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RESEARCH ARTICLE (ORIGINAL)

Validation of an educational intervention to promote health behaviors in cancer survivors: e-Delphi technique

Validação de uma intervenção educacional para promover comportamentos de saúde nos sobreviventes de cancro: Técnica e-Delphi

Validación de una intervención educativa para promover comportamientos saludables en los supervivientes de cáncer: técnica e-Delphi

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Abstract
Background: Although international evidence demonstrates that health promotion improves the quality of life and optimizes several health behaviors of cancer survivors, educational programs for cancer survivors are scarce in Portugal.
Objectives: To validate the content and structure of an educational nursing intervention to promote health behaviors in cancer survivors.
Methodology: A modified e-Delphi study was conducted with three rounds of online questionnaires. Twenty-six of the 30 invited expert nurses participated in the study.
Results: The experts reached a consensus to include 25 structure-related items and 110 content-related items. The experts considered that the intervention should include four to eight presential sessions, with the possible inclusion of a family member, or in a group, reinforced the idea of nurses' initial preparation, discussed participant inclusion criteria, and strengthened the use of standardized language to support the contents.
Conclusion: The expert consensus adds robustness and consistency to this educational intervention and will promote the health of cancer survivors.

Keywords: delphi technique; nursing, practical; oncology nursing; healthy lifestyle; health promotion

Resumo
Enquadramento: Embora as evidências internacionais demonstrem que a promoção da saúde melhora a qualidade de vida e otimiza vários comportamentos de saúde dos sobreviventes de cancro, os programas educacionais dirigidos aos sobreviventes de cancro em Portugal são escassos.
Objetivos: Validar o conteúdo e a estrutura de uma intervenção educacional em enfermagem para promover os comportamentos de saúde nos sobreviventes de cancro.
Metodologia: Conduziu-se um e-Delphi modificado, com três rondas de questionários *online*. Participaram 26 dos 30 enfermeiros peritos convidados.
Resultados: Os peritos chegaram a consenso para inclusão de 25 itens relacionados com a estrutura e 110 relacionados com o conteúdo. Os peritos admitiram uma intervenção de quatro a oito sessões presenciais, com possível inclusão de um familiar ou em grupo, reforçaram a ideia de preparação inicial dos enfermeiros, pronunciaram-se sobre os critérios de inclusão dos participantes e cimentaram a utilização da linguagem classificada para suportar o conteúdo.
Conclusão: O consenso obtido entre os peritos produz robustez e consistência à intervenção educacional em desenvolvimento e promoverá a saúde dos sobreviventes de cancro.

Palavras-chave: técnica delfos; enfermagem prática; enfermagem oncológica; estilo de vida saudável; promoção da saúde

Resumen
Marco contextual: Aunque las pruebas internacionales demuestren que la promoción de la salud mejora la calidad de vida y optimiza varios comportamientos de salud de los supervivientes de cáncer, los programas educativos dirigidos a los supervivientes de cáncer en Portugal son escasos.
Objetivos: Validar el contenido y la estructura de una intervención educativa de enfermería para promover conductas de salud en los supervivientes de cáncer.
Metodología: Se realizó un e-Delphi modificado, con tres rondas de cuestionarios en línea. Participaron 26 de los 30 enfermeros expertos invitados.
Resultados: Los expertos llegaron a un consenso para incluir 25 elementos relacionados con la estructura y 110 con el contenido. Los expertos aceptaron una intervención de cuatro a ocho sesiones presenciales, con la posibilidad de incluir a un familiar o un grupo, reforzaron la idea de la preparación inicial de los enfermeros, opinaron sobre los criterios de inclusión de los participantes y cimentaron el uso de un lenguaje clasificado para apoyar el contenido.
Conclusión: El consenso alcanzado entre los expertos proporciona solidez y coherencia a la intervención educativa que se está desarrollando y promoverá la salud de los supervivientes de cáncer.

