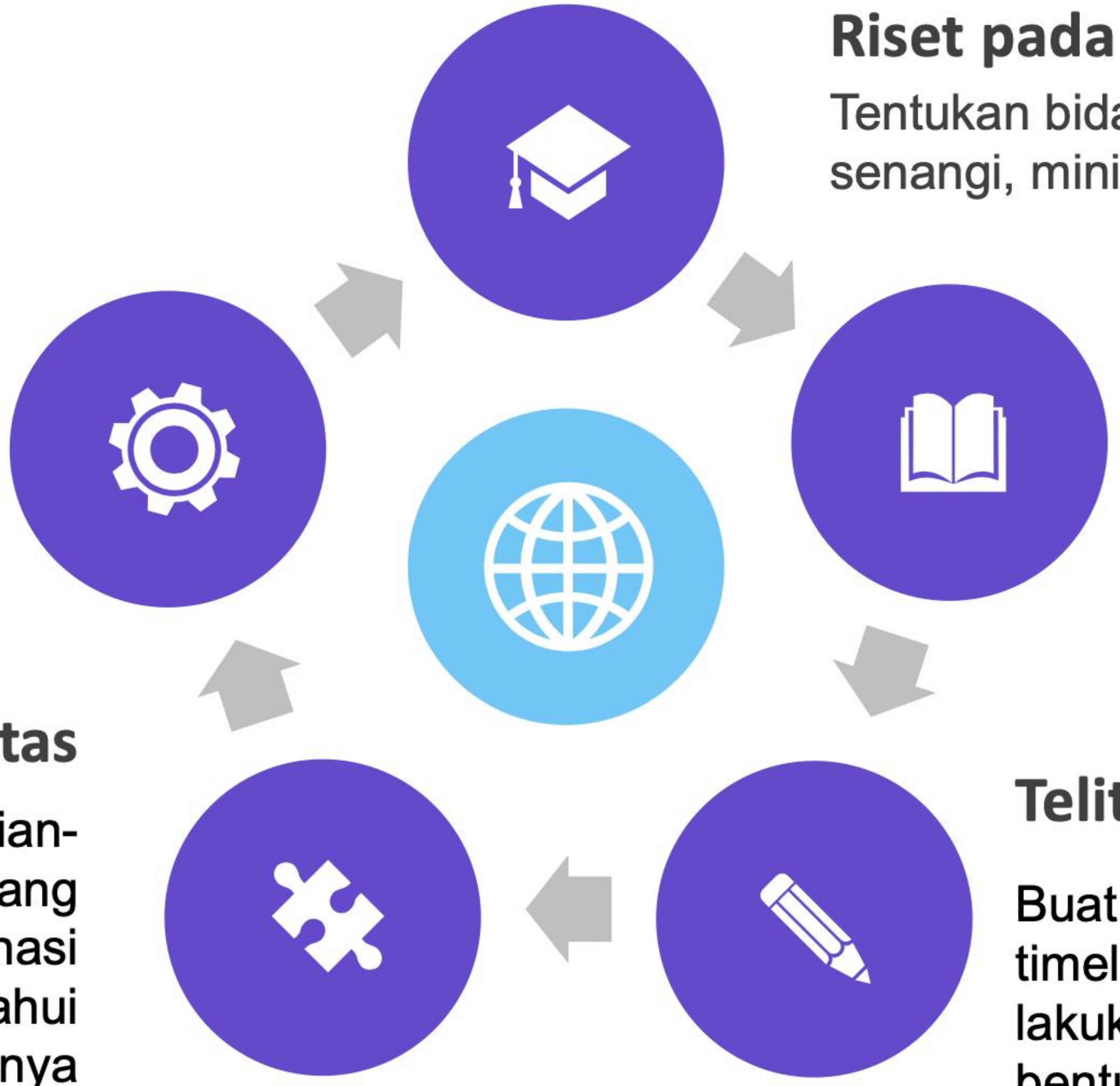
02

Bagaimana memilih jurnal yang baik?

03

Bagaimana proses mempublikasikan artikel ilmiah pada jurnal yang baik?

Menyusun manuskrip



Riset pada topik yang disenangi

Tentukan bidang kajian atau topik riset yang kita senangi, minimal berdasarkan minat selama studi.

Kajian yang komprehensif

Baca dan belajar secara detail dan mendalam terhadap topik riset kita, serta cari dosen atau kolega yang expert di bidang tersebut dan jadikan sebagai mentor atau pembimbing

Teliti dan Tulis

Buat detail rancangan penelitian, timeline penelitian, target penelitian, lakukan penelitian, dan tuliskan dalam bentuk karya ilmiah

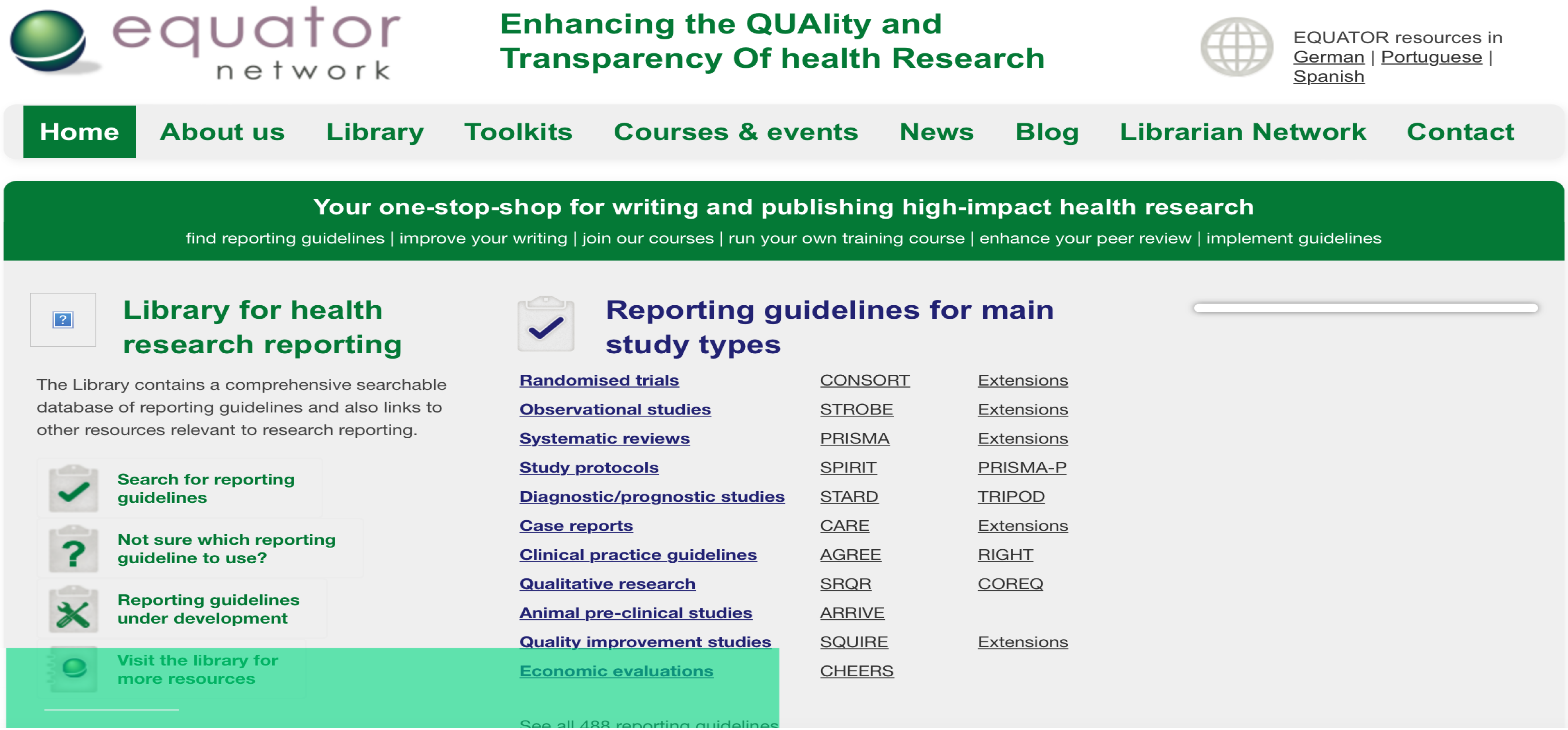
Komunitas

Ikuti seminar, konferensi, atau kajian-kajian yang sesuai dengan bidang ilmu yang kita sukai untuk diseminasi hasil riset kita dan mengetahui perkembangan keilmuannya

Research Collaboration

Lakukan kolaborasi riset dengan sejumlah peneliti yang sesuai dengan bidang kajian yang kita tekuni dengan dukungan penuh dari dosen pembimbing atau kolega kita

Menyusun manuskrip



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Library for health research reporting

The Library contains a comprehensive searchable database of reporting guidelines and also links to other resources relevant to research reporting.

- Search for reporting guidelines
- Not sure which reporting guideline to use?
- Reporting guidelines under development
- Visit the library for more resources

Reporting guidelines for main study types

Randomised trials	CONSORT	Extensions
Observational studies	STROBE	Extensions
Systematic reviews	PRISMA	Extensions
Study protocols	SPIRIT	PRISMA-P
Diagnostic/prognostic studies	STARD	TRIPOD
Case reports	CARE	Extensions
Clinical practice guidelines	AGREE	RIGHT
Qualitative research	SRQR	COREQ
Animal pre-clinical studies	ARRIVE	
Quality improvement studies	SQUIRE	Extensions
Economic evaluations	CHEERS	

See all 488 reporting guidelines

Menyusun manuskrip

Manuskrip yang baik harus mengandung

- Introduction
- Methods
- Results
- Discussion

Menyusun manuskrip

Introduction/Pendahuluan

- Bagian ini harus menceritakan pentingnya penelitian ini dilakukan yang di dukung oleh kajian ilmiah yang relevan
- Gap
- Tujuan

1 | INTRODUCTION

Cancer is of great concern due to the increasing number of new cases and deaths globally (Wang et al., 2016). The International Agency for Research on Cancer (IARC) in 2018 reported a global increase of 18.1 million new cases of cancer and 9.6 million deaths during that year. According to the World Health Organization (WHO) the overall number of individuals living within 5 years of cancer diagnosis, the 5-year prevalence, is estimated at 43.8 million worldwide (WHO, 2018).

People who have been diagnosed with cancer experience devastating changes in their lives including threats to their bodies and even their existence (Madsen et al., 2019). A study by Morgan et al. (2017) found that patients with advanced cancer experience a loss of functionality due to physical decline. Erol et al. (2018) found that advanced cancer patients with unrelieved pain experienced anxiety, helplessness and hopelessness. They also suggest the inability to cope with pain resulted in many limitations on aspects of daily life. Furthermore, a study by Stanze et al. (2019) revealed that patients with cancer feel powerless due to high psychological and social burden and additionally the side effects of treatment can lead to a desire to die. These are all manifestations of suffering. Nurses have an important role in such situations, as they spend more time with patients in providing comprehensive care at times when cancer patients are suffering (Canzona et al., 2018). Our planned qualitative systematic review aims to explore suffering in cancer patients, documented in the international literature, to increase understanding for nurses to better address suffering in cancer setting.

Conversely, not knowing details of diagnosis and prognosis of the disease, creates excruciating uncertainty (Hartogh, 2017).

In the phase of living with advanced cancer, patients generally move rapidly into a cancer world dominated by physical or psychological complaints, hospital care regimens and medical appointments (Kendall et al., 2015; van Roij et al., 2019). Uncertainty and low mood often occur as a result of managing treatments and difficulty in adjusting to life as a patient with cancer. When symptoms appear they are sometimes interpreted as implying relapse (Kendall et al., 2015). Symptoms of advanced cancer include pain, weakened physical strength and paralysis. These have an impact on patients ability to move freely, resulting in loss of independence and being unable to actively contribute to society (Madsen et al., 2019). Socially patients are treated differently after diagnosis as cancer becomes the center of their social identity (Hartogh, 2017; van Roij et al., 2019). Patients are concerned about how others perceive them. They feel isolated and excluded from social life, especially when being asked questions that focus on cancer and its treatment (Madsen et al., 2019; van Roij et al., 2019). In this situation, feelings of losing control of their own lives and feelings of alienation make the suffering even more real. The desire to hasten death arises in patients who want to avoid continued suffering, leading to the possibility of suicide (Granek et al., 2017).

Suffering increases when death is imminent and inevitable, especially when patients who will die of cancer continue to be treated for their disease (Best et al., 2015; Hartogh, 2017; Kendall et al., 2015). Death becomes clear with relapse and increasing symptoms at end of life (Kendall et al., 2015). The negative emotions that arise in patients who do not accept death are depression and anxiety (Kyota &

Barriers to the use of health technology include the appearance of unattractive health technology apps, the difficulty in using them because of the complexity, unclear information and/or guidelines, and the lack of good-quality interventions in management strategies for chronic diseases in older people (Kim & Lee, 2017; Nimrod, 2018). Another barrier is that older people are also generally unaware of new technologies and their uses (Lee & Maher, 2021). Barriers of older people using e-health include a lack of ability, skills, and knowledge of using digital technology owing to decreased sensory perception (because of aging), a lack of support for resources that provide assistance and training in implementing tools or programs of e-health, anxiety, worry about using devices, and a perception that using technology is expensive, which may not be supported by older people's limited income. The self-choice barriers that affect older people include a lack of time or other priorities, lack of motivation, distrust of clinical outcomes, poor information technology systems, and lack of perceived need for technology (Nymberg et al., 2019; Peek et al., 2016). It is also important to understand the differences in access to health technology. Rural areas often have lower infrastructure and broadband services than urban areas because of their remoteness causing people in rural areas have less access to health technology (Park, 2017). However, the ambivalence of older people toward e-health occurs, and Nymberg et al. (2019) show that they do have a desire and need to move forward, particularly in health home monitoring, even if they do so reluctantly.

Older people's involvement and enthusiasm are critical to the success of using health technology (Lee & Maher, 2021), but their

ing, and treatment for the majority of chronic diseases (Mahendradhata et al., 2017).

Since 2010, BPJS Kesehatan has initiated the Chronic Disease Management Program or *Program Pengelolaan Penyakit Kronis* (Prolanis), which aims to provide proactive health care for patients with chronic diseases, including hypertension and type 2 diabetes mellitus as the main focus (Alkaff et al., 2021; Khoe et al., 2020; Yusransyah & Suwantika, 2020).

The Indonesian government involves people aged over 45 to 59 years and older people (over 60 years) (Kemenkes, 2016) who have chronic disease as target for Prolanis (Khoe et al., 2020; Yusransyah & Suwantika, 2020). In almost 5 decades (1971–2019), the percentage of Indonesian older people has doubled to 9.6%, approximately 25 million people (Maylasari et al., 2019). This program is expected to achieve optimal results in terms of chronic disease management (Yusransyah & Suwantika, 2020). Indonesia has implemented several e-health technologies, but there is no research on acceptance or factors that influence the adoption of home health monitoring technology among older people in Indonesia.

GAP

Therefore, we conducted research to explore the acceptance of health technology among older people who receive primary health care (FKTP) in Indonesia. We examined the perceptions, attitudes, experiences, and expectations of older people patients regarding e-health services used in primary care. A thorough study of older people population's acceptance and comfort with current health technology is required to design future health technologies that meet their needs and preferences.

TUJUAN

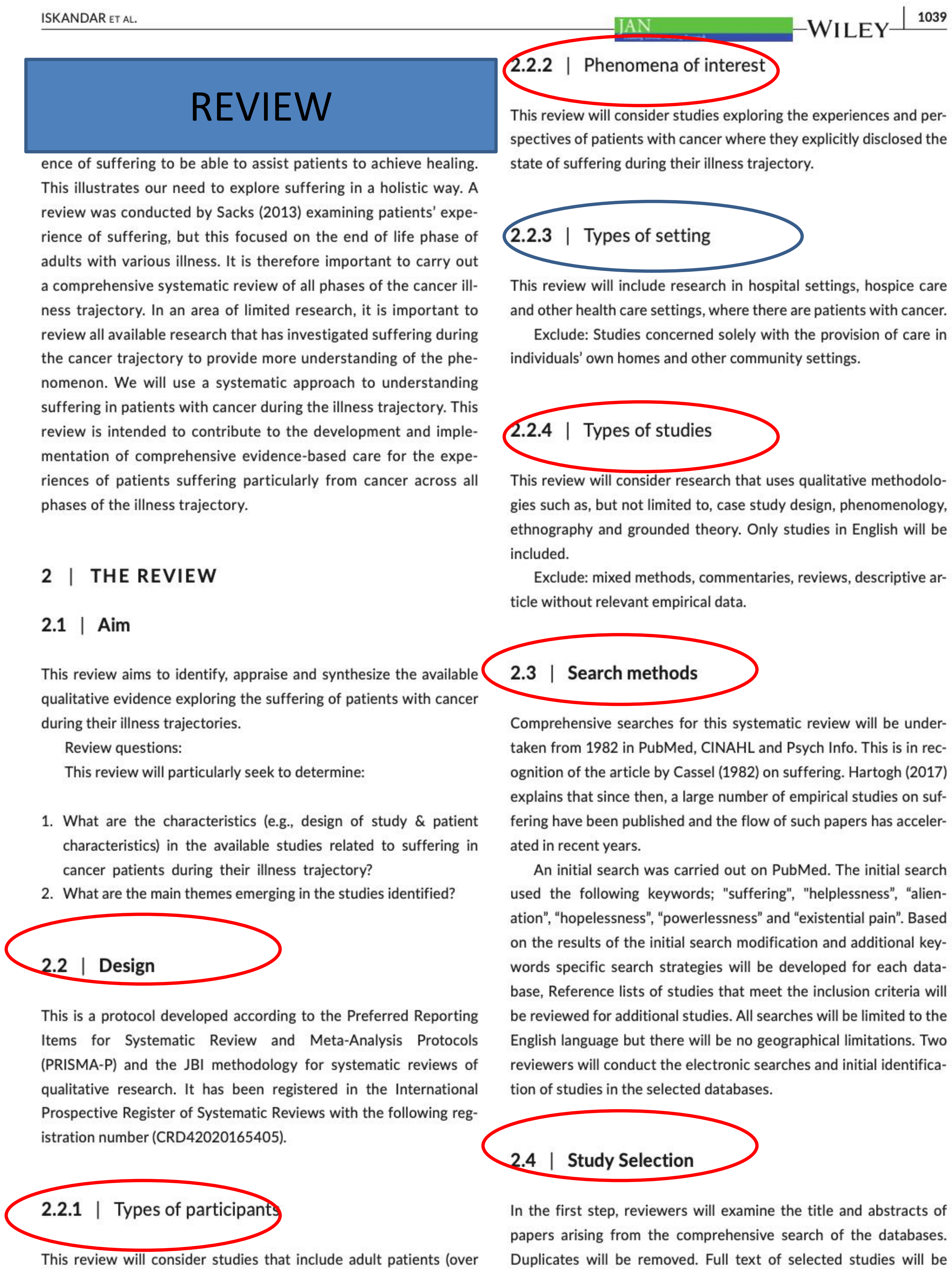
Menyusun manuskrip

Method

- Bagian ini harus dituliskan dengan tahapan yang dapat dilacak, sehingga dapat diulangi oleh peneliti lain
- Tergantung jenis: penelitian primer atau review

Apa yang harus ditulis di bagian metode?

- Desain penelitian
- Sample/participant
- Etika penelitian
- Metode pengambilan data
- Outcome measurements
- Data analisis



REVIEW

ence of suffering to be able to assist patients to achieve healing. This illustrates our need to explore suffering in a holistic way. A review was conducted by Sacks (2013) examining patients' experience of suffering, but this focused on the end of life phase of adults with various illness. It is therefore important to carry out a comprehensive systematic review of all phases of the cancer illness trajectory. In an area of limited research, it is important to review all available research that has investigated suffering during the cancer trajectory to provide more understanding of the phenomenon. We will use a systematic approach to understanding suffering in patients with cancer during the illness trajectory. This review is intended to contribute to the development and implementation of comprehensive evidence-based care for the experiences of patients suffering particularly from cancer across all phases of the illness trajectory.

2 | THE REVIEW

2.1 | Aim

This review aims to identify, appraise and synthesize the available qualitative evidence exploring the suffering of patients with cancer during their illness trajectories.

Review questions:

This review will particularly seek to determine:

1. What are the characteristics (e.g., design of study & patient characteristics) in the available studies related to suffering in cancer patients during their illness trajectory?
2. What are the main themes emerging in the studies identified?

2.2 | Design

This is a protocol developed according to the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) and the JBI methodology for systematic reviews of qualitative research. It has been registered in the International Prospective Register of Systematic Reviews with the following registration number (CRD42020165405).

2.2.1 | Types of participants

This review will consider studies that include adult patients (over

2.2.2 | Phenomena of interest

This review will consider studies exploring the experiences and perspectives of patients with cancer where they explicitly disclosed the state of suffering during their illness trajectory.

2.2.3 | Types of setting

This review will include research in hospital settings, hospice care and other health care settings, where there are patients with cancer.

Exclude: Studies concerned solely with the provision of care in individuals' own homes and other community settings.

2.2.4 | Types of studies

This review will consider research that uses qualitative methodologies such as, but not limited to, case study design, phenomenology, ethnography and grounded theory. Only studies in English will be included.

Exclude: mixed methods, commentaries, reviews, descriptive article without relevant empirical data.

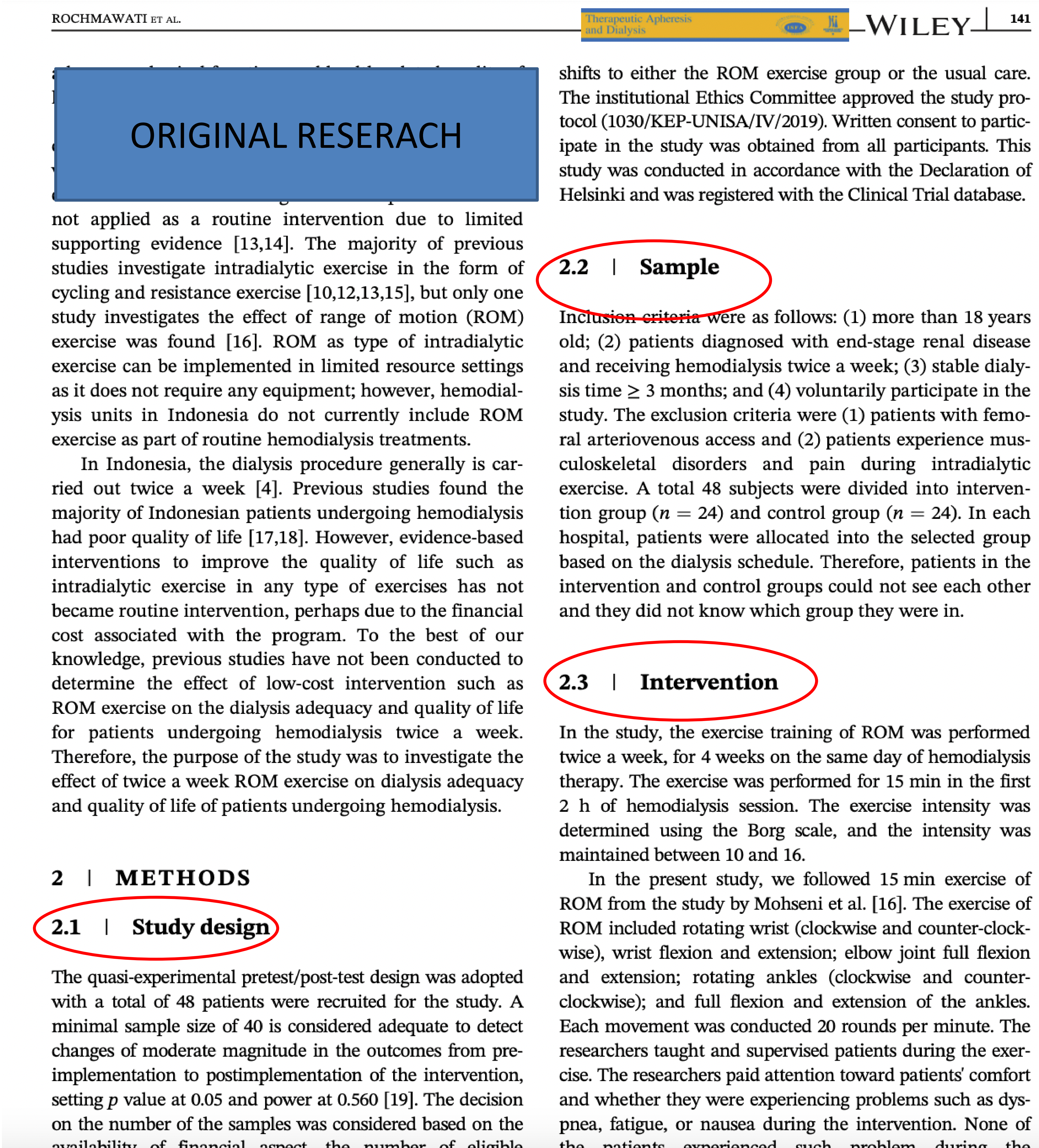
2.3 | Search methods

Comprehensive searches for this systematic review will be undertaken from 1982 in PubMed, CINAHL and Psych Info. This is in recognition of the article by Cassel (1982) on suffering. Hartogh (2017) explains that since then, a large number of empirical studies on suffering have been published and the flow of such papers has accelerated in recent years.

An initial search was carried out on PubMed. The initial search used the following keywords; "suffering", "helplessness", "alienation", "hopelessness", "powerlessness" and "existential pain". Based on the results of the initial search modification and additional keywords specific search strategies will be developed for each database, Reference lists of studies that meet the inclusion criteria will be reviewed for additional studies. All searches will be limited to the English language but there will be no geographical limitations. Two reviewers will conduct the electronic searches and initial identification of studies in the selected databases.

2.4 | Study Selection

In the first step, reviewers will examine the title and abstracts of papers arising from the comprehensive search of the databases. Duplicates will be removed. Full text of selected studies will be



ORIGINAL RESERACH

not applied as a routine intervention due to limited supporting evidence [13,14]. The majority of previous studies investigate intradialytic exercise in the form of cycling and resistance exercise [10,12,13,15], but only one study investigates the effect of range of motion (ROM) exercise was found [16]. ROM as type of intradialytic exercise can be implemented in limited resource settings as it does not require any equipment; however, hemodialysis units in Indonesia do not currently include ROM exercise as part of routine hemodialysis treatments.

In Indonesia, the dialysis procedure generally is carried out twice a week [4]. Previous studies found the majority of Indonesian patients undergoing hemodialysis had poor quality of life [17,18]. However, evidence-based interventions to improve the quality of life such as intradialytic exercise in any type of exercises has not became routine intervention, perhaps due to the financial cost associated with the program. To the best of our knowledge, previous studies have not been conducted to determine the effect of low-cost intervention such as ROM exercise on the dialysis adequacy and quality of life for patients undergoing hemodialysis twice a week. Therefore, the purpose of the study was to investigate the effect of twice a week ROM exercise on dialysis adequacy and quality of life of patients undergoing hemodialysis.

2 | METHODS

2.1 | Study design

The quasi-experimental pretest/post-test design was adopted with a total of 48 patients were recruited for the study. A minimal sample size of 40 is considered adequate to detect changes of moderate magnitude in the outcomes from pre-implementation to postimplementation of the intervention, setting p value at 0.05 and power at 0.560 [19]. The decision on the number of the samples was considered based on the

shifts to either the ROM exercise group or the usual care. The institutional Ethics Committee approved the study protocol (1030/KEP-UNISA/IV/2019). Written consent to participate in the study was obtained from all participants. This study was conducted in accordance with the Declaration of Helsinki and was registered with the Clinical Trial database.

2.2 | Sample

Inclusion criteria were as follows: (1) more than 18 years old; (2) patients diagnosed with end-stage renal disease and receiving hemodialysis twice a week; (3) stable dialysis time ≥ 3 months; and (4) voluntarily participate in the study. The exclusion criteria were (1) patients with femoral arteriovenous access and (2) patients experience musculoskeletal disorders and pain during intradialytic exercise. A total 48 subjects were divided into intervention group ($n = 24$) and control group ($n = 24$). In each hospital, patients were allocated into the selected group based on the dialysis schedule. Therefore, patients in the intervention and control groups could not see each other and they did not know which group they were in.

2.3 | Intervention

In the study, the exercise training of ROM was performed twice a week, for 4 weeks on the same day of hemodialysis therapy. The exercise was performed for 15 min in the first 2 h of hemodialysis session. The exercise intensity was determined using the Borg scale, and the intensity was maintained between 10 and 16.

In the present study, we followed 15 min exercise of ROM from the study by Mohseni et al. [16]. The exercise of ROM included rotating wrist (clockwise and counter-clockwise), wrist flexion and extension; elbow joint full flexion and extension; rotating ankles (clockwise and counter-clockwise); and full flexion and extension of the ankles. Each movement was conducted 20 rounds per minute. The researchers taught and supervised patients during the exercise. The researchers paid attention toward patients' comfort and whether they were experiencing problems such as dyspnea, fatigue, or nausea during the intervention. None of

ORIGINAL RESEARCH

3 | METHOD

3.1 | Design

This research is part of a larger study to develop a smart mobile app and smartwatch solution for home health monitoring. We aimed to explore older people patients who use primary healthcare facilities for the acceptance of health technology as a means of home health monitoring. An exploratory qualitative method was adopted to understand the perception of older people in terms of health technology. This approach can provide a deeper understanding of the factors that influence participants' acceptance of health technology, especially in Indonesia because of limited studies on the use of health technology in older people. Additionally, this approach is able to present more authentic data based on participants' perspectives and experiences and is more naturalistic in essence (Creswell & Poth, 2016). We present this study in alignment with the items of the consolidated criteria for reporting qualitative research (COREQ) and includes the information required in this guideline.

3.2 | Setting

We conducted this research in a suburban primary clinic (FKTP) in central Indonesia. Javanese ethnicity makes up the majority of the population, and the languages spoken are Javanese and Indonesian. The majority of older people in this area are retirees (57–82 years old). Although health technology is rapidly evolving in this field, not everyone, particularly older people, uses it. Internet access is available, but not all areas have stable internet access. Each subdistrict has its own health facility, known as Puskesmas, and several primary health clinics that provide an alternative to other health facilities. Not every health center offers online health services. For older people, the subhealth district's center offers a chronic disease management program called Prolanis, which is covered by the BPJS health insurance. Monthly visits to the health center for consultations, routine health checks, and medicines are part of the program.

research in more detail and provided an explanation of the research protocol, which included the participants' rights and obligations while participating in the research. Participants confirmed their voluntariness and willingness to engage in the study by signing a consent form.

There were 11 participants (Table 1). Before the interview, participants received more information about the research aims, their rights, and the research procedures that would be used. Permission was also sought to record their voices during the interview. All individuals consented to participate in written form. Their identities were protected by the use of an allocated number per individual.

3.4 | Data collection

Data were collected between May and June, 2021. All participants were interviewed using semistructured interviews, and the audio was recorded. We aimed in the interviews to ascertain older people's perceptions of health technology acceptance. The interview guide was developed through a review of related literature and was refined based on the findings of participant interviews. The interview guide included questions about the participants' health condition, their experience with first-level health facilities, and their access to and use of technology to monitor their health at home. If necessary, additional in-depth questions not included in the guide were asked to obtain a better grasp of the participants' perceptions.

Interviews took between 36–102 min with an average of 65 min. Interviews were conducted face to face at the participants' homes (nine people) and at the clinic (two people). Interviews were conducted by two researchers (FK and ACI), both of whom were

TABLE 1 Participant demographic data ($n = 11$)

Age (mean)	**66.9**
Gender	
Female	63.3%
Male	36.7%
Diagnose	
Diabetes mellitus	45.5%

Menyusun manuskrip

Results/hasil

- Seluruh data yang ingin disampaikan harus diilustrasikan dan diinterpretasikan dengan baik.

Apa yang harus ditulis di bagian results/hasil?

- Tabel demografi
- Tabel sesuai dengan variable yang ada
- Interpretasi/narasi dari table

QUASY EXPERIMENT STUDY

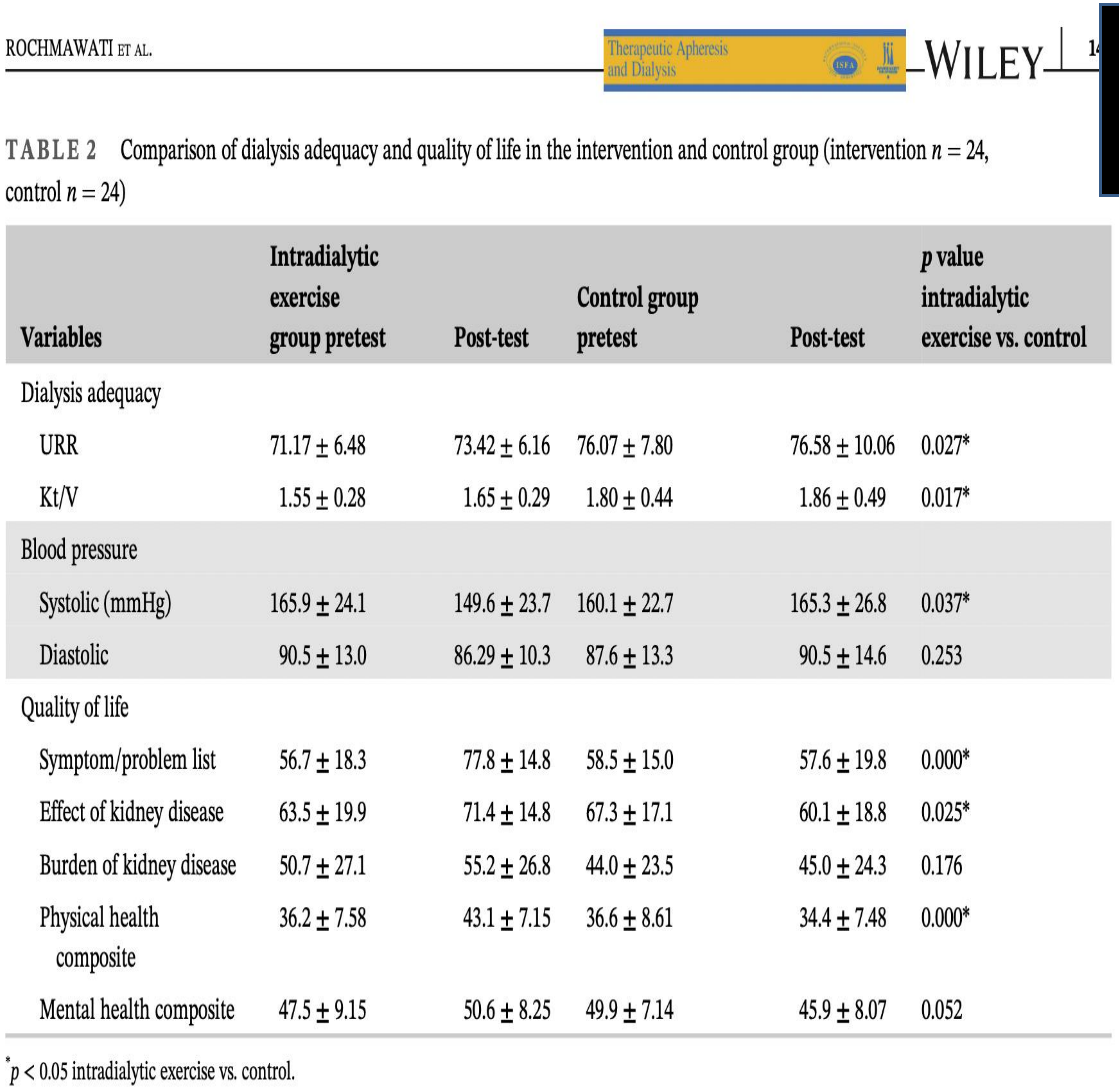
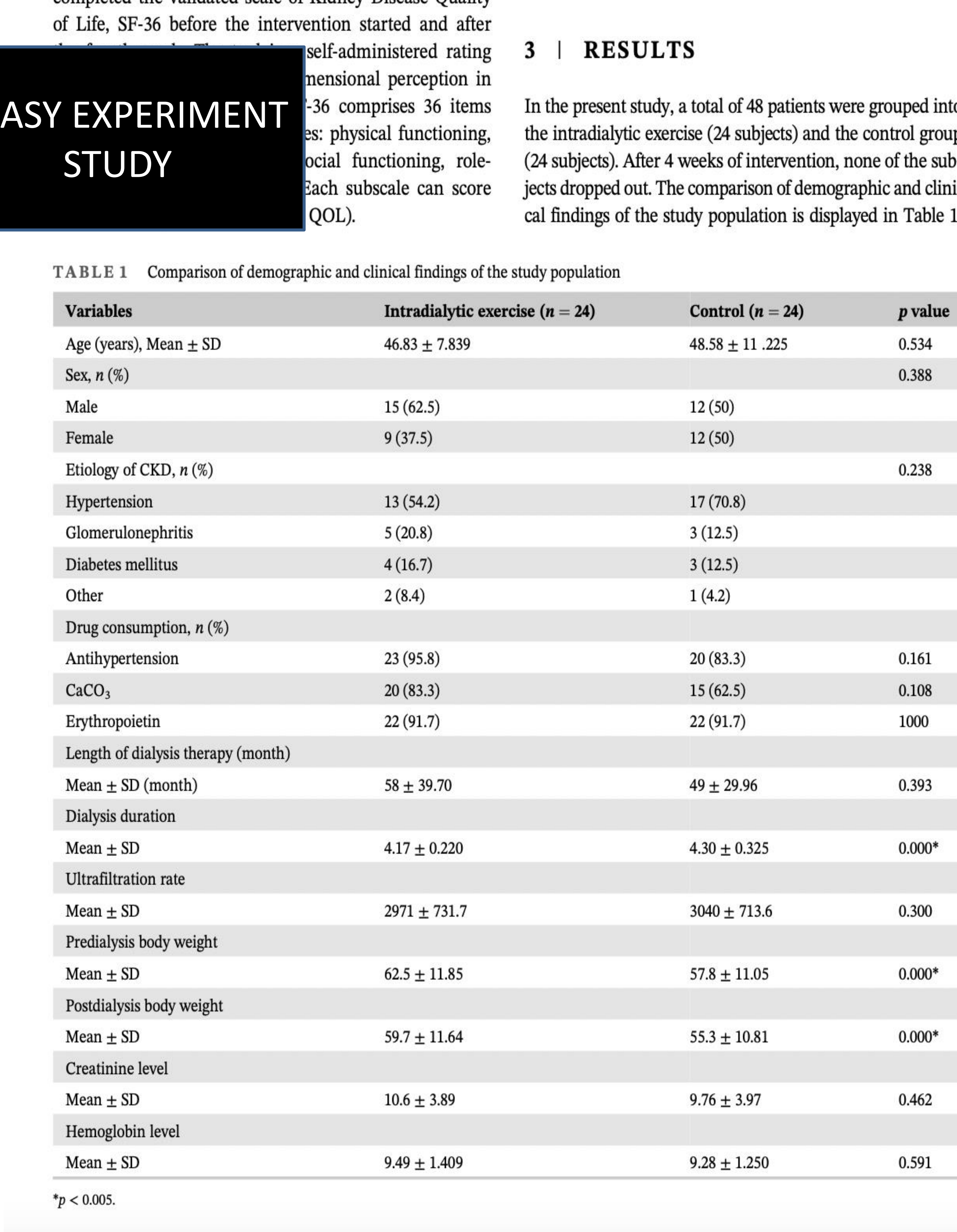


TABLE 2 Comparison of dialysis adequacy and quality of life in the intervention and control group (intervention $n = 24$, control $n = 24$)

Variables	Intradialytic exercise group pretest	Post-test	Control group pretest	Post-test	*p* value intradialytic exercise vs. control
Dialysis adequacy					
URR	71.17 ± 6.48	73.42 ± 6.16	76.07 ± 7.80	76.58 ± 10.06	0.027*
Kt/V	1.55 ± 0.28	1.65 ± 0.29	1.80 ± 0.44	1.86 ± 0.49	0.017*
Blood pressure					
Systolic (mmHg)	165.9 ± 24.1	149.6 ± 23.7	160.1 ± 22.7	165.3 ± 26.8	0.037*
Diastolic	90.5 ± 13.0	86.29 ± 10.3	87.6 ± 13.3	90.5 ± 14.6	0.253
Quality of life					
Symptom/problem list	56.7 ± 18.3	77.8 ± 14.8	58.5 ± 15.0	57.6 ± 19.8	0.000*
Effect of kidney disease	63.5 ± 19.9	71.4 ± 14.8	67.3 ± 17.1	60.1 ± 18.8	0.025*
Burden of kidney disease	50.7 ± 27.1	55.2 ± 26.8	44.0 ± 23.5	45.0 ± 24.3	0.176
Physical health composite	36.2 ± 7.58	43.1 ± 7.15	36.6 ± 8.61	34.4 ± 7.48	0.000*
Mental health composite	47.5 ± 9.15	50.6 ± 8.25	49.9 ± 7.14	45.9 ± 8.07	0.052

*$p < 0.05$ intradialytic exercise vs. control.



of Life, SF-36 before the intervention started and after
self-administered rating
mensional perception in
-36 comprises 36 items
es: physical functioning,
ocial functioning, role-
Each subscale can score
QOL).