Palabras clave: técnica delfos; enfermería práctica; enfermería oncológica; estilo de vida saludable; promoción de la salud

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Introduction

There are currently more than 50 million cancer survivors, and even with the preventive measures in force, 200 million cases of cancer will be diagnosed over the next decade (World Health Organization [WHO], 2020). With improvements in cancer management and the high life expectancy, survivorship care has become a priority. Managing the late adverse effects of cancer and the psychosocial needs of long-term cancer survivors are increasingly important (WHO, 2020). Even though people diagnosed with cancer have a higher risk of developing a second cancer due to the risk factors that led to the original cancer, some of them may not die from a direct effect of cancer but rather from causes that are modifiable through lifestyle changes or secondary prevention activities (Vera et al., 2019). Some studies have shown that cancer survivors receive fewer recommendations about preventive activities than people who have never had cancer (Vera et al., 2019) and engage in fewer healthy behaviors, such as physical activity, healthy eating, and weight control, than the general population (Meraviglia et al., 2013). Promoting healthy behaviors among cancer survivors seems to be extremely important because it can increase survivors' resources for adopting health behaviors and benefit their physical and psychological health, quality of life, and long-term survival (Meraviglia et al., 2013). The development of new models of survivorship care is a priority, and wellness interventions are at the center of these models (Stan et al., 2020). Oncology clinicians have limited time to address some health issues, so collaboration with nurses specifically trained to educate and motivate people about wellness behaviors can bridge this gap (Stan et al., 2020). Although there are several nursing programs and interventions for cancer survivors in the international literature, Portugal lacks salutogenic interventions for this population (Peixoto et al., 2021a). Therefore, an educational nursing intervention was developed to promote health behaviors in cancer survivors. To this end, a series of studies were conducted. This article corresponds to the third study in this process and aims to validate the content and structure of an educational nursing intervention to promote health behaviors in cancer survivors with the help of a group of experts.

Background

In recent years, several international organizations, namely the American Cancer Society [ACS], the American Society of Clinical Oncology [ASCO], the National Cancer Survivorship Resource Center [NCSRC], and others have created survivorship care models and published survivorship care plans (SCPs) to support survivors transitioning from active disease phase to survivorship (Austin et al., 2020). These SCPs have proved effective in increasing confidence in one's ability to manage care, change in health behaviors, and improvements in overall health indicators during the survivorship phase (Austin et al., 2020). The survivorship phase is currently accepted and understood as the period after completing primary and adjuvant cancer treatment until recurrence or death (León-Salas et al., 2020). Caring for cancer survivors includes monitoring cancer recurrence, following up and managing health problems related to treatment toxicity, and assessing the development of other cancers (WHO, 2020). Survivorship care is divided into: (1) management of physical effects, (2) management of psychosocial effects, (3) management of chronic medical conditions, (4) prevention and surveillance for recurrent and new cancers, and (5) health promotion and disease prevention (WHO, 2020). However, even though this categorization divides attention between health promotion and disease management, surveillance, and monitoring, a major clinical concern related to cancer recurrence prevails at this stage. For this reason, several clinical standards point to the search for tumor markers and the detection of recurrence as priorities of follow-up consultations (Vera et al., 2019). However, although survivors have a higher risk of recurrence and additional cancers than the general population, other acute or chronic diseases can result from cancer and treatment and affect their quality of life (ACS, 2019). At an international level, some nursing intervention programs aimed at promoting health and, consequently, minimizing/managing the adverse effects of cancer and treatments and preventing cardiovascular diseases, diabetes, and other types of cancer, have assumed a prominent role (Cairo et al., 2020; León-Salas et al., 2020). There are consistent data from recent scientific studies that show the benefits of changes in physical activity and nutrition after cancer. For example, they point out that physical activity improves heart health, decreases the risk of osteoporosis, and may help mitigate the cardiotoxic effects of chemotherapy and other long-term effects of treatment. They also report that healthy eating habits reduce cardiovascular risk factors and improve body weight (Vera et al., 2019). Indeed, nurses' challenge is now to optimize the health of cancer survivors by improving their involvement in activities that can manage the late effects of cancer and promote health. In recent years, attention has been given to nursing programs and interventions related to healthy eating (Knobf et al., 2018), physical activity (Stan et al., 2020), maintaining an adequate weight (Krusche et al., 2019), and smoking cessation (Ehrenzeller et al., 2018) in cancer survivors. In parallel, the literature highlights that the contribution of oncology nurses produces significant gains across the care continuum (Oncology Nursing Society [ONS], 2017). Nurses can and should be part of multidisciplinary teams that initiate and implement survivor care plans, particularly those focusing on symptom management and psychosocial support (Young et al., 2020). Therefore, and given the complex needs of people with cancer, nurses must have deep knowledge, high-level engagement with multi-professional teams, critical thinking, self-reflection, and clinical skills to ensure the safe delivery of high-quality care (Gaguski et al., 2017). In the active phase of the disease, the context of clinical practice is underpinned by a robust, scientifically evolved, and highly technological body of knowledge, especially concerning treatments and