3 | RESULTS

In the present study, a total of 48 patients were grouped int the intradialytic exercise (24 subjects) and the control group (24 subjects). After 4 weeks of intervention, none of the sub jects dropped out. The comparison of demographic and clini cal findings of the study population is displayed in Table 1

TABLE 1 Comparison of demographic and clinical findings of the study population

Variables	Intradialytic exercise ($n = 24$)	Control ($n = 24$)	*p* value
Age (years), Mean ± SD	46.83 ± 7.839	48.58 ± 11 .225	0.534
Sex, *n* (%)			0.388
Male	15 (62.5)	12 (50)	
Female	9 (37.5)	12 (50)	
Etiology of CKD, *n* (%)			0.238
Hypertension	13 (54.2)	17 (70.8)	
Glomerulonephritis	5 (20.8)	3 (12.5)	
Diabetes mellitus	4 (16.7)	3 (12.5)	
Other	2 (8.4)	1 (4.2)	
Drug consumption, *n* (%)			
Antihypertension	23 (95.8)	20 (83.3)	0.161
$CaCO_3$	20 (83.3)	15 (62.5)	0.108
Erythropoietin	22 (91.7)	22 (91.7)	1000
Length of dialysis therapy (month)			
Mean ± SD (month)	58 ± 39.70	49 ± 29.96	0.393
Dialysis duration			
Mean ± SD	4.17 ± 0.220	4.30 ± 0.325	0.000*
Ultrafiltration rate			
Mean ± SD	2971 ± 731.7	3040 ± 713.6	0.300
Predialysis body weight			
Mean ± SD	62.5 ± 11.85	57.8 ± 11.05	0.000*
Postdialysis body weight			
Mean ± SD	59.7 ± 11.64	55.3 ± 10.81	0.000*
Creatinine level			
Mean ± SD	10.6 ± 3.89	9.76 ± 3.97	0.462
Hemoglobin level			
Mean ± SD	9.49 ± 1.409	9.28 ± 1.250	0.591

*$p < 0.005$.

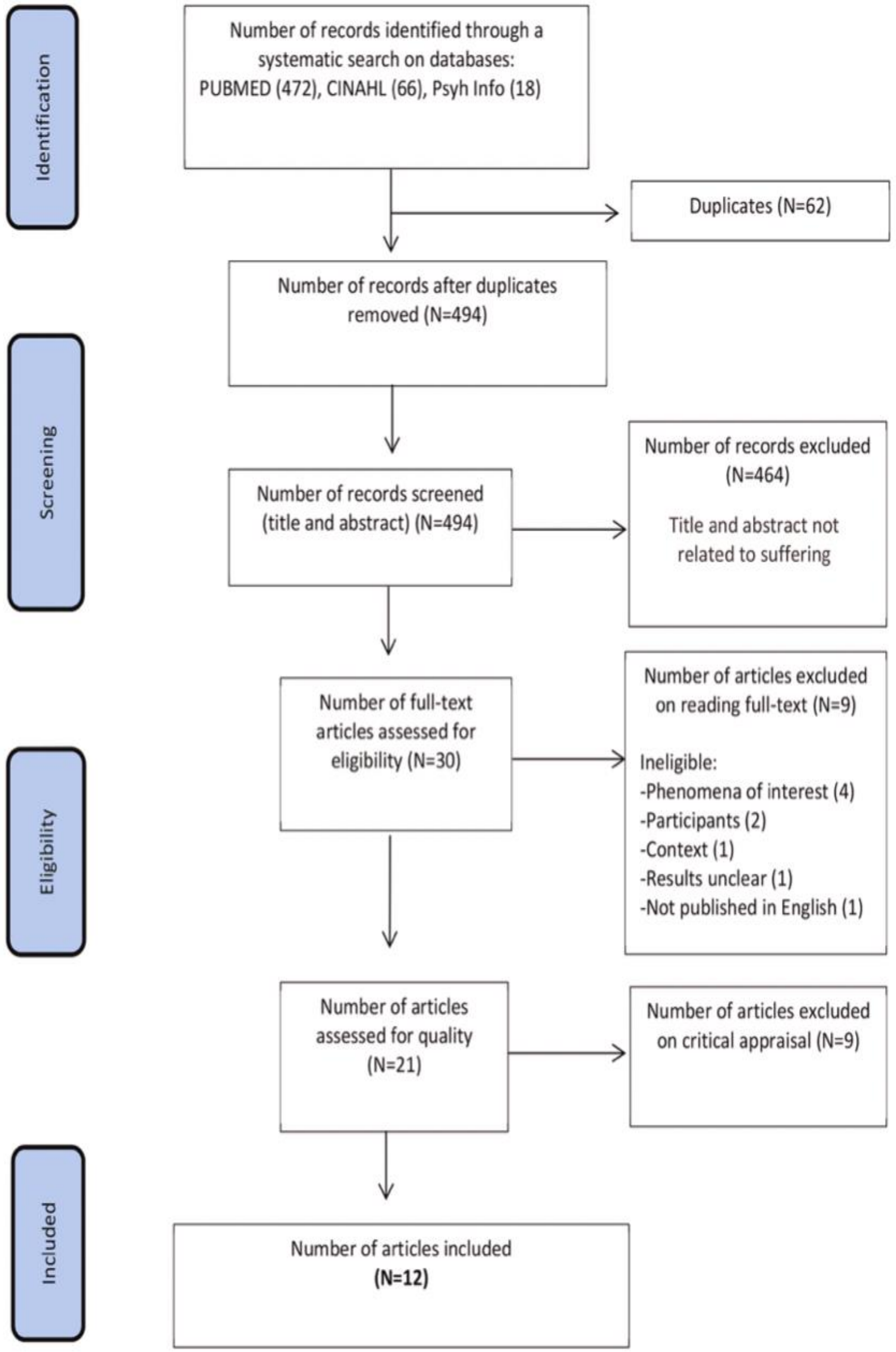


Figure 1. PRISMA flow diagram of search and study selection

Fig. 1. PRISMA flow diagram of search and study selection.

REVIEW

Table 2
Characteristics of included studies.

Study	Methods for data collection and analysis	Country	Phenomena of interest	Setting/context/culture	Participant characteristics and sample size	Description of main results
Korhan et al. (2013)	Phenomenology. Data Collection: In-depth interviews with open ended questions ranging from 60 to 90 min. Analysis: Colaizzi's Phenomenological Data Analysis.	Turkey	The individual experience of living with cancer pain.	The Oncological Department of University Hospital.	Fifteen of the patients; 8 male and 7 female; the mean age was found to be 44.13; 53.3% of them were graduates of primary school. Four of the patients were diagnosed with breast cancer; 2 with testis cancer; 2 with osteosarcoma; 2 with pancreas cancer; and the others with synovial sarcoma, papillary serous carcinoma, the Hodgkin lymphoma, the Ewing sarcoma, and stomach cancer. Sixty percent of the patients had metastasis.	Five themes and 19 subthemes reported. There were 5 themes: description of pain experienced; physical and psychological effects of pain; saddening experiences; methods to cope with pain; and effect of pain on interpersonal relations.
Arman et al. (2002)	Vancouver School of Doing Phenomenology approach. Data Collection: Open qualitative interviews. Analysis: The Vancouver School of Doing Phenomenology.	Sweden and Finland	Experience of suffering among women with breast cancer in different care cultures.	University hospital, chemotherapeutic treatment unit; regional hospital, outpatient department; private complementary medical hospital (anthroposophic medicine); and follow-up support clinic of a cancer association.	Seventeen women with different stages of breast cancer and 16 significant others from 4 different care cultures in Sweden and Finland participated. Five of the women had advanced metastatic breast cancer, and 12 had local limited breast cancer with no metastases. The average time since diagnosis is 30 months. The mean age was 48 years.	Overall theme: the field of force in cancer suffering. Subthemes: the "doubled" suffering; an enduring surrounding and relief from the suffering; the suffering opens questions about life and meaning; the suffering body, and suffering related to healthcare.
Erol et al. (2018)	A qualitative descriptive study. Data Collection: Semi-structured interviews. Analysis: Colaizzi's	Turkey	The pain experiences, pain management of nurses, and a view of pain from the	Oncology clinic of a university hospital in Edirne city, located in, Northwestern Turkey.	Sixteen patients with advanced cancer hospitalized in an Oncology clinic of a university hospital in	Themes and subthemes reported. Four themes were pain perception and patient experience; effects of pain on daily life; pain

QUALITATIVE STUDY

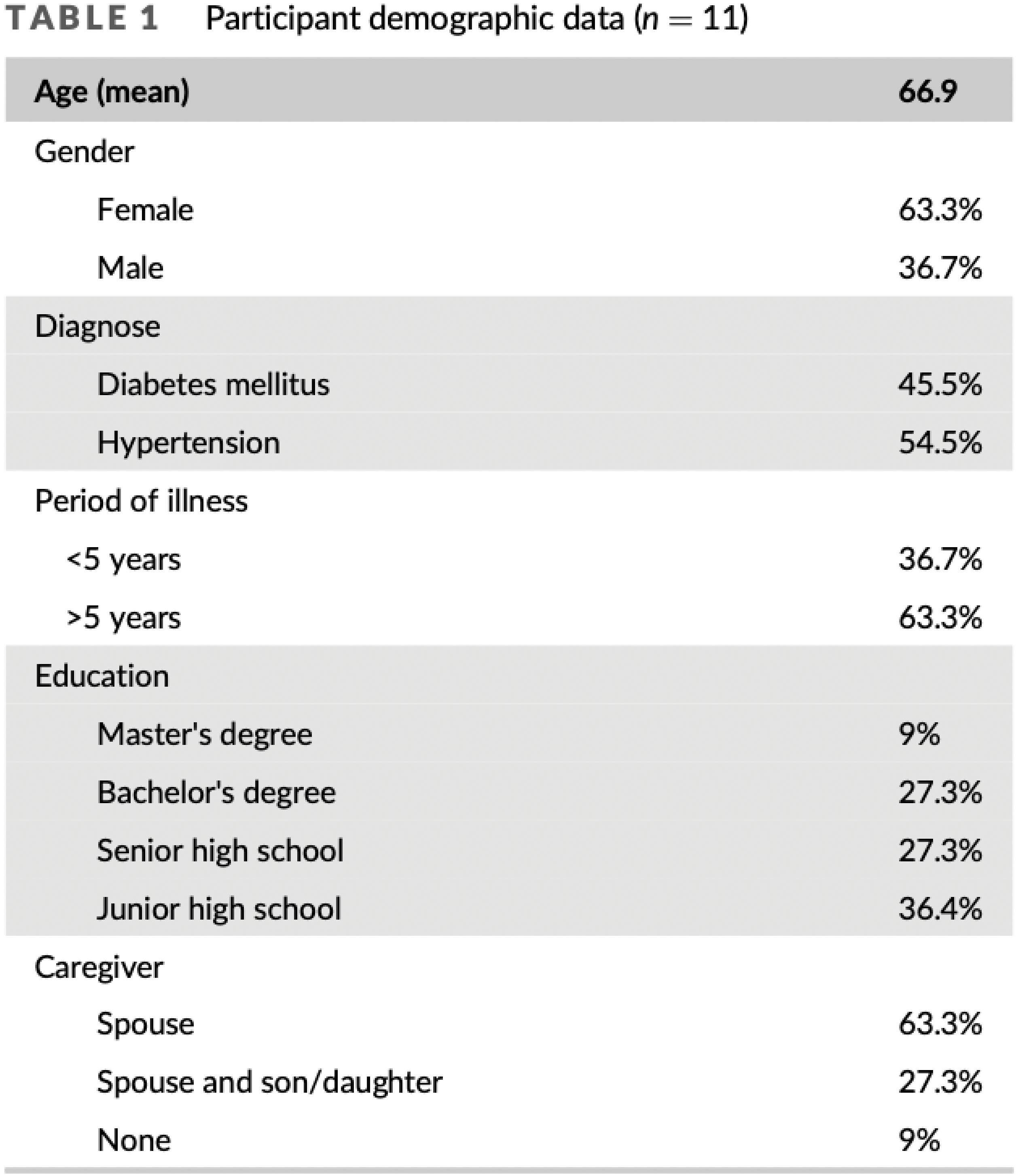


TABLE 1 Participant demographic data ($n = 11$)

Age (mean)	**66.9**
Gender	
Female	63.3%
Male	36.7%
Diagnose	
Diabetes mellitus	45.5%
Hypertension	54.5%
Period of illness	
<5 years	36.7%
>5 years	63.3%
Education	
Master's degree	9%
Bachelor's degree	27.3%
Senior high school	27.3%
Junior high school	36.4%
Caregiver	
Spouse	63.3%
Spouse and son/daughter	27.3%
None	9%

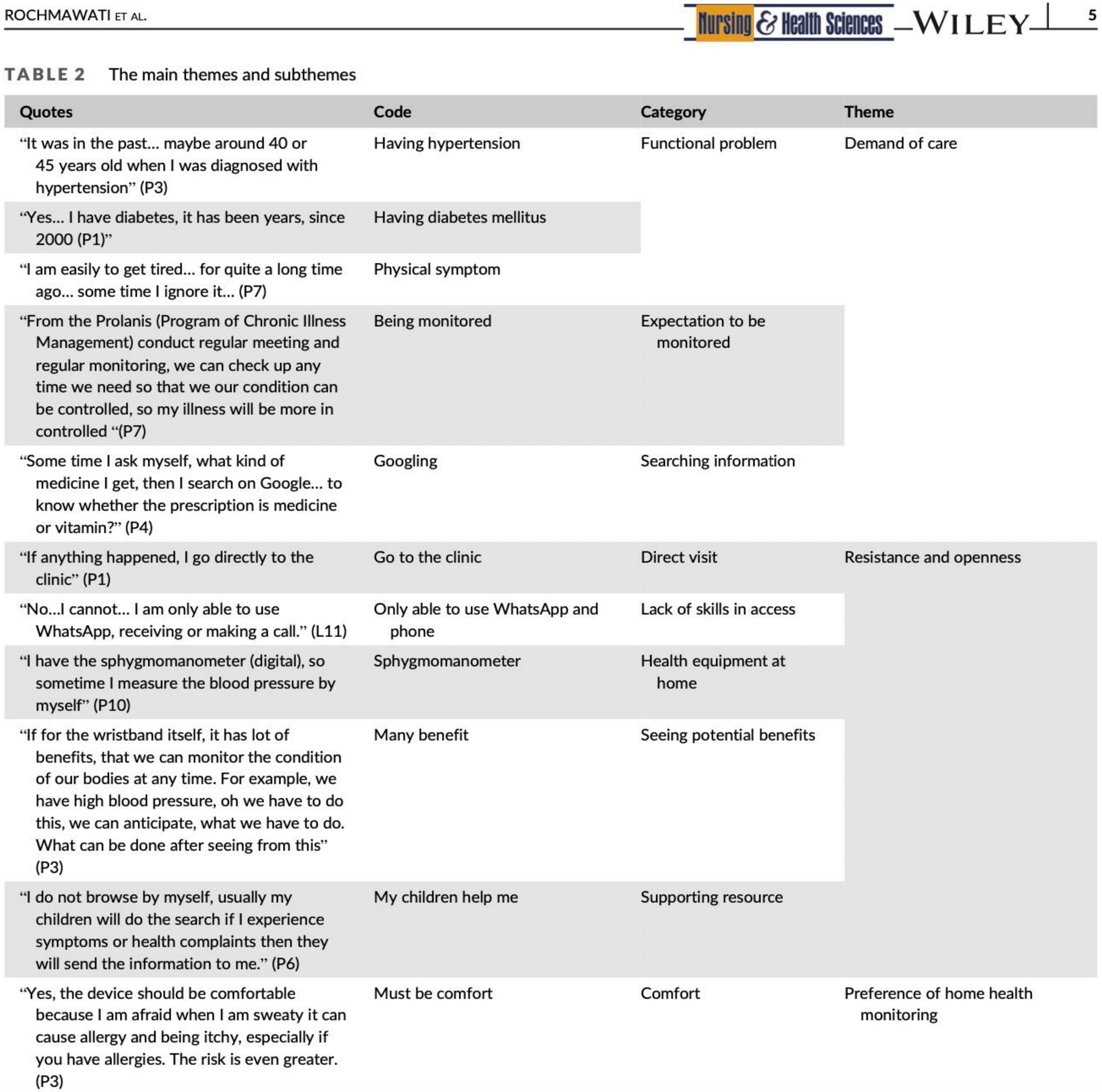


TABLE 2 The main themes and subthemes

Quotes	Code	Category	Theme
"It was in the past… maybe around 40 or 45 years old when I was diagnosed with hypertension" (P3)	Having hypertension	Functional problem	Demand of care
"Yes… I have diabetes, it has been years, since 2000 (P1)"	Having diabetes mellitus		
"I am easily to get tired… for quite a long time ago… some time I ignore it… (P7)	Physical symptom		
"From the Prolanis (Program of Chronic Illness Management) conduct regular meeting and regular monitoring, we can check up any time we need so that we our condition can be controlled, so my illness will be more in controlled "(P7)	Being monitored	Expectation to be monitored	
"Some time I ask myself, what kind of medicine I get, then I search on Google… to know whether the prescription is medicine or vitamin?" (P4)	Googling	Searching information	
"If anything happened, I go directly to the clinic" (P1)	Go to the clinic	Direct visit	Resistance and openness
"No…I cannot… I am only able to use WhatsApp, receiving or making a call." (L11)	Only able to use WhatsApp and phone	Lack of skills in access	
"I have the sphygmomanometer (digital), so sometime I measure the blood pressure by myself" (P10)	Sphygmomanometer	Health equipment at home	
"If for the wristband itself, it has lot of benefits, that we can monitor the condition of our bodies at any time. For example, we have high blood pressure, oh we have to do this, we can anticipate, what we have to do. What can be done after seeing from this" (P3)	Many benefit	Seeing potential benefits	
"I do not browse by myself, usually my children will do the search if I experience symptoms or health complaints then they will send the information to me." (P6)	My children help me	Supporting resource	
"Yes, the device should be comfortable because I am afraid when I am sweaty it can cause allergy and being itchy, especially if you have allergies. The risk is even greater. (P3)	Must be comfort	Comfort	Preference of home health monitoring

Menyusun manuskrip

***Discussion*/pembahasan**

- Hasil data tersebut dikomparasikan dengan teori dan hasil penelitian yang relevan

Apa yang harus ditulis di bagian pembahasan?

- Penjelasan singkat tentang hasil
- Teori dan hasil penelitian yang relevan: sesuai atau tidak sesuai
- Argumen peneliti
- *Limitation*/keterbatasan

4 | DISCUSSION

Ethnography is a particular qualitative approach used to describe culture or subculture in a specific context (Oliffe, 2005). The results of this study provide further understanding of the centrality of spirituality and religion in the provision of palliative care. Religion and spirituality are important aspects of everyday life for many people, with two thirds of people in 18 countries stating that religion is important in their lives (Theodorou, 2015). There are several major religious orientations (e.g. Islam, Christianity, Catholicism, Buddhism, and Hinduism) in Indonesia. People in Indonesia generally perceive religion as a fundamental part of life, and this was reflected among the participants of the present study. Religious beliefs and practices are the way for the patients, the families, and the palliative staff to express their spirituality. Importantly, in addition to practicing their own religions, there was an encouragement to engage in spiritual/religious practices by the participants, regardless of their own religious affiliation, as observed in the present study.

As expected, most of the patients and the families were affiliated with various religions. It was also observed in this study that the palliative staff were equally willing to demonstrate their religious affiliation. A previous study demonstrated that more than half of physicians in the USA are affiliated with religions and influenced by their religious belief in medical practice (Curlin, Lantos, Roach, Sellergren, & Chin, 2005). This study suggests an even stronger role of religion, with all staff observed engaging in religious practices at work (e.g. prayer) and in home visits.

Patients tried the best they could to maintain their religious practices with support from their families. Other studies identified the

In a number of studies, the use of a spiritual assessment tool to formally assess spiritual needs has been demonstrated (Ahmed *et al*., 2004; Blaber, Jone, & Willis, 2015). This was not, however, identified in this current study. Moving from the assessment of spiritual needs and supporting the patients to maintain their religious practices to actually joining patients in prayer is somewhat contentious and quite culturally specific. In their study, Poole and Cook (2011) debated this issue within the context of psychiatric practice in the UK, suggesting that patient–practitioner prayer is considered a breach of professional boundaries. Balboni *et al*. (2011), in contrast, surveyed patients and practitioners in advanced cancer settings in the USA, and reported that the majority felt it was dependent on the appropriate circumstance. In this study, the practice of praying together, to some extent, depended on the religion of the palliative team members. Muslim staff would step out of the room when Christian prayers were conducted, but this was not seen as a lack of support.

An important aspect of the spiritual/religious practices in the present study was the reciprocal nature of these practices. The palliative team provided spiritual/religious care to the patients and the relatives; in return, the relatives facilitated the palliative team to perform spiritual/religious practice in their homes. For example, a family caregiver provided a room, a prayer carpet, and clothes so that the palliative team could perform *Dhuhr Salat* (one of the five compulsory prayers in Islam, which must be performed at noon). To date, there have been no studies indicating this type of reciprocity in the relationship between patients/relatives and health professionals with respect to the spirituality/religion dimension. This reciprocity could be an important influence in maintaining the relationship between staff and patients and relatives, as it represents a very tangible sign of mutual respect.

4 | DISCUSSION

The number of older people worldwide is increasing significantly (WHO, 2020), and most of the them have at least one chronic medical condition due to decreased physiological functions, which makes them susceptible to degenerative diseases such as diabetes and hypertension (Adu-Sarkodie, 2017). The need for primary healthcare services is increasing. In this study, the participants with diabetes or hypertension realized that they had problems with their decreased body condition; they stated that they needed more comprehensive information about their disease, assistance to maintain health stability, and that they needed to prevent worsening of the disease. The findings are consistent with those of a previous review by McGilton et al. (2018) that older people with chronic diseases basically require increased knowledge about their medical condition, prevention strategies, recovery and maintenance, and a patient-centered strategy.

This study was conducted in Indonesia where primary health services (FKTP) support older people in managing their chronic diseases to prevent an increase in hospitalization. Freilich et al. (2020) explained continuous monitoring, easy accessibility to primary health care, and e-health are potential tools to support self-management of older people patients with chronic disease. Furthermore, e-health can be beneficial for older people who need extra support, such as those who are anxious or live alone.

In this study, we demonstrated a prototype of an e-health monitoring tool using a smartwatch and mobile phone app designed for older people. Most of the participants showed enthusiasm for e-health monitoring. A participant used a smartwatch for activities/sports; however, no one had used mobile phone health apps. The participants stated that they had little knowledge about digital literacy and limitations in the use of digital tools and were not familiar with the use of health technology, especially e-health monitoring. This finding supports the previous scoping review conducted by Vergouw et al. (2020), which identified barriers to older people using e-health, including unfamiliarity with online e-health apps and incompatibility of e-health with older people's health needs owing to limited expertise with technology. This is reinforced by the fact that they prefer to communicate directly with their physicians.

Although some older people refuse to use e-health technology, some of them are open to it as is shown in their increased use of digital technologies such as the internet and mobile phones (Klimova &

from family members (Amagasa et al., 2021). Some participants could also access YouTube to watch physical exercise videos and perform a Google search to verify health facts. Digital technology may provide a diverse range of activities and can assist individuals in maintaining their health status. Additionally, some participants continue to use laptops as a means of communication, information retrieval, and work-related media. Older people are a diverse group, and age is irrelevant in terms of digital exclusion. This study suggests that older people recognize that technology can assist them in remaining independent, active, and healthy individuals.

Digital technologies, including tracking and monitoring of health, have the potential to improve health care, notably by facilitating self-management of chronic conditions (Mielonen et al., 2020). As the majority of people with chronic diseases are older people, technology should be designed for them, but the primary problem of bringing technology to them is integrating technology into their lives (Wilson et al., 2021). Our findings indicate that the device's ease of use, convenience, and attractive design make technology appealing for the older people. This confirms the findings of Mercer et al. (2016), that emphasized that the adoption of technology by older people is based on the ease of use, the benefits received from the tools used, daily data collection, and affordability of the device.

The ease of using the programs or devices is the main reason that participants use technology. Older people frequently assume that new technology would be too difficult to use, which diminishes their desire to use it (Peek et al., 2016; Wilson et al., 2021). Numerous participants in our study expressed their concern that the developed technology was needlessly complicated and difficult to use. This reiterates Rogers' theory of innovation diffusion, which suggests that lack of information about the devices being used leads to usage delay, even if the devices are similar to those previously used. Kim et al. (2016) suggested that new devices should provide a simple paper-based manual that clearly describes the settings, how to use the device, and basic troubleshooting to assist older people in comprehending the technology. Additionally, older people may benefit from the help of family and friends in using technology. The participants in our study were considerably aided in gaining access to available technologies by their children or grandchildren. Because of older people's inability to access or resolve system problems, the family plays an important role in the use of technology by older people (Marston & Musselwhite, 2021). Before deciding whether to accept a technology, older people learn from their family's and neighbors' experiences with technology. This is similar to the innovation diffusion theory where others and can be exacerbated when the person with cancer is not being treated as a whole person, the pre cancer person. This then draws the person with cancer to contemplate their sense of self, recognizing a loss of self, leading to despair and anguish and ultimately the contemplation of death, either as something to be feared contributing to their suffering or as an end to suffering. On the other hand, significant others can promote healing, not of the disease but of the person.

The synthesized finding, 'Suffering the loss of normality' addresses the multidimensional suffering experienced by people with cancer. This finding supports the previous systematic review conducted by Best et al. (2015) that indicated suffering includes both physical and distress symptoms. The current review captured the experience of physical and psychological suffering during the course of the cancer illness that lead to fundamental life changes. Included studies have shown that patients' suffering stems from unbearable pain. Unbearable pain hinders or prevents the activities of normal life. The findings confirm previous studies that pain limits the ability of persons to take care of themselves, even for the most basic aspects of self-care (Bueno-Gómez, 2017; Hartogh, 2017). This review revealed that suffering is also manifest as uncertainty and not having the ability to control what happens in the present and future. The uncertainty is rooted in illness, treatment, and social relationships.

As suffering continues, persons with cancer feel alienated from their own self, and they may no longer recognize themselves. Included studies show that patients can lose the sense of being human when their damaged body cannot be controlled; being unable to perform the roles and responsibilities that are the essence of their identity. Previous systematic review synthesizes a feeling of loss as part of suffering experienced by patients undergoing chemotherapy (Mendonça et al., 2021). They have a sense of losing the essential elements that define their role as a partner, a member of a family, and society more generally. This aligns with Tang et al. (2016) findings. Patients' social lives becomes threatened by the attitudes of others toward cancer. This can be in the form of sympathy, over-cautiousness, and even pity. Suffering therefore is provoked by the way others treat the person with cancer, not treating them as a whole person, the pre cancer person. Participants from the included studies identified that the failure of health professionals to care for the person as a whole person significantly increased their suffering. Laursen et al. (2019) explains that when healthcare professionals are not knowledgeable of a person's circumstances, and there is a lack of support or poor symptom management the result is a feeling of

Menyusun manuskrip

Kesimpulan

- Rangkuman dari jawaban atas rumusan masalah yang diajukan dan telah di bahas pada bagian sebelumnya.

References

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tings for data collection and a small number of participants in the semistructured interviews. Because the study was conducted at one hospital-based and a non-profit organization-based palliative care service, the organizational culture could limit the transferability of the results. Although the limited number of semistructured interviews was balanced with observations, one should be careful to not generalize the study findings to larger populations, or into other healthcare systems or ethnic groups.

4.2 | Conclusion

There were many situations that demonstrated the importance of religion and spirituality for the patients/relatives and the palliative care team involved in this study. These included not only the acknowledgment and support by the palliative care team for the patients and their relatives' religious practices but also how religion and spirituality were central to the team's life and their practice. Spirituality/religiosity was so central to the daily life of the patients, their relatives, and the palliative care staff that it became a significant element in the palliative care provision. The participants in this study (the palliative team, the patients, and the relatives) were affiliated with particular religions. The patients and their relatives performed their religious practices (e.g. prayer, worship) in their daily life, including during palliative care home visits. It was also observed that the patients' relatives commonly acknowledged and addressed patients' needs for spiritual care. The palliative care staff also provided spiritual care to the patients (e.g. religious/spiritual discussion, praying together). In return, the patients and relatives acknowledged the religious needs of the staff. The findings of the present study could help the palliative care staff in delivering spiritual/religion care for both patients with

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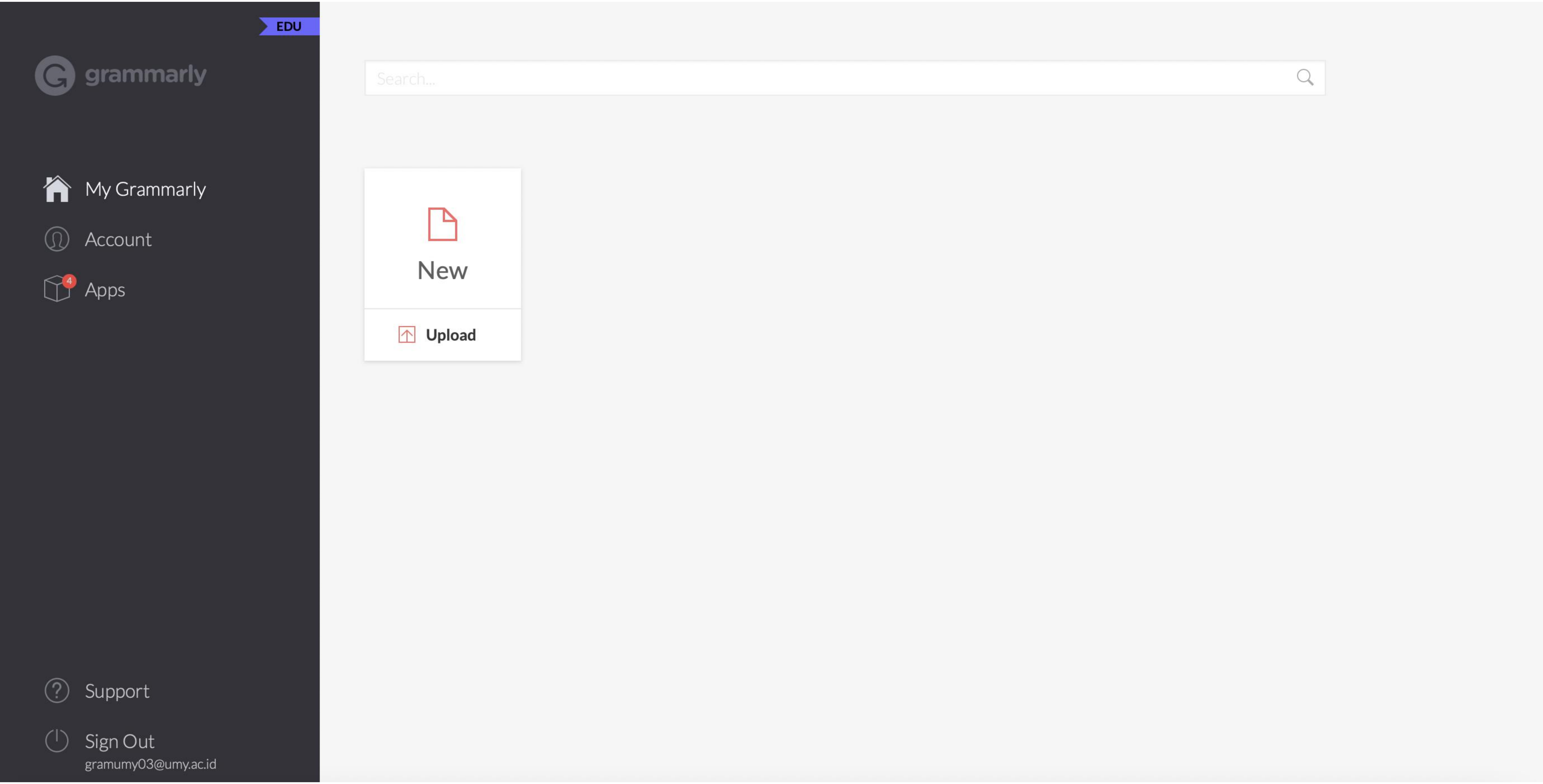
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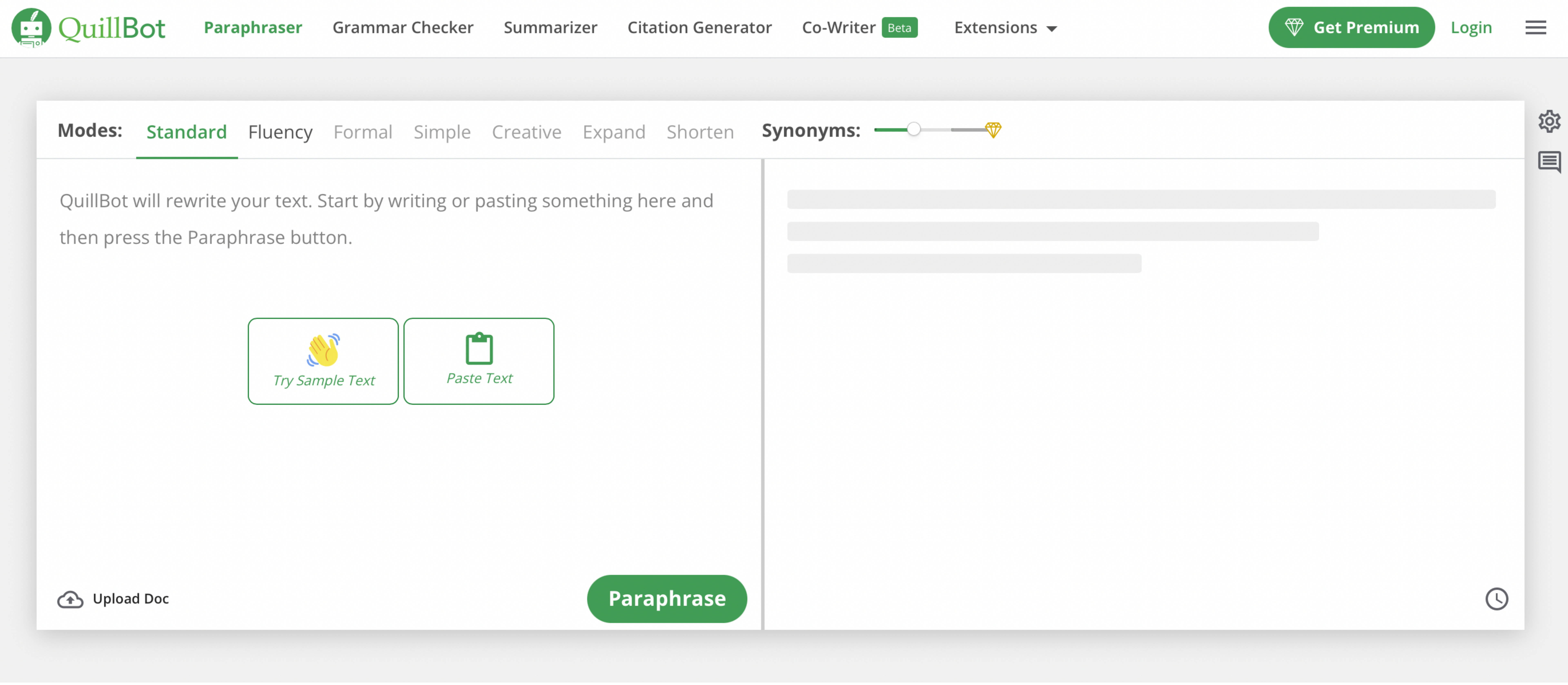

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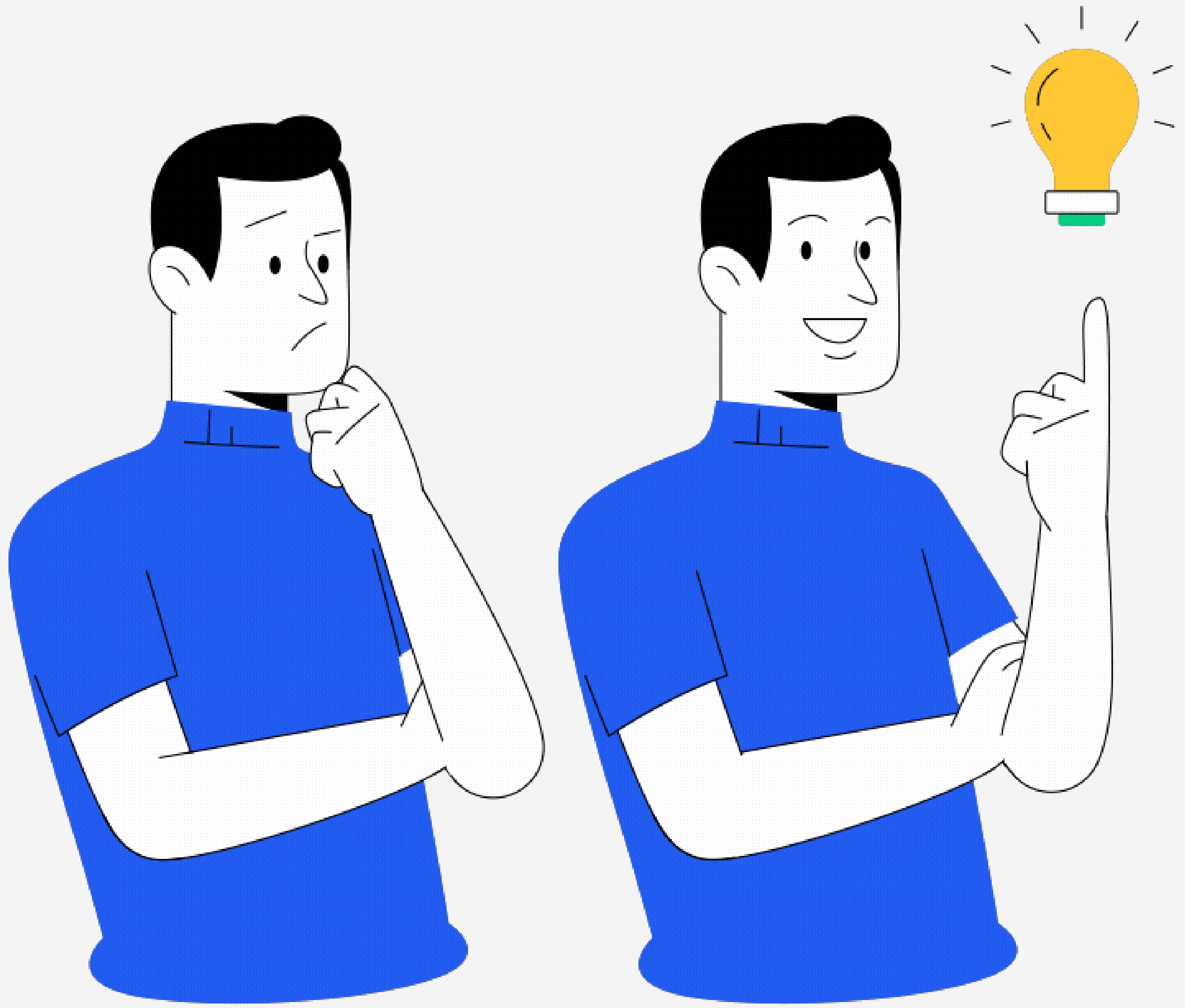