the rapid incorporation of research into clinical practice. This scientific innovation encourages nurses to constantly update themselves to achieve and maintain a high level of competence to deliver safe, holistic care to people with cancer. Unlike what happens in the active phase, in the post-treatment phase, care is not so well structured, individuals are lost in this transition and lose the support associated with the frequent contact with the health systems, and professional support is insufficient (Hewitt et al., 2006). Contrary to what is internationally proposed and implemented, the review conducted by Peixoto et al. (2021a) points out that the national evidence on nurse-led health promotion programs and interventions for cancer survivors is scarce. In this context, this study surveyed a group of expert oncology nurses who, due to their academic, scientific, and professional background, are able to validate the structure and content of the educational nursing intervention under development. The data obtained from this group of experts will add robustness and consistency to the educational intervention under development and promote cancer survivors' health.

Research question

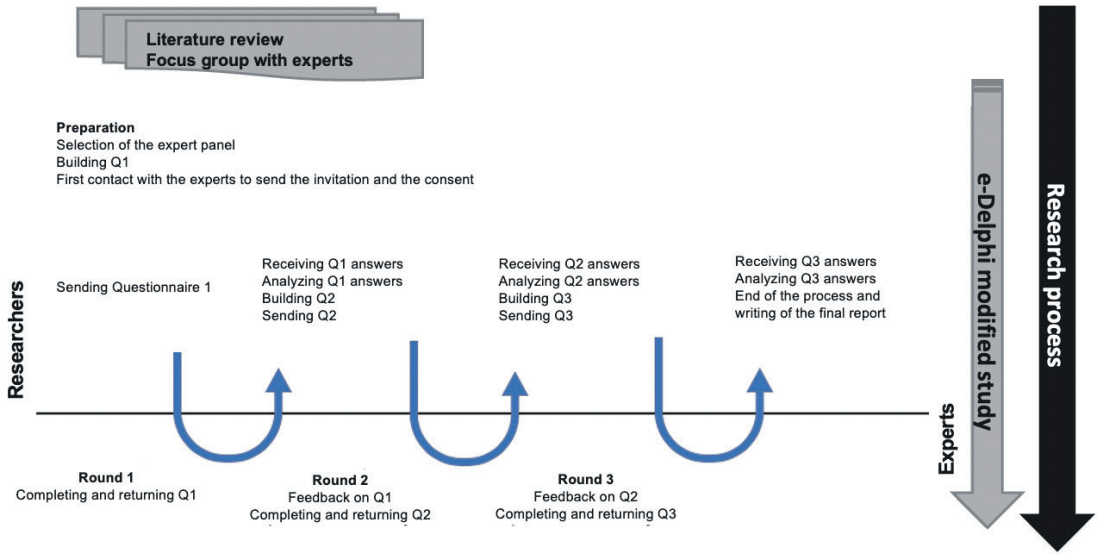
What is the content and structure validity of the educational nursing intervention to promote health behaviors in cancer survivors?

Methodology

A multistage study was developed according to the methodological recommendations of the modified e-Delphi technique (Keeney et al., 2011). This technique was chosen because it allows experts to interact and dialogue at a distance to achieve consensus on the validity of the educational intervention under development (Keeney et al., 2011). Online questionnaires were used for data collection. They were sent to the participants via email to maximize time and resources and because they are easier to use and facilitate data management. A modified technique was used because the process started with a set of pre-selected items extracted from the findings of previous studies, namely a literature review (Peixoto et al., 2021a) and a focus group meeting with experts (Peixoto et al., 2021b). This study aims to reach consensus on the structure and content of the educational nursing intervention. The sample consisted of 30 nurse specialists who were considered experts by the researchers. The participant inclusion criteria were based on the methodological recommendations proposed by Keeney et al. (2011) and aligned with the definition of experts from the previous study (Peixoto et al., 2021b): a) holding the title of nurse specialist of the Ordem dos Enfermeiros (Portuguese nursing regulator), and b) meeting at least one of the following criteria: (1) being a head nurse of a unit providing care to cancer patients for at least 5 years, (2) working with cancer patients for at least 5 years, (3) having teaching activity in the area of health promotion and/or management of chronic/cancer disease for at least 5 years, (4) having conducted at least one research study on health promotion in the last 5 years, (5) having conducted at least one research study on disease management in the last 5 years, or (6) having conducted at least one research study on oncology in the last 5 years. Participants were ensured confidentiality and anonymity at all stages of the study. All participants accepted and consented to participate in the study by completing an informed consent form. The study was approved by the shared Ethics Committee of the Institute of Biomedical Sciences Abel Salazar of the University of Porto and the Porto University Hospital Center, with code 2020/CE/P018 (P330/CETI/ICBAS). This study based on the modified e-Delphi technique was implemented over several steps. According to the literature consulted, these phases can be organized as follows (Figure 1; Marques & Freitas, 2018):