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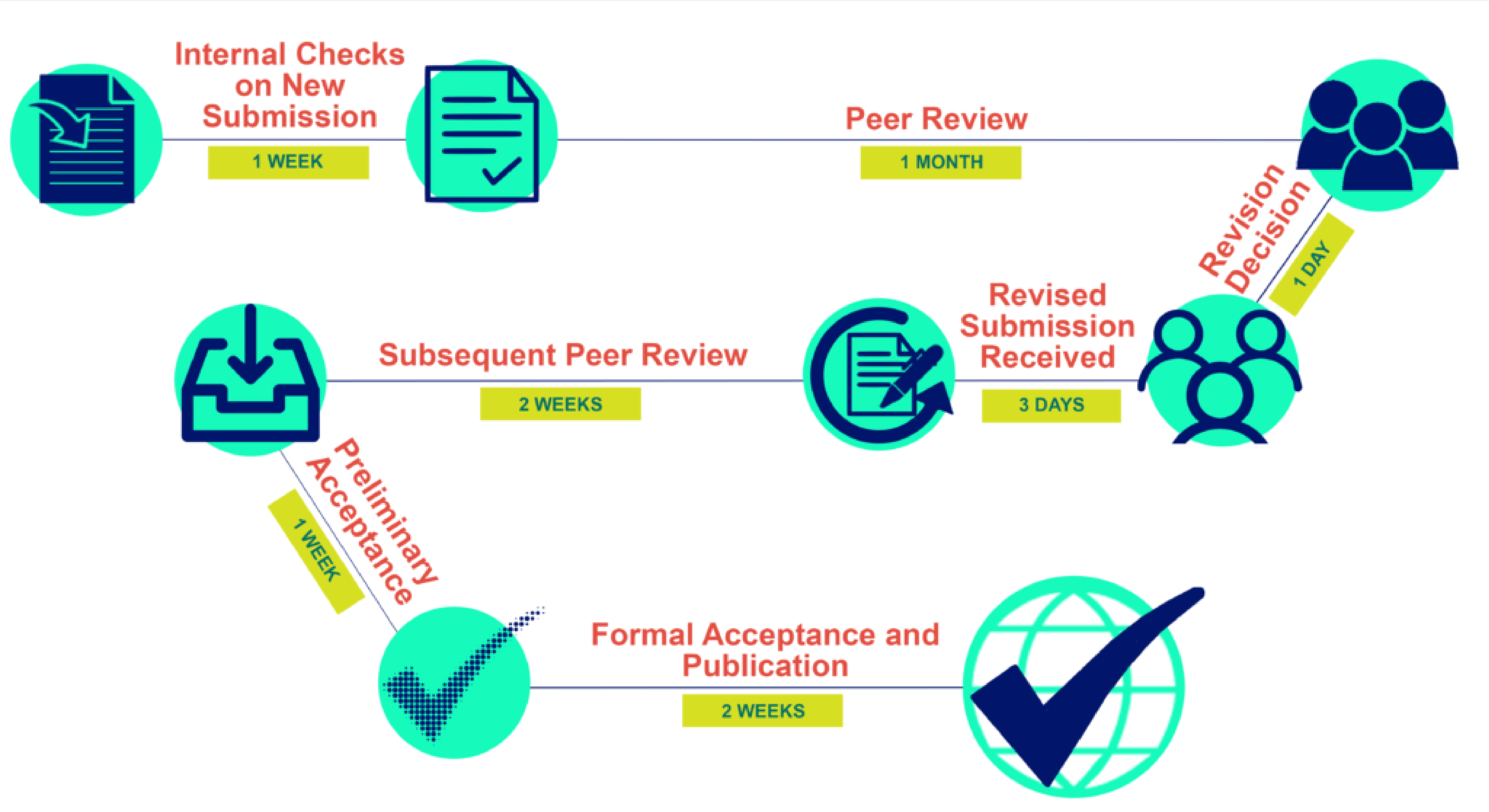

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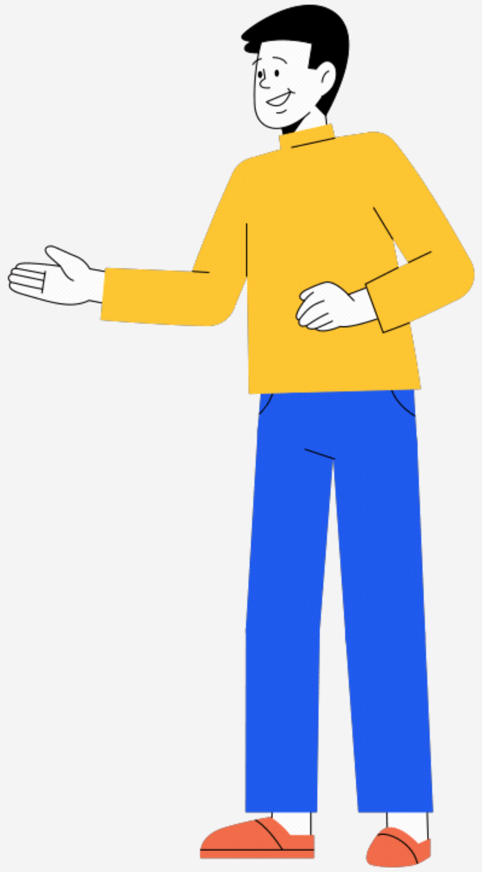

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WILEY Nursing & Health Sciences

RESEARCH ARTICLE

Centrality of spirituality/religion in the culture of palliative care service in Indonesia: An ethnographic study

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Abstract

Experiencing life-threatening illness could impact on an individual's spirituality or religious beliefs. In this paper, we report on a study which explored cultural elements that influence the provision of palliative care for people with cancer. A contemporary ethnographic approach was adopted. Observations and interviews were undertaken over 3 months with 48 participants, including palliative care staff, patients, and their families. An ethnographic data analysis framework was adopted to assist in the analysis of data at item, pattern, and structural levels. Religion was identified as central to everyday life, with all participants reporting being affiliated to particular religions and performing their religious practices in their daily lives. Patients' relatives acknowledged and addressed patients' needs for these practices. Staff provided spiritual care

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Barriers and facilitators in the provision of palliative care in adult intensive care units: a scoping review

Christantie Effendy[1], Yodang Yodang[2], Sarah Amalia[3], Erna Rochmawati[3]

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The provision of palliative care in the intensive care unit (ICU) is increasing. While some scholars have suggested the goals of palliative care to not be aligned with the ICU, some evidence show benefits of the integration. This review aimed to explore and synthesize research that identified barriers and facilitators in the provision of palliative care in the ICU. This review utilized Preferred Reporting Items for Systematic Reviews and Meta-Analyses-scoping review guidelines based on population, concept, and context. We searched for eligible studies in five electronic databases (Scopus, PubMed, ProQuest, Science Direct, and Sage) and included studies on the provision of palliative care (concept) in the ICU (context) that were published in English between 2005–2021. We describe the provision of palliative care in terms of barriers and facilitators. We also describe the study design and context. A total of 14 papers was included. Several barriers and facilitators in

Review Article

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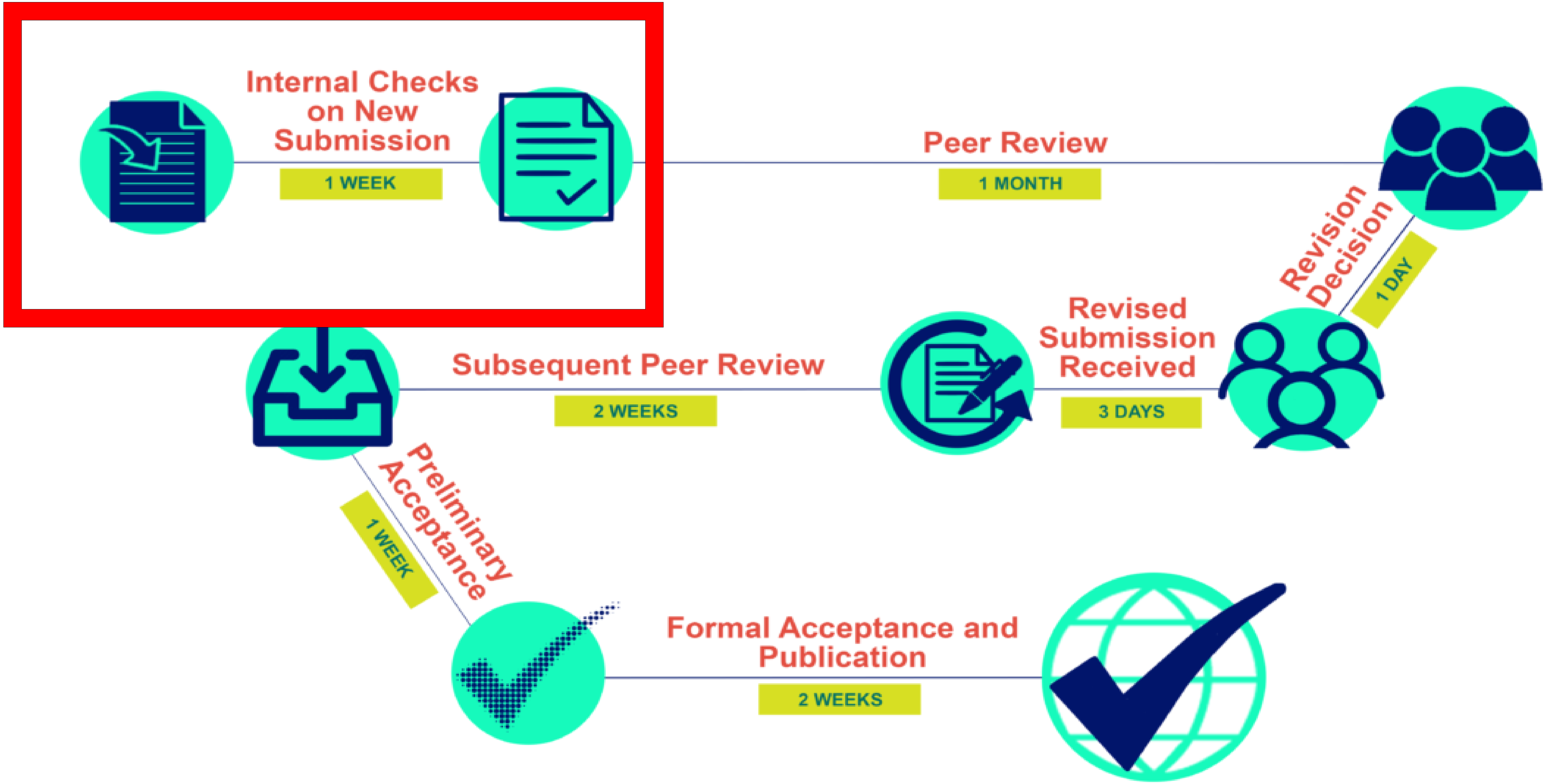

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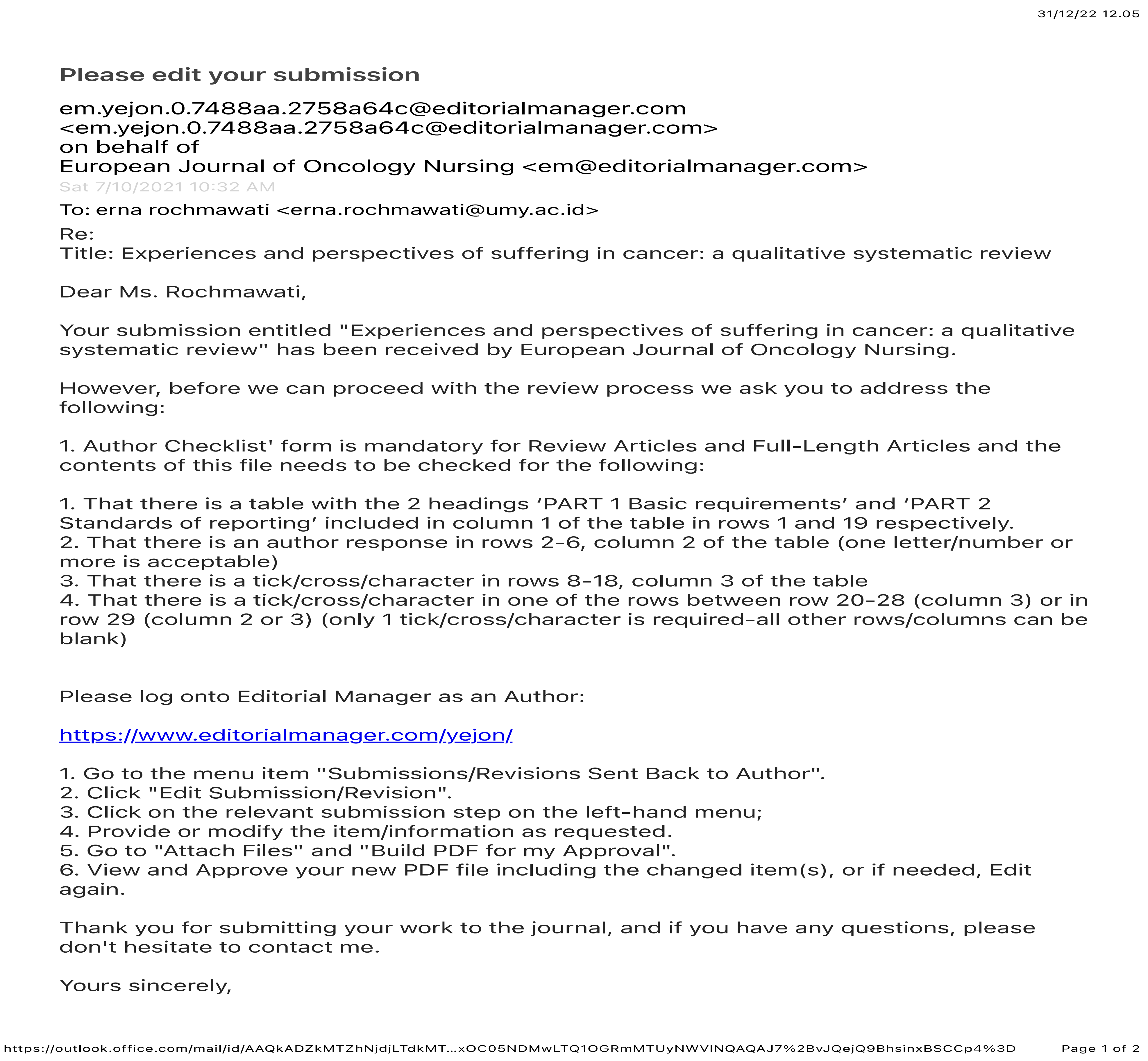

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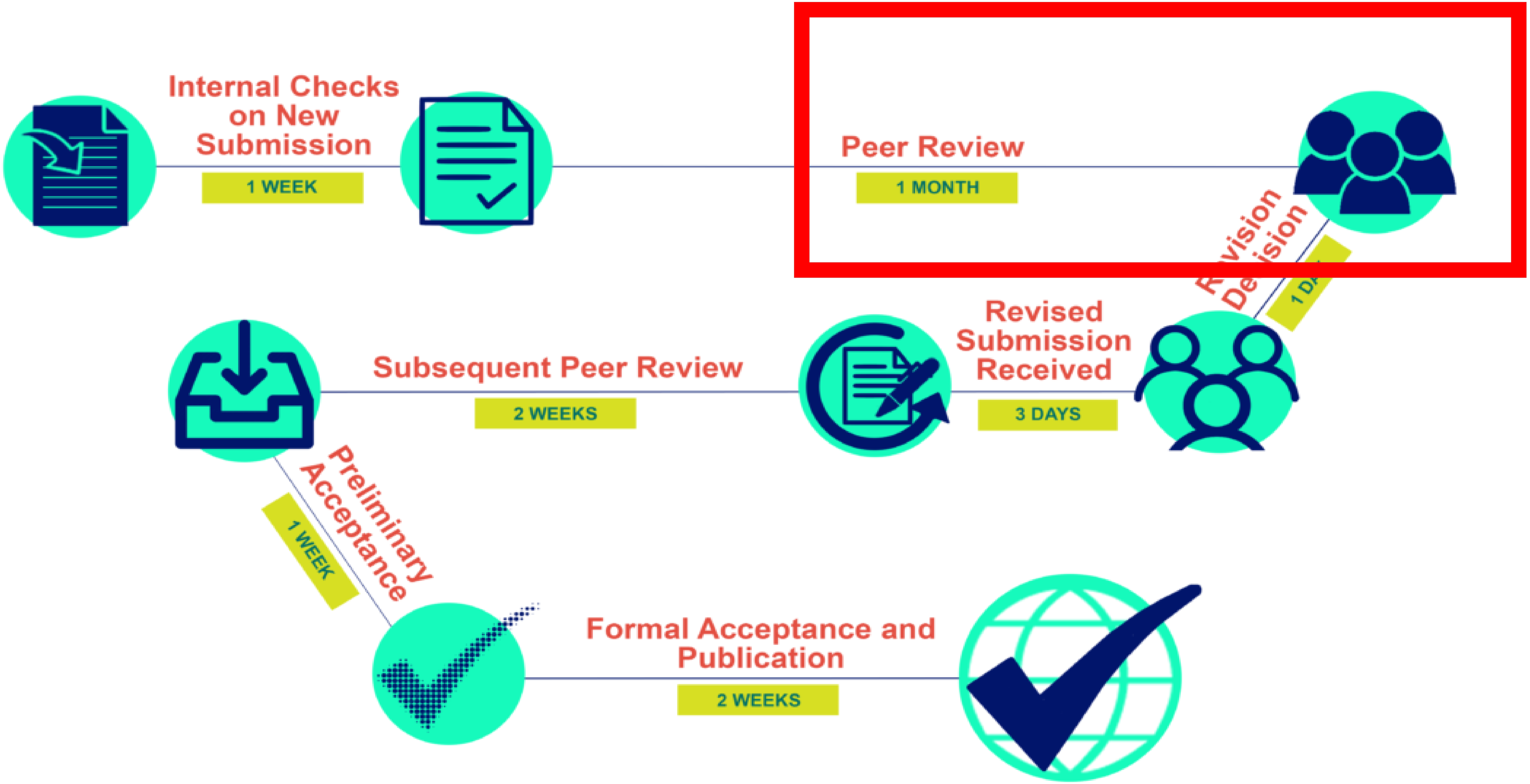
4. Provide or modify the item/information as requested.
5. Go to "Attach Files" and "Build PDF for my Approval".
6. View and Approve your new PDF file including the changed item(s), or if needed, Edit again.

Thank you for submitting your work to the journal, and if you have any questions, please don't hesitate to contact me.

Yours sincerely,

https://outlook.office.com/mail/id/AAQkADZkMTZhNjdjLTdkMT...xOC05NDMwLTQ1OGRmMTUyNWVINQAQAJ7%2BvJQejQ9BhsinxBSCCp4%3D Page 1 of 2

Submission Process



Internal Checks on New Submission

1 WEEK

Peer Review

1 MONTH

R vision De ision

1 DA

Revised Submission Received

3 DAYS

Subsequent Peer Review

2 WEEKS

Preliminary Acceptance

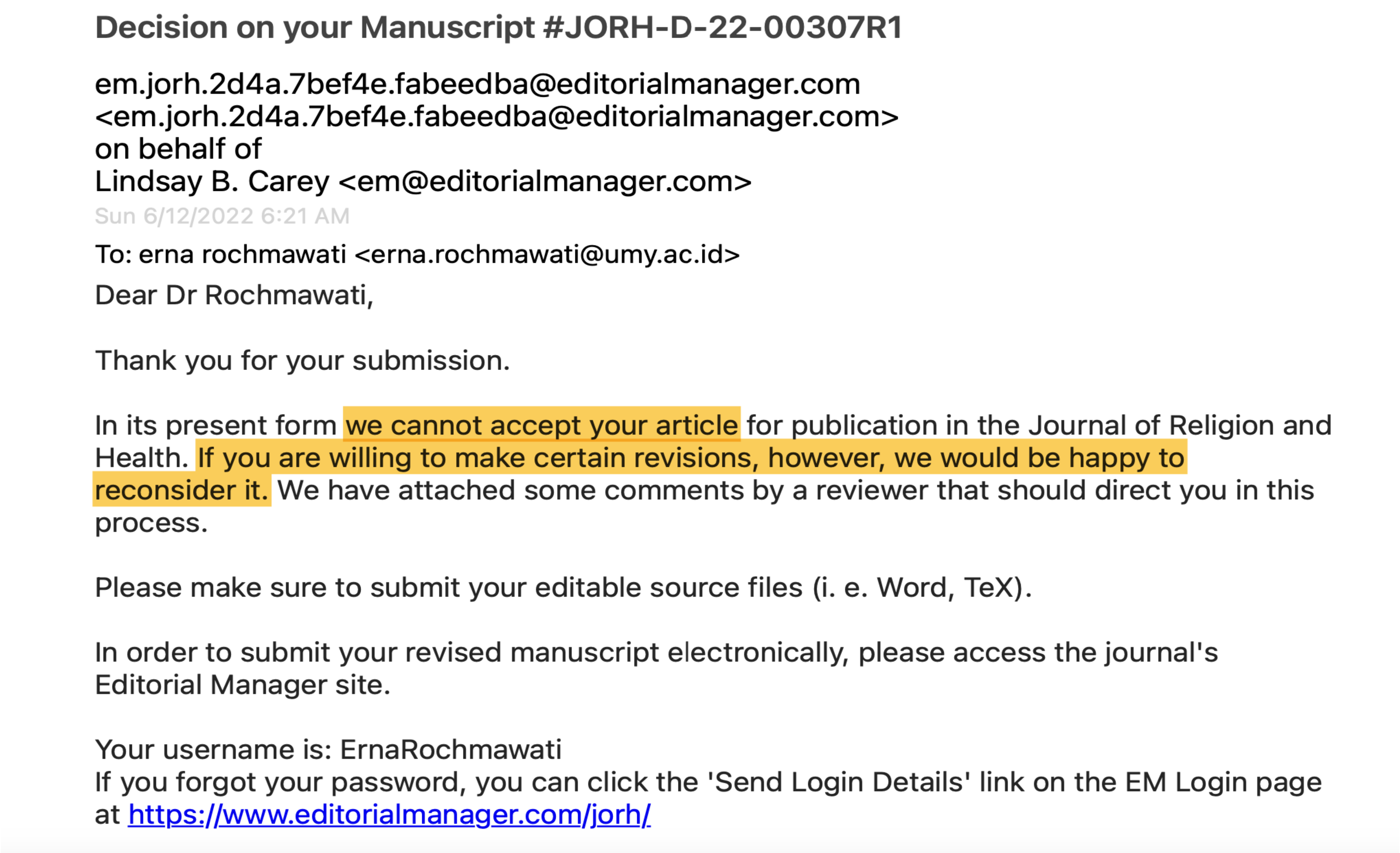
1 WEEK

Formal Acceptance and Publication

2 WEEKS

Submission Process

Editor decision: revision decision



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em.jorh.2d4a.7bef4e.fabeedba@editorialmanager.com
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on behalf of
Lindsay B. Carey <em@editorialmanager.com>
Sun 6/12/2022 6:21 AM

To: erna rochmawati <erna.rochmawati@umy.ac.id>

Dear Dr Rochmawati,

Thank you for your submission.