Figure 1

Phases of the research process (Modified e-Delphi Technique)



Note. Q1 = Questionnaire 1; Q2 = Questionnaire 2; Q3 = Questionnaire 3.

1) Selection of the expert panel: A non-probability purposive sampling technique was used. Expert clinical practitioners and academics were included to achieve a heterogeneous sample, capable of delivering better solutions. There is no consensus on the number of experts to be included, but a minimum number of 10 and less than 30 is advocated (Marques & Freitas, 2018). Therefore, consensus can be reached if there are 15 or more answers in each round. As some participants could withdraw throughout the rounds or not answer the questionnaire, the same 30 experts were invited for all rounds. 2) Building Questionnaire 1 (Q1): A semi-structured questionnaire was built and divided into four areas: (i) Structure of the educational intervention, (ii) Exclusion criteria for participants in the educational intervention, (iii) Focuses of nursing practice, and (iv) Nursing interventions. In this questionnaire, the experts could provide suggestions on the topics. The options regarding the structure of the intervention and the participant exclusion criteria were based on the findings of previous studies (Peixoto et al., 2021a; Peixoto et al., 2021b). The areas related to focuses of nursing practice and nursing interventions were designed based on the International Classification for Nursing Practice (ICNP®) in order to standardize the content of the intervention. 3) First contact with the experts, sending the invitation to participate and the informed consent: In the first contact via email on October 3, 2020, they received the invitation and the informed consent. In the invitation, anonymity was ensured to capture all panel experts' opinions and knowledge and avoid distortions associated with participant interactions. Informed consent was sent, and all research procedures were explained. 4) Sending Q1: Prior to submission, Q1 was pre-tested to assess the comprehensibility of the questionnaire items and the contact methodology established with two external members of the research team who met the expert requirements. After the pre-test was analyzed and minor linguistic details were introduced, Q1 was sent to the participants, along with the invitation and the consent, to maximize time and resources. It was sent in digital format via an online platform to create questionnaires (GoogleDocs). Study participants were asked to rate the importance of each item on a five-point Likert scale, with a score of 5 representing the highest degree of agreement. 5) Receiving Q1 answers: Three weeks after the Q1 was sent out (October 24, 2020), access to it was blocked, making it temporarily impossible to change or provide new answers. The answers were organized and forwarded for analysis. 6) Analysis of the Q1 answers: Given that the experts could comment, suggest changes, and/or argue in favor of their positions in the submitted questionnaires, the qualitative analysis consisted of the content analysis of the small text excerpts based on Bardin's methodological assumptions (2011). Therefore, recording/context units and categories were created to identify items to be included in Round 2. The quantitative analysis consisted of the statistical analysis of the experts' assessment of each item through the mean (Me), median (Md), standard deviation (SD), Content Validity Index (CVI), Coefficient of Variation (CV), and Percentage of answers 1 and 2. The CVI is computed as the number of answers rated 4 and 5 divided by the total number of answers. While there is no universally defined level of agreement for reaching consensus in studies using the Delphi method, a decision was made to define the

level of consensus for item inclusion and exclusion (Table 1). Some authors argue that it is the stability, even more than consensus, of the answers throughout the rounds that can end the rounds (Martins & Theóphilo, 2007). The stability of the answers can be calculated through the coefficient of variation (CV). Thus, it is determined that there is low dispersion (homogeneous data) of answers if the CV is lower than 15%, medium dispersion if the CV is between 15 and 30%, and high dispersion (heterogeneous data) if the CV is higher than 30%.