In its present form we cannot accept your article for publication in the Journal of Religion and Health. If you are willing to make certain revisions, however, we would be happy to reconsider it. We have attached some comments by a reviewer that should direct you in this process.

Please make sure to submit your editable source files (i. e. Word, TeX).

In order to submit your revised manuscript electronically, please access the journal's Editorial Manager site.

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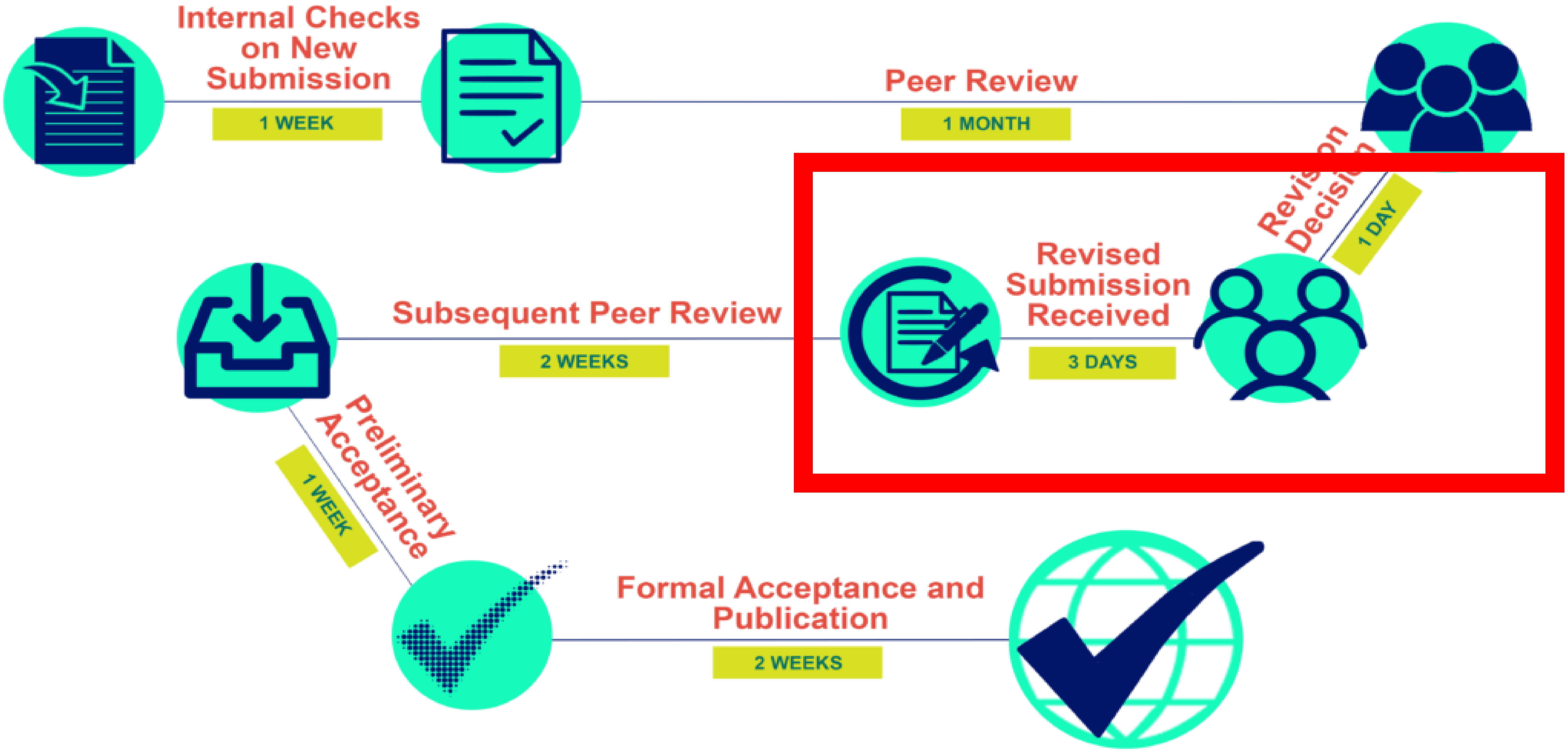

Internal Checks on New Submission

1 WEEK

Peer Review

1 MONTH

Revision Decision

1 DAY

Revised Submission Received

3 DAYS

Subsequent Peer Review

2 WEEKS

Preliminary Acceptance

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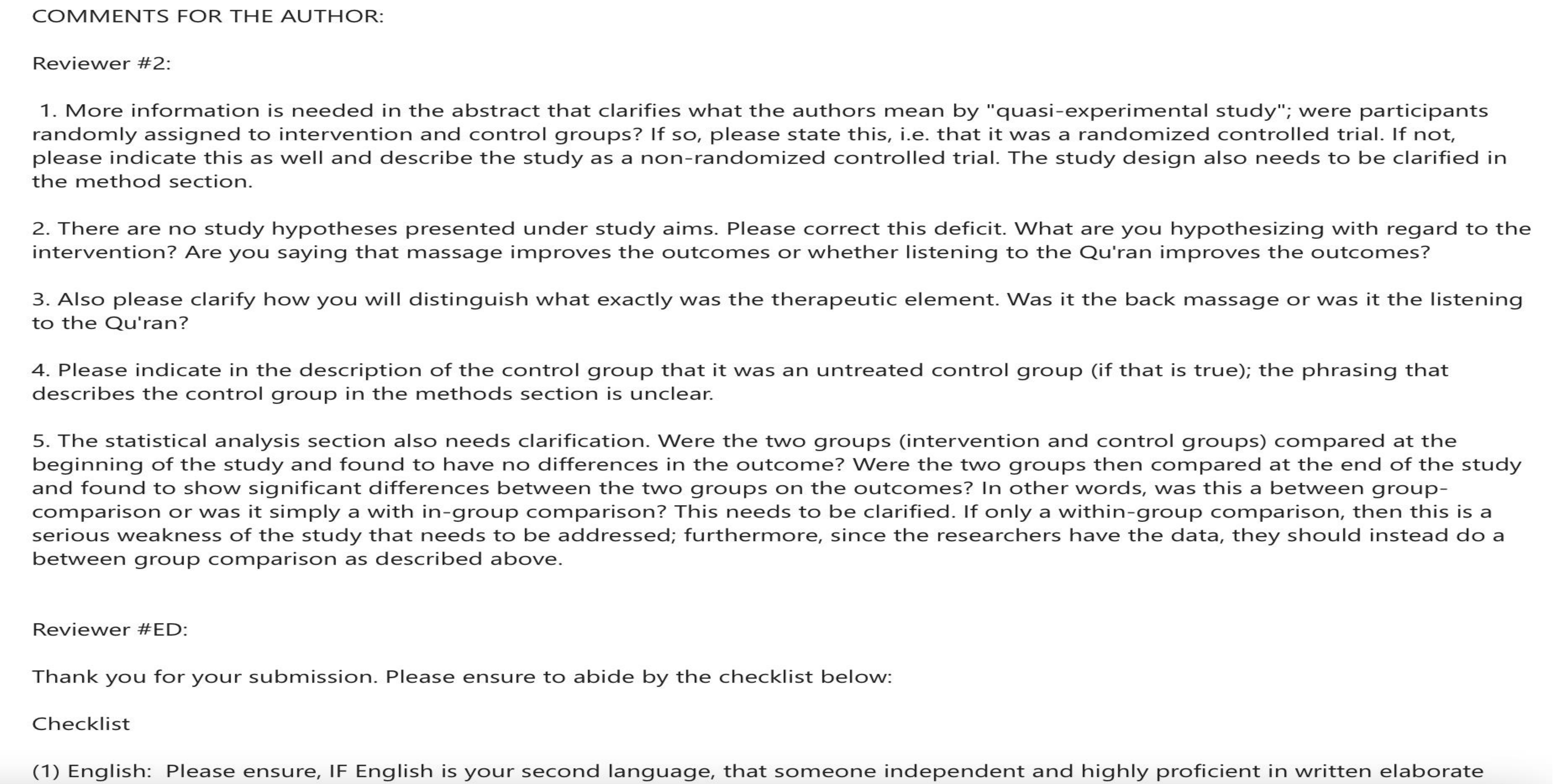
Formal Acceptance and Publication

2 WEEKS

Responding to editor’s/reviewer’s comments



COMMENTS FOR THE AUTHOR:

Reviewer #2:

1. More information is needed in the abstract that clarifies what the authors mean by "quasi-experimental study"; were participants randomly assigned to intervention and control groups? If so, please state this, i.e. that it was a randomized controlled trial. If not, please indicate this as well and describe the study as a non-randomized controlled trial. The study design also needs to be clarified in the method section.

2. There are no study hypotheses presented under study aims. Please correct this deficit. What are you hypothesizing with regard to the intervention? Are you saying that massage improves the outcomes or whether listening to the Qu'ran improves the outcomes?

3. Also please clarify how you will distinguish what exactly was the therapeutic element. Was it the back massage or was it the listening to the Qu'ran?

4. Please indicate in the description of the control group that it was an untreated control group (if that is true); the phrasing that describes the control group in the methods section is unclear.

5. The statistical analysis section also needs clarification. Were the two groups (intervention and control groups) compared at the beginning of the study and found to have no differences in the outcome? Were the two groups then compared at the end of the study and found to show significant differences between the two groups on the outcomes? In other words, was this a between group-comparison or was it simply a with in-group comparison? This needs to be clarified. If only a within-group comparison, then this is a serious weakness of the study that needs to be addressed; furthermore, since the researchers have the data, they should instead do a between group comparison as described above.

Reviewer #ED:

Thank you for your submission. Please ensure to abide by the checklist below:

Checklist

(1) English: Please ensure, IF English is your second language, that someone independent and highly proficient in written elaborate

Responding to editor's/reviewer's comments

- Baca dengan teliti, sebaiknya dibaca beberapa kali untuk memastikan komentar yang ada
- Memahami semua komentar yang didapatkan
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- Mulai memperbaiki sesuai masukan, dipilih dari yang paling mudah dilakukan
- Perbaikan dilakukan di main text/manuskrip, tabel, figure sesuai dengan review yang didapatkan (diberikan warna berbeda)
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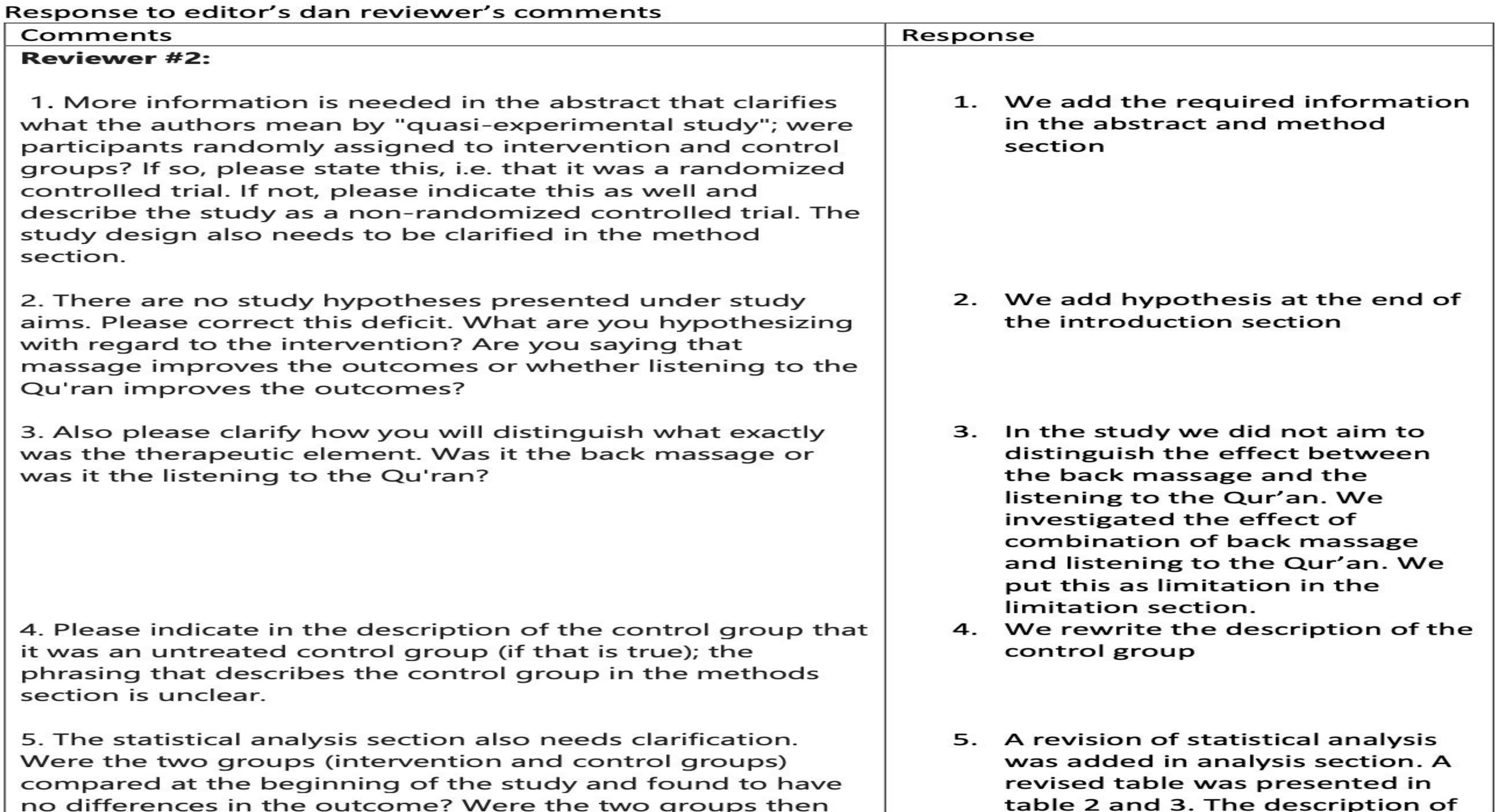
Responding to editor’s/reviewer’s comments



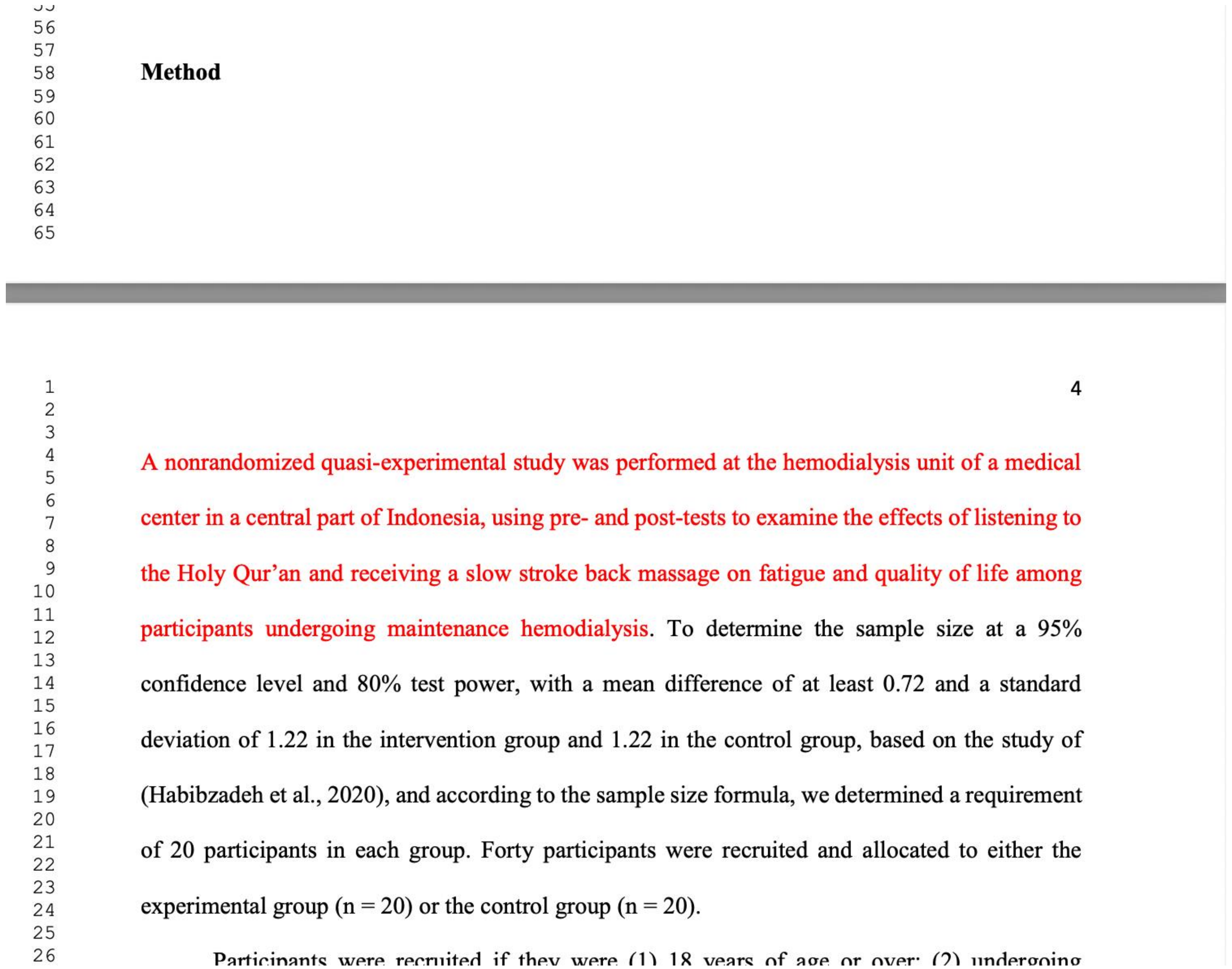
Response to editor’s dan reviewer’s comments

Comments	Response
Reviewer #2:	
1. More information is needed in the abstract that clarifies what the authors mean by "quasi-experimental study"; were participants randomly assigned to intervention and control groups? If so, please state this, i.e. that it was a randomized controlled trial. If not, please indicate this as well and describe the study as a non-randomized controlled trial. The study design also needs to be clarified in the method section.	1. We add the required information in the abstract and method section
2. There are no study hypotheses presented under study aims. Please correct this deficit. What are you hypothesizing with regard to the intervention? Are you saying that massage improves the outcomes or whether listening to the Qu'ran improves the outcomes?	2. We add hypothesis at the end of the introduction section
3. Also please clarify how you will distinguish what exactly was the therapeutic element. Was it the back massage or was it the listening to the Qu'ran?	3. In the study we did not aim to distinguish the effect between the back massage and the listening to the Qur’an. We investigated the effect of combination of back massage and listening to the Qur’an. We put this as limitation in the limitation section.
4. Please indicate in the description of the control group that it was an untreated control group (if that is true); the phrasing that describes the control group in the methods section is unclear.	4. We rewrite the description of the control group
5. The statistical analysis section also needs clarification. Were the two groups (intervention and control groups) compared at the beginning of the study and found to have no differences in the outcome? Were the two groups then	5. A revision of statistical analysis was added in analysis section. A revised table was presented in table 2 and 3. The description of

Responding to editor’s/reviewer’s comments

Editors’ and reviewers comments	Responses to comments	Page number and paragraph where the changes were made
Assosiate Editor		
1. The interviews were conducted in Bahasa, transcribed verbatim and member checked. But were there any translation issues in reporting the findings in English? how were potential translation errors handled?	Brief explanation about this was added	p.6 line 3-11
1. There is still no discussion of policy in the section on implications for nursing practice and policy. Just recommendations for practice.	Added as suggested	p.13 line 11-22
Reviewer 1		
1. Abstract: The first sentence in background states: Communication is a major component in cancer care and have impact on patient’s outcome. The verb should be has since the subject “communication” is singular. The second sentence should read Evidence is lacking... again the subject (evidence) is singular so the verb should be also.	Revised as suggested	p.1 line 6
2. Design – second sentence (line 24). The word purposely should be purposively to be consistent with phenomenological language. The last two sentences in the design paragraph are redundant (say the same thing). Use one or the other.	Revised as suggested	P 1 line 10-11
Implications. As will be pointed out later in the manuscript, these are only implications for nursing practice. What policy implications do you propose?	Revised as suggested	P 1 line 30-31

Responding to editor’s/reviewer’s comments



Method

A nonrandomized quasi-experimental study was performed at the hemodialysis unit of a medical center in a central part of Indonesia, using pre- and post-tests to examine the effects of listening to the Holy Qur’an and receiving a slow stroke back massage on fatigue and quality of life among participants undergoing maintenance hemodialysis. To determine the sample size at a 95% confidence level and 80% test power, with a mean difference of at least 0.72 and a standard deviation of 1.22 in the intervention group and 1.22 in the control group, based on the study of (Habibzadeh et al., 2020), and according to the sample size formula, we determined a requirement of 20 participants in each group. Forty participants were recruited and allocated to either the experimental group (n = 20) or the control group (n = 20).