Table 1

Definition of consensus adapted from Havers et al. (2019)

CONSENSUS	DEFINITION
Consensus to include an item	• 80% of answers scoring equal to or higher than 4 (1-5 Likert scale). (CVI X 100 ≥ 80%) and • Median equal to or higher than 4 (1-5 Likert scale) and • None of the items found that the item was ambiguous or difficult to understand.
Consensus to exclude an item	• 80% of answers scoring equal to or lower than 2 (1-5 Likert scale) or • Median equal to or lower than 2 (1-5 Likert scale)
No consensus	• All other items

Note. CVI = Content Validity Index.

7) Building and sending Questionnaire 2 (Q2) with feedback: A detailed report on Q1 was built to send to the experts. Q2 was built based on the reorganization of the items of Q1, considering that the items that reached expert consensus, either for inclusion or exclusion, were deleted in Q2. New items suggested by the participants in Q1 were included. Q2 was sent to the participants, along with the summary of the analysis of Q1 items on November 4, 2020. 8) Receiving and analyzing Q2 answers: Three weeks after Q2 was sent out (November 25, 2020), access to it was blocked. The answers were organized and forwarded for analysis, using a procedure similar to that performed for Q1. 9) Building and sending Questionnaire 3 (Q3) with feedback: Q3 was built in the same way as Q2. It was sent out on December 1, 2020. 10) Receiving and analyzing Q3 answers: Three weeks after Q3 was sent out (December 22, 2020), access to it was blocked. The answers were organized and forwarded for analysis. In this final round, items without consensus were excluded. 11) End of the process and writing of the final report: A final report was prepared with the participants' characterization (Table 2) and a quantitative analysis of the three rounds (Tables 3, 4, and 5).

Results

The expert panel consisted of 26 participants. Four invited experts did not participate in any round. The participants gave 51 answers to the questionnaires (18 answers in Round 1, 18 in Round 2, and 15 in Round 3). The study ended after three rounds of questionnaires, as Q3 data were highly dispersed. At least 15 answers were obtained in all three rounds, meeting the minimum participant requirement. Table 2 shows the participants' characteristics. Over the three rounds, the participants reached a consensus to include 25 structure-related items and 110 content-related items. In Round 1, 108 items were included (INC) and 17 items were excluded (EXC; Table 3); in Round 2, 27 items were included and 12 items excluded (Table 4), and in Round 3, one item was excluded and all others were deleted for not reaching consensus (N/CON) in all three rounds and having high dispersion/heterogeneous data (CV > 30%). After each round, new items were added to the next round (code: NEW). The items that did not reach consensus moved on to the next round. Overall, the results indicate a high agreement for inclusion (INC) of the standardized nursing interventions under analysis. Despite the great variability of interventions, they fall under the focuses of nursing practice under discussion and can validate the content to support the development of the educational intervention. Interestingly, although the participant exclusion criteria were derived from previous studies (Peixoto et al., 2021a; Peixoto et al., 2021b), the experts considered that the intervention should be adapted to the participants' constraints rather than restrictive.

Table 2

Participants' characteristics

		Round 1	*Round 2*	*Round 3*
Total number of participants		**18**	**18**	**15**
Gender	Male	2	5	5
	Female	16	13	10
Age [mean]		**42.7**	**43.6**	**40**
Years of professional experience [mean]		**20.5**	**20.9**	**17.2**
Academic qualifications	Undergraduate degree	6	6	3
	Master's degree	7	8	8
	Doctoral degree	5	6	4
Main professional activity	**Clinical Practice**	**12**	**10**	**9**
	Day Hospital	2	3	1
	Inpatient Unit	7	5	7
	Operating Room	1	0	0
	Infection Control Committee	1	0	0
	Outpatient Consultation	1	2	1
	Teaching	**5**	**6**	**4**
	Management/Direction/ Quality Department	**1**	**2**	**2**