Participants were recruited if they were (1) 18 years of age or over; (2) undergoing

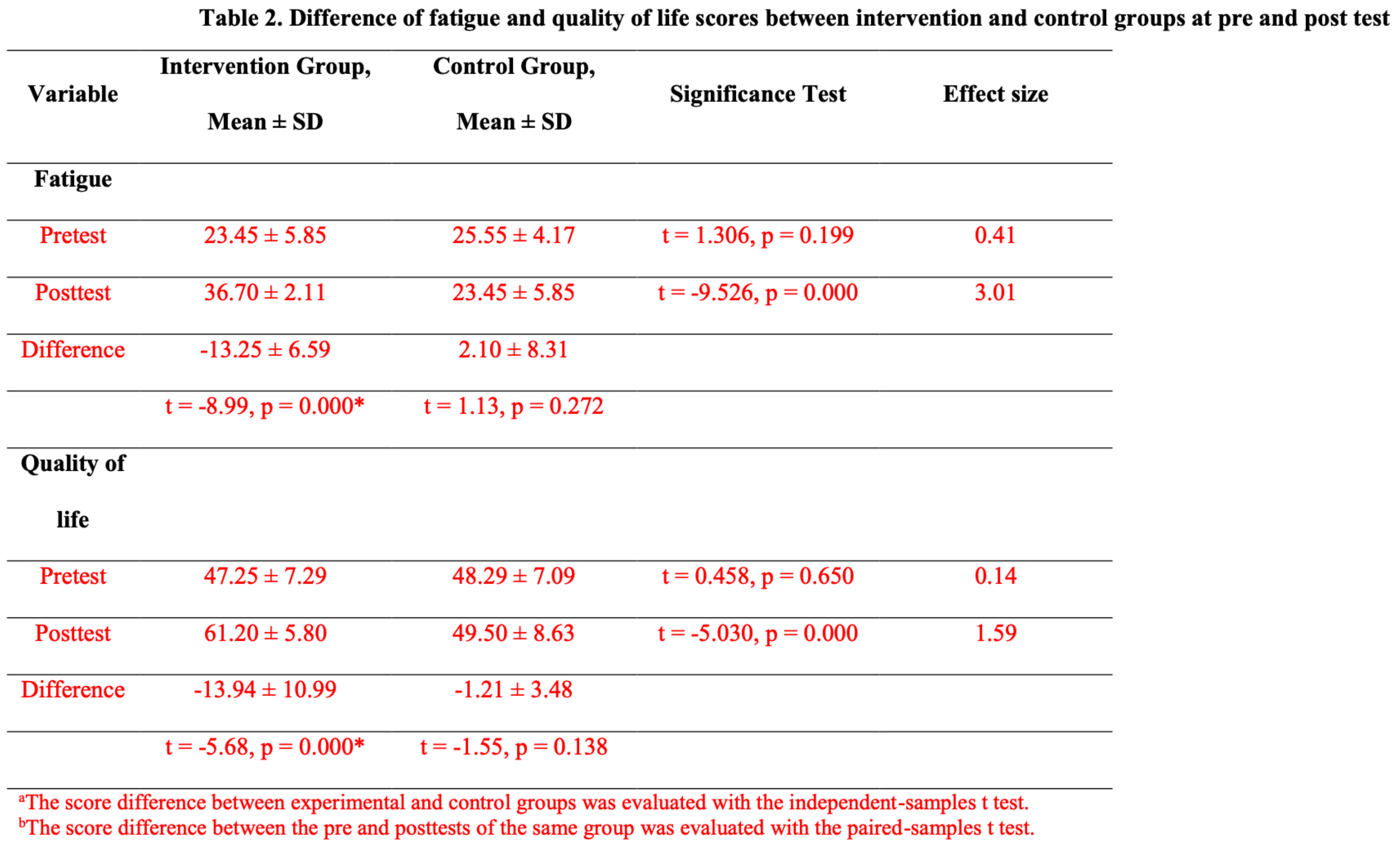
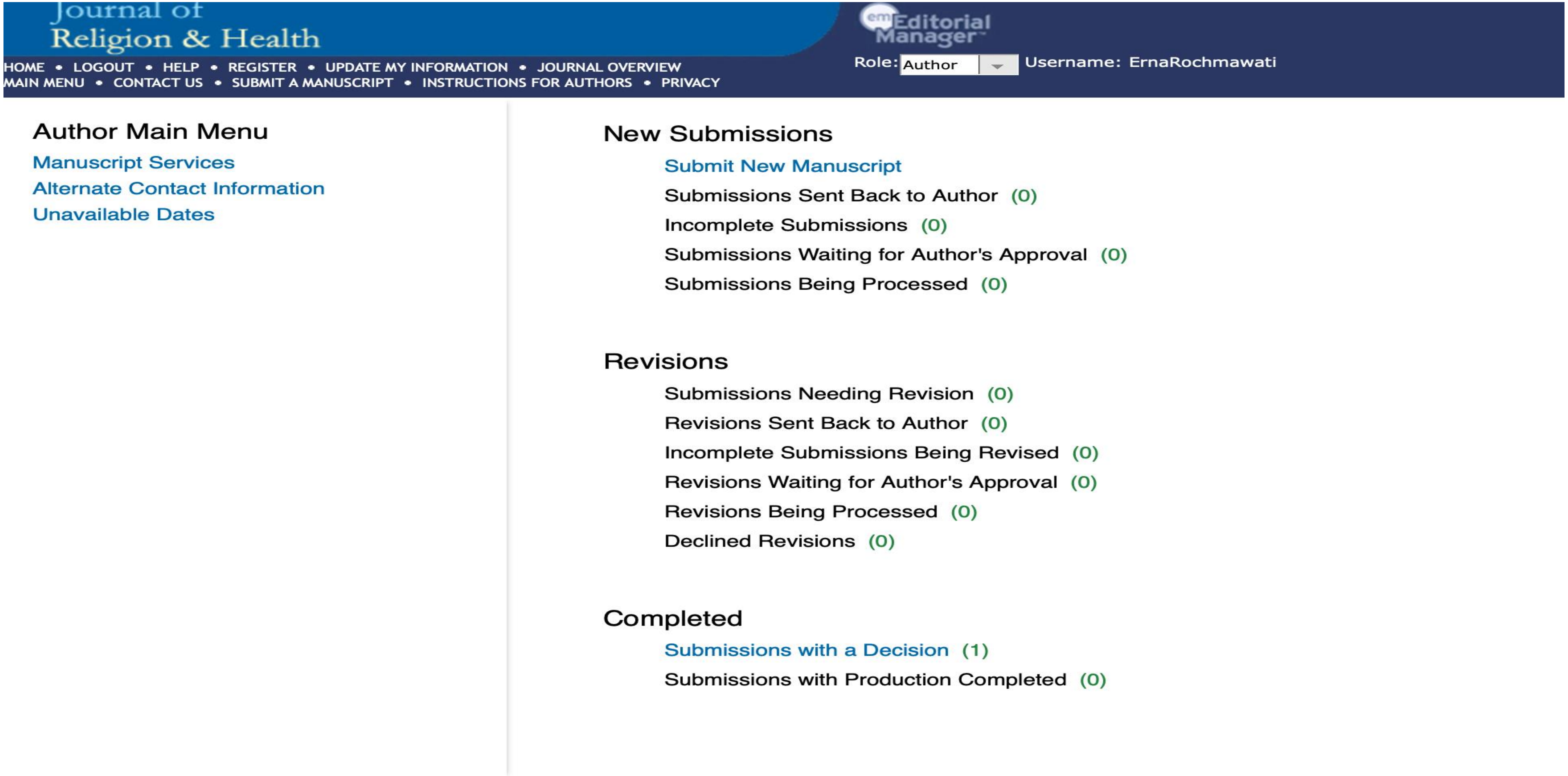


Table 2. Difference of fatigue and quality of life scores between intervention and control groups at pre and post test

Variable	Intervention Group, Mean ± SD	Control Group, Mean ± SD	Significance Test	Effect size
Fatigue				
Pretest	23.45 ± 5.85	25.55 ± 4.17	t = 1.306, p = 0.199	0.41
Posttest	36.70 ± 2.11	23.45 ± 5.85	t = -9.526, p = 0.000	3.01
Difference	-13.25 ± 6.59	2.10 ± 8.31		
	t = -8.99, p = 0.000*	t = 1.13, p = 0.272		
Quality of life				
Pretest	47.25 ± 7.29	48.29 ± 7.09	t = 0.458, p = 0.650	0.14
Posttest	61.20 ± 5.80	49.50 ± 8.63	t = -5.030, p = 0.000	1.59
Difference	-13.94 ± 10.99	-1.21 ± 3.48		
	t = -5.68, p = 0.000*	t = -1.55, p = 0.138		

[a] The score difference between experimental and control groups was evaluated with the independent-samples t test.
[b] The score difference between the pre and posttests of the same group was evaluated with the paired-samples t test.

Responding to editor’s/reviewer’s comments



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Username: ErnaRochmawati

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Responding to editor’s/reviewer’s comments

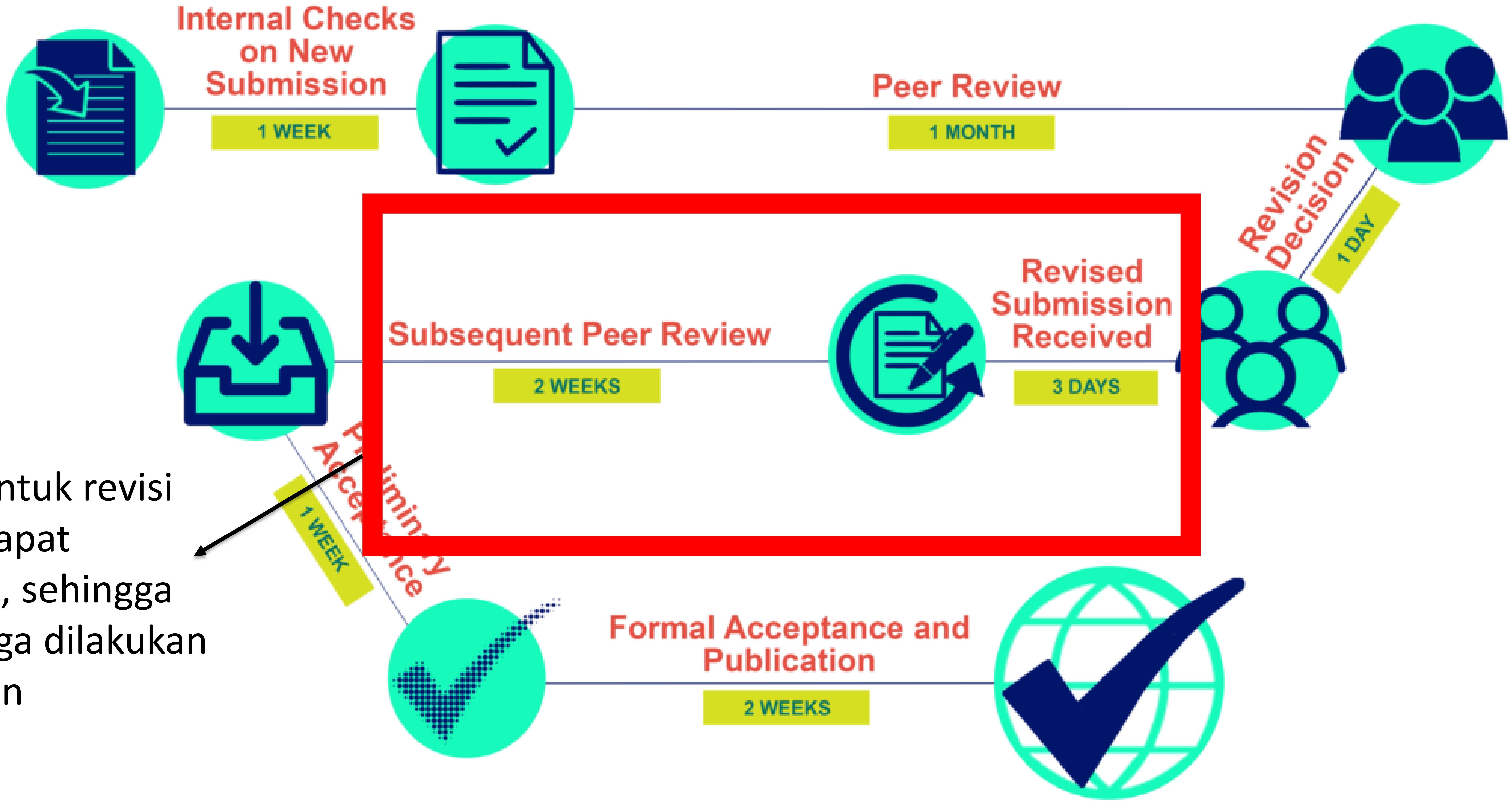
Journal of Religion and Health

The effect of listening to Holy Qur'an and a back massage on fatigue and quality of life for participants undergoing hemodialysis: A quasi-experimental study

--Manuscript Draft--

Manuscript Number:	JORH-D-22-00307R7
Full Title:	The effect of listening to Holy Qur'an and a back massage on fatigue and quality of life for participants undergoing hemodialysis: A quasi-experimental study
Article Type:	Original Research
Keywords:	chronic kidney disease; fatigue; Hemodialysis; Indonesia; listening to the Qur'an; slow stroke back massage; quality of life
Corresponding Author:	Erna Rochmawati Universitas Muhammadiyah Yogyakarta Yogyakarta, INDONESIA
Corresponding Author Secondary Information:	
Corresponding Author's Institution:	Universitas Muhammadiyah Yogyakarta
Corresponding Author's Secondary Institution:	
First Author:	Ade Komariah, SKep.,Ns
First Author Secondary Information:	
Order of Authors:	Ade Komariah, SKep.,Ns
	Erna Rochmawati

Submission Process



Internal Checks on New Submission

1 WEEK

Peer Review

1 MONTH

Revision Decision

1 DAY

Revised Submission Received

3 DAYS

Subsequent Peer Review

2 WEEKS

Preliminary Acceptance

1 WEEK

Formal Acceptance and Publication

2 WEEKS

Keputusan untuk revisi manuskrip dapat berulang kali, sehingga perbaikan juga dilakukan sesuai dengan keputusan

Submission Process

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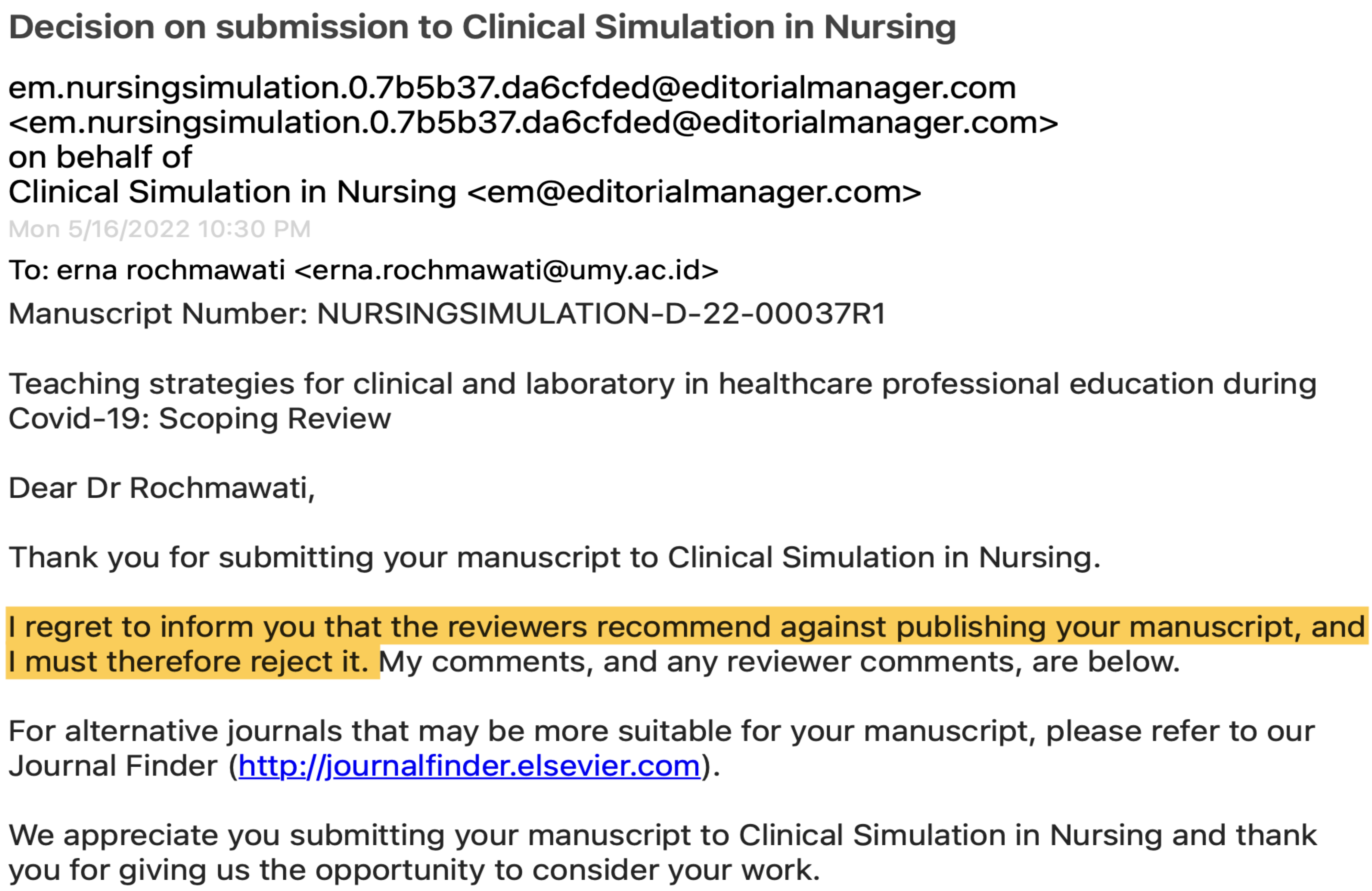

Decision on submission to Clinical Simulation in Nursing

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<em.nursingsimulation.0.7b5b37.da6cfded@editorialmanager.com>
on behalf of
Clinical Simulation in Nursing <em@editorialmanager.com>
Mon 5/16/2022 10:30 PM
To: erna rochmawati <erna.rochmawati@umy.ac.id>
Manuscript Number: NURSINGSIMULATION-D-22-00037R1

Teaching strategies for clinical and laboratory in healthcare professional education during Covid-19: Scoping Review

Dear Dr Rochmawati,

Thank you for submitting your manuscript to Clinical Simulation in Nursing.

I regret to inform you that the reviewers recommend against publishing your manuscript, and I must therefore reject it. My comments, and any reviewer comments, are below.

For alternative journals that may be more suitable for your manuscript, please refer to our Journal Finder (http://journalfinder.elsevier.com).

We appreciate you submitting your manuscript to Clinical Simulation in Nursing and thank you for giving us the opportunity to consider your work.