Table 3

Results of the quantitative analysis of Round 1

Item	Me	Md	CVI (%)	*D*	CV (%)	% of answers 1 or 2	CONSENSUS
1. Structure of the intervention							
1.1. Strategies of the educational intervention							
Individual session	4	4	**88.9**	0.8	21	11.1	**INC**
Individual sessions with a family member	4.1	4	**88.9**	0.7	17.9	5.6	**INC**
Individual and group sessions	4.4	5	**83.3**	0.9	20.9	5.6	**INC**
Individual and group sessions with a family member	3.7	4	61.1	1.1	28.9	16.7	-
1.2. Types of contacts to be established							
Face-to-face consultation in the health institution	4.2	4	**88.9**	0.6	*14.8*	0	**INC**
Telephone (follow-up call)	4.3	4	**94.4**	0.8	17.7	5.6	**INC**
1.3. Number of sessions/contacts							
1 session/contact	1.4	1	5.6	0.9	*63.8*	**83.3**	**EXC**
1.4. Duration of sessions/contacts							
60-90 minute sessions/contacts	2.1	2	22.2	1.2	*56*	72.2	**EXC**
1.5. Frequency of sessions/contacts							
3 sessions/contacts per week	1.9	2	0	0.9	*44.9*	66.7	**EXC**
4 or more sessions/contacts per week	1.7	1	0	0.8	*50.4*	77.8	**EXC**
1.6. Start of the intervention							
In the last session of treatment	2.2	2	22.2	1.2	*52.5*	66.7	**EXC**
In the first week after the end of treatment	2.6	2	33.3	1.3	*52.4*	55.6	**EXC**
Between the second and the fourth week after the end of treatment	2.2	2	11.1	1	*45.5*	66.7	**EXC**
One month after the end of treatment	1.9	1	11.1	1.3	*69.4*	72.2	**EXC**
Two to three months after the end of treatment	1.8	1	11.1	1.1	*59.9*	72.2	**EXC**

1.7. Nurses' preparation							
Allow nurses to participate in training sessions	4.4	4	100	0.5	*11.5*	0	INC
Develop guidelines for contacts/consultations	4.7	5	100	0.5	*10.4*	0	INC
Allow the nurse to explore individual aspects of the client and family	4.6	5	94.4	0.6	*13.5*	0	INC
Allow the nurse to design an individualized care plan	4.7	5	100	0.5	*10.4*	0	INC
Provide scientific information for nurses to provide to patients	4.4	4.5	94.4	0.6	*13.9*	0	INC
Enable the researcher's support	4.3	4.5	83.3	0.8	17.7	0	INC
2. Exclusion criteria for participants in the educational intervention							
Being in the treatment phase of cancer (chemotherapy or radiotherapy)	2.4	2	22.2	1.1	*47.9*	72.2	EXC
Existence of disease progression (metastases)	2.9	2	44.4	1.3	*45.8*	55.6	EXC
Not being an adult (< 18 or > 65 years)	2.8	2	38.9	1.4	*50.3*	55.6	EXC
Being illiterate (unable to read and/or write)	1.8	2	5.6	1	*56.4*	88.9	EXC
Being the caregiver of a dependent person	2	2	11.1	1	*48.5*	77.8	EXC
Impaired physical ability to go to the hospital and/or walk unassisted for 15 minutes	2.3	2	11.1	1	*44.7*	72.2	EXC
Having been diagnosed with more than one cancer	1.9	2	5.6	0.9	*44.9*	77.8	EXC
Having a caregiver	2.2	2	16.7	1	*48.1*	72.2	EXC
3. Focuses of nursing practice							
3.1. DOMAIN: Health behavior change							
Acceptance of health status (ICNP code: 10044273)	4.5	5	94.4	0.8	17.5	5.6	INC
Adherence (ICN code: 10030298)	4.2	4	83.3	0.9	20.8	5.6	INC
Adherence to therapeutic regime (ICN code: 10030365)	4.6	5	94.4	0.6	*13.5*	0	INC
Attitude toward health status (ICN code: 10040627)	4.6	5	100	0.5	*11.2*	0	INC
Self-efficacy (ICN code: 10024911)	4.7	5	100	0.5	*10.4*	0	INC
Self-management of risk for disease (ICN code: 10035255)	4.4	4.5	94.4	0.6	*13.9*	0	INC
Barriers to adherence (ICN code: 10024768)	4.4	4	94.4	0.6	*13.8*	0	INC
Ability to perform health maintenance (ICN code: 10000081)	4.4	4	94.4	0.6	*13.8*	0	INC
Health knowledge (ICN code: 10008753)	4.5	4.5	100	0.5	*11.4*	0	INC
Knowledge of behaviour change process (ICN code: 10024907)	4.6	5	100	0.5	*10.9*	0	INC
Awareness (ICN code: 10003083)	4.7	5	100	0.5	*9.8*	0	INC
Health belief (ICN code: 10022058)	4.4	5	83.3	0.8	17.6	0	INC
Initiative (ICN code: 10010250)	4.1	4	83.3	0.9	23.1	11.1	INC
Meaninglessness (ICN code: 10023900)	4.3	4	94.4	0.6	*13.7*	0	INC
3.2. DOMAIN: Health-promoting behaviors							
3.2.1. Exercise							
Adherence to exercise regime (ICN code: 10030320)	4.4	4.5	88.9	0.7	15.9	0	INC
Attitude toward exercise regime (ICN code: 10023549)	4.5	5	88.9	0.7	15.7	0	INC
Knowledge of exercise regime (ICN code: 10023793)	4.4	5	88.9	0.7	15.9	0	INC
Exercising (ICN code: 10007315)	4.2	4	88.9	0.8	19.1	5.6	INC
Managing exercise regime (ICN code: 10023890)	4.4	4	94.4	0.6	*13.9*	0	INC
Exercise regime (ICN code: 10023667)	4.2	4	83.3	0.7	17.3	0	INC
3.2.2. Nutrition and diet							
Adherence to dietary regime (ICN code: 10030312)	4.5	5	94.4	0.6	*13.7*	0	INC
Attitude toward dietary regime (ICN code: 10022418)	4.5	5	94.4	0.6	*13.7*	0	INC
Attitude toward nutritional status (ICN code: 10002976)	4.3	4	88.9	0.7	15.8	0	INC
Knowledge of dietary regime (ICN code: 10021902)	4.5	5	94.4	0.6	*13.7*	0	INC
Food intake (ICN code: 10008101)	4.2	4	88.9	0.8	19.1	5.6	INC
Nutritional intake (ICN code: 10013403)	4.3	4	88.9	0.7	15.6	0	INC
Dietary regime (ICN code: 10005951)	4.3	4	88.9	0.7	15.8	0	INC
3.2.3. Weight status							