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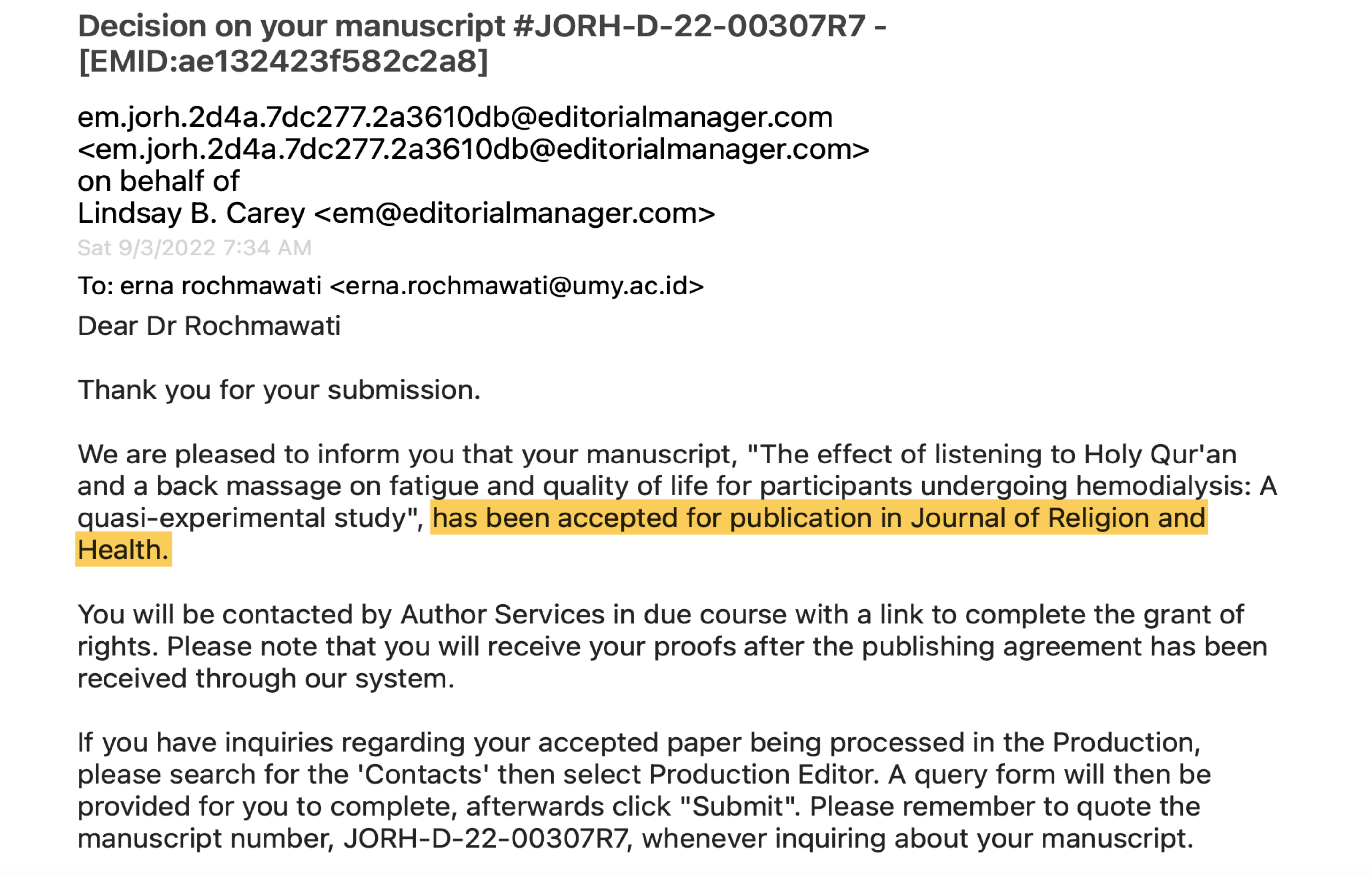
ACCEPTED



Decision on your manuscript #JORH-D-22-00307R7 - [EMID:ae132423f582c2a8]

em.jorh.2d4a.7dc277.2a3610db@editorialmanager.com
<em.jorh.2d4a.7dc277.2a3610db@editorialmanager.com>
on behalf of
Lindsay B. Carey <em@editorialmanager.com>
Sat 9/3/2022 7:34 AM

To: erna rochmawati <erna.rochmawati@umy.ac.id>

Dear Dr Rochmawati

Thank you for your submission.

We are pleased to inform you that your manuscript, "The effect of listening to Holy Qur'an and a back massage on fatigue and quality of life for participants undergoing hemodialysis: A quasi-experimental study", has been accepted for publication in Journal of Religion and Health.

You will be contacted by Author Services in due course with a link to complete the grant of rights. Please note that you will receive your proofs after the publishing agreement has been received through our system.

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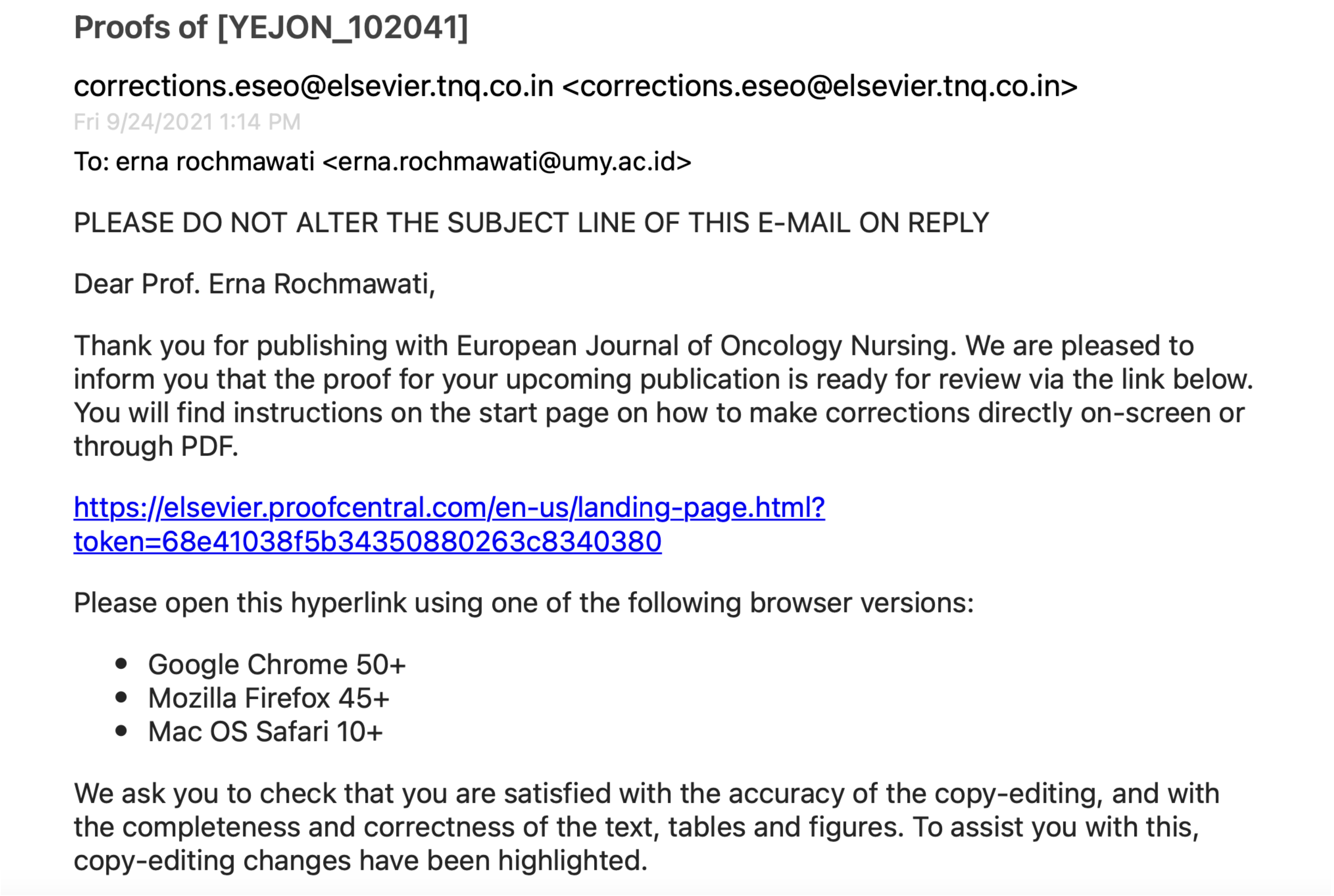

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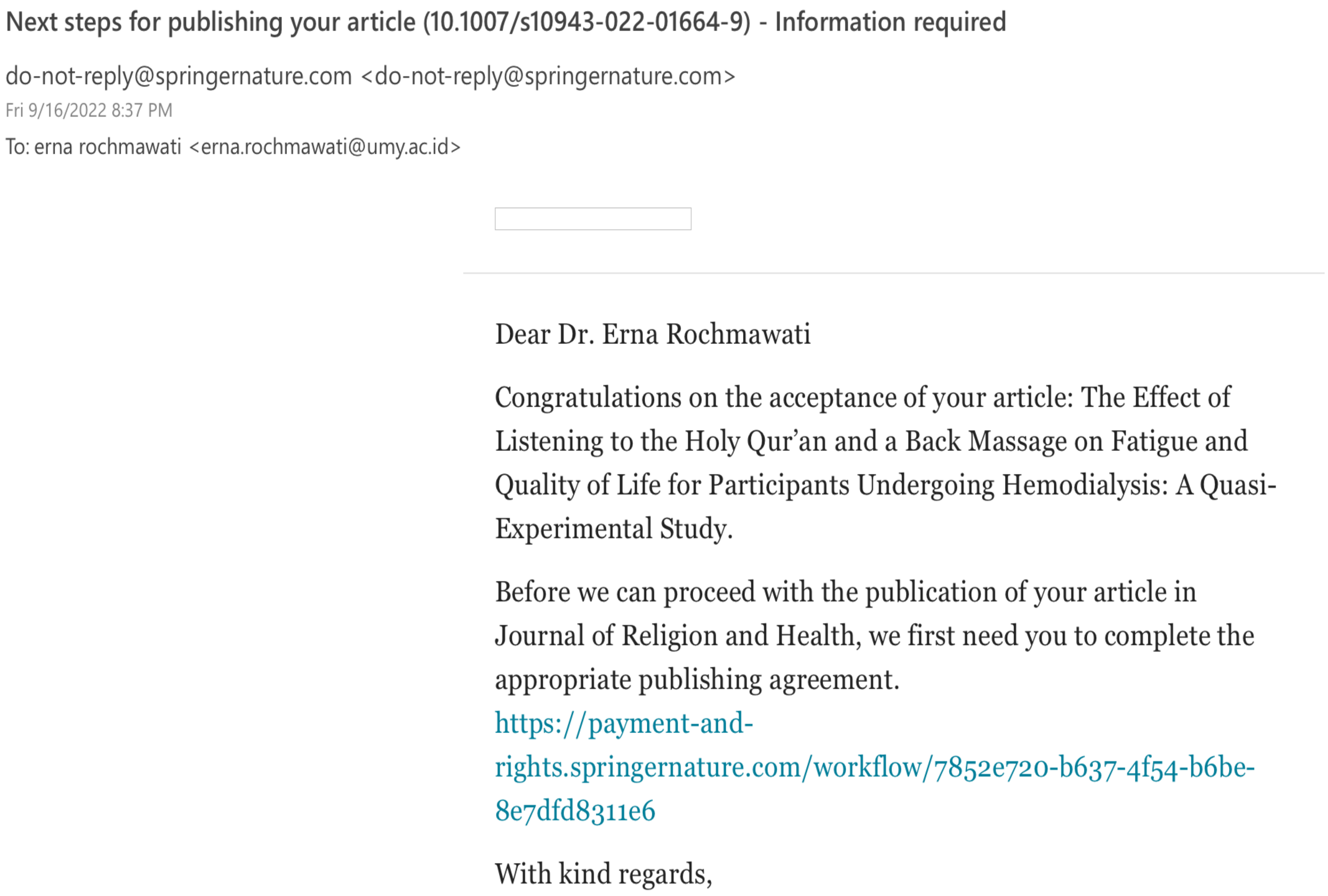

Next steps for publishing your article (10.1007/s10943-022-01664-9) - Information required

do-not-reply@springernature.com <do-not-reply@springernature.com>
Fri 9/16/2022 8:37 PM
To: erna rochmawati <erna.rochmawati@umy.ac.id>

Dear Dr. Erna Rochmawati

Congratulations on the acceptance of your article: The Effect of Listening to the Holy Qur'an and a Back Massage on Fatigue and Quality of Life for Participants Undergoing Hemodialysis: A Quasi-Experimental Study.

Before we can proceed with the publication of your article in Journal of Religion and Health, we first need you to complete the appropriate publishing agreement. https://payment-and-rights.springernature.com/workflow/7852e720-b637-4f54-b6be-8e7dfd8311e6

With kind regards,

Submission Process

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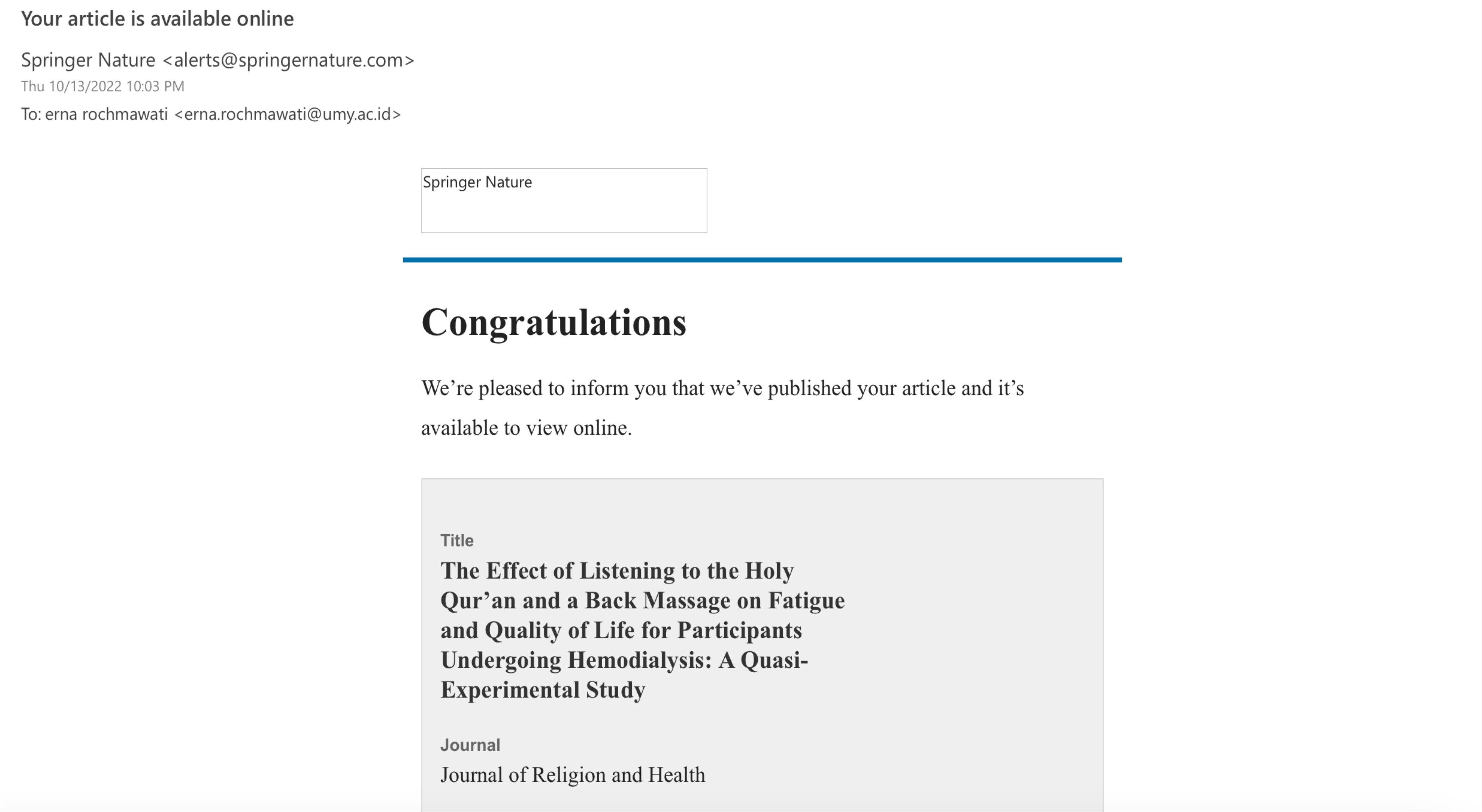

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Journal of Religion and Health

Published

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Effectiveness of dignity therapy on well-being among patients under palliative care: A systematic review and meta-analysis

Bertha Tesma Wulandari, Erna Rochmawati *

School of Nursing, Universitas Muhammadiyah Yogyakarta, Indonesia

ARTICLE INFO

Article history:
Received 25 January 2023
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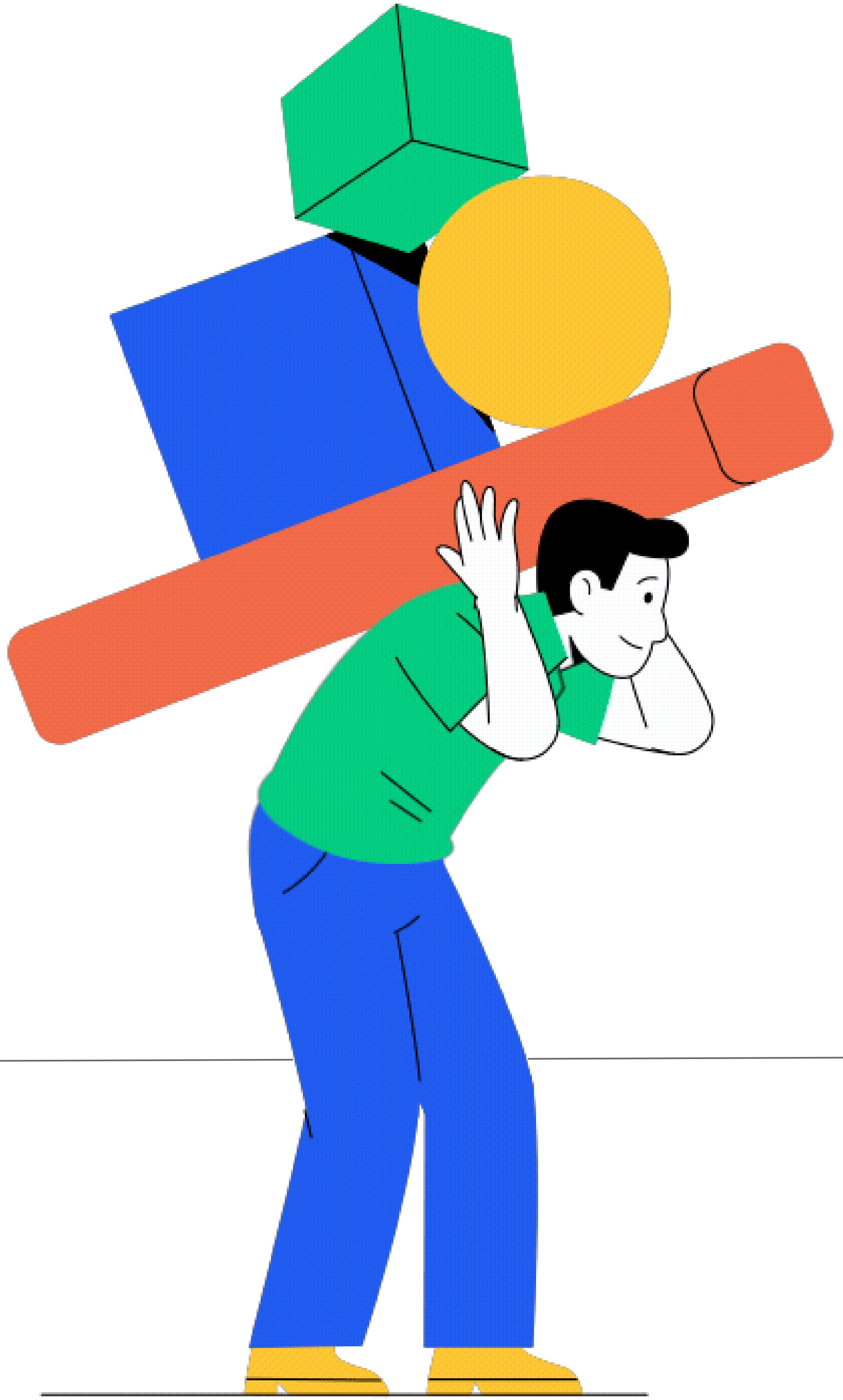
Keywords:
Dignity intervention
Dignity therapy
Effectiveness
Palliative
Systematic review
Terminal illness

ABSTRACT

Background: Dignity therapy is a psychotherapeutic intervention that is potentially effective in improving the well-being of patients receiving palliative care. However, the effects of dignity therapy are not well-understood.
Objective: We attempted to determine the effectiveness of dignity therapy in palliative patients to provide evidence that dignity therapy could be used in their care.
Design: Systematic review.
Participants: The number of participants from all the studies was 1202 (intervention group, 619 patients; control group, 583 patients).
Methods: The review was reported according to the updated Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020. Relevant studies were collected with database searching of PubMed, Scopus, ScienceDirect, ProQuest Health & Medical Complete, CINAHL, and Psych Info databases from the inception of dignity therapy in 2002 to 2022. Literature was selected to identify trials of dignity therapy in patients with palliative care needs including cancer and non-cancer condition. Critical appraisal was performed independently by two

TIPS

- Collaboration, teamwork
- Commitment
- Focus management
- Never give up



The hardest thing about publishing is starting.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QUESTIONS?