Self-control (ICN code: 10017690)	4.5	5	94.4	0.6	*13.7*	0	INC
Self-management (ICN code: 10046837)	4.3	4	88.9	0.7	15.8	0	INC
Self-monitoring (ICN code: 10052146)	4.4	4.5	94.4	0.6	*13.9*	0	INC
3.2.4. Consumption of addictive substances							
Substance abuse (ICN code: 10018992)	4.3	4.5	83.3	0.8	17.7	0	INC
Alcohol abuse (ICN code: 10002137)	4.6	5	94.4	0.6	*13.5*	0	INC
Tobacco abuse (ICN code: 10019766)	4.4	4.5	94.4	0.6	*13.9*	0	INC
Smoking cessation (ICN code: 10038756)	4.4	5	88.9	0.7	15.9	0	INC
Knowledge of drug abuse (ICN code: 10042576)	4.3	4	88.9	0.7	15.8	0	INC
Knowledge of alcohol abuse (ICN code: 10042553)	4.4	4.5	94.4	0.6	*13.9*	0	INC
Alcohol dependence (ICN code: 10041375)	4.3	4	88.9	0.7	15.6	0	INC
Readiness for smoking cessation (ICN code: 10038610)	4.5	5	88.9	0.7	15.7	0	INC
Managing substance abuse (ICN code: 10050879)	4.3	4	94.4	0.6	*13.7*	0	INC
Managing alcohol abuse (ICN code: 10050674)	4.4	4	94.4	0.6	*13.8*	0	INC
3.2.5. Use of health resources							
Family support (ICN code: 10023680)	4.9	5	100	0.3	*6.6*	0	INC
Social support act (ICN code: 10018434)	4.8	5	100	0.4	*9*	0	INC
Spiritual support (ICN code: 10027033)	4.3	5	83.3	0.9	20.9	5.6	INC
Health-seeking behaviour (ICN code: 10008782)	4.6	5	94.4	0.6	*13.2*	0	INC
Social support role (ICN code: 10026979)	4.3	4.5	83.3	0.9	20.9	5.6	INC
Community service (ICN code: 10027359)	4.5	5	94.4	0.6	*13.7*	0	INC
Self-help service (ICN code: 10038760)	4.3	4.5	83.3	0.8	17.7	0	INC
4. Nursing interventions							
4.1. DOMAIN: Health behavior change							
Supporting decision-making process (ICN code: 10024589)	4.7	5	100	0.5	*9.8*	0	INC
Assessing preferences (ICN code: 10040586)	4.4	4.5	94.4	0.6	*13.9*	0	INC
Contracting for adherence (ICN code: 10024349)	4.5	5	88.9	0.9	19.1	5.6	INC
Teaching family about health-seeking behaviour (ICN code: 10033119)	4.7	5	100	0.5	*9.8*	0	INC
Teaching about health-seeking behaviour (ICN code: 10032956)	4.8	5	100	0.4	*9*	0	INC
Teaching about impulse control (ICN code: 10036148)	4.5	5	94.4	0.6	*13.7*	0	INC
Teaching about relapse prevention (ICN code: 10038668)	4.6	5	100	0.5	*10.9*	0	INC
Establishing trust (ICN code: 10024396)	4.6	5	88.9	0.8	18.4	5.6	INC
Prioritising (treatment) regime (ICN code: 10024438)	4.4	5	88.9	0.9	19.3	5.6	INC
Facilitating access to treatment (ICN code: 10024401)	4.5	5	94.4	0.6	*13.7*	0	INC
Promoting self-efficacy (ICN code: 10035962)	4.8	5	100	0.4	*9*	0	INC
Promoting self-esteem (ICN code: 10024455)	4.8	5	100	0.4	*7.9*	0	INC
Promoting limit setting (ICN code: 10026334)	4.3	4	83.3	0.8	17.6	0	INC
Reinforcing adherence (ICN code: 10024562)	4.5	5	88.9	0.9	19.1	5.6	INC
Reinforcing self-efficacy (ICN code: 10022537)	4.6	5	88.9	0.8	18.4	5.6	INC
Reinforcing capabilities (ICN code: 10026436)	4.6	5	88.9	0.7	15.1	0	INC
Reinforcing positive behaviour (ICN code: 10036176)	4.7	5	100	0.5	*10.4*	0	INC
Reinforcing achievements (ICN code: 10026427)	4.6	5	94.4	0.6	*13.5*	0	INC
Reinforcing impulse control (ICN code: 10036107)	4.4	4.5	88.9	0.7	15.9	0	INC
Reinforcing priority setting (ICN code: 10026188)	4.4	5	88.9	0.9	19.3	5.6	INC
Reinforcing behavioural regime (ICN code: 10039002)	4.4	5	88.9	0.9	19.3	5.6	INC
4.2. DOMAIN: Health-promoting behaviors							
4.2.1. Exercise							
Teaching how to increase activity tolerance (ICN code: 10024660)	4.3	4	88.9	0.7	15.8	0	INC
Teaching about exercise (ICN code: 10040125)	4.5	5	94.4	0.6	*13.7*	0	INC

Teaching about fatigue (ICN code: 10050996)	4.6	5	94.4	0.6	*13.2*	0	INC
Promoting adherence to exercise regime (ICN code: 10041628)	4.6	5	94.4	0.6	*13.5*	0	INC
4.2.2. Nutrition and diet							
Collaborating on dietary regime (ICN code: 10026190)	4.3	4	88.9	0.7	15.6	0	INC
Teaching about diet (ICN code: 10046533)	4.8	5	100	0.4	*9*	0	INC
Teaching about nutrition (ICN code: 10024618)	4.6	5	100	0.5	*11.2*	0	INC
Teaching about eating pattern (ICN code: 10032918)	4.7	5	100	0.5	*10.4*	0	INC
Promoting positive nutritional intake (ICN code: 10051875)	4.6	5	94.4	0.6	*13.5*	0	INC
4.2.3. Weight status							
Collaborating with nutritionist (ICN code: 10040435)	4.3	4	94.4	1	22.4	5.6	INC
Teaching self-monitoring (ICN code: 10046994)	4.6	5	100	0.5	*11.2*	0	INC
Teaching about effective weight (ICN code: 10033001)	4.2	4	88.9	0.8	19.1	5.6	INC
Promoting positive nutritional status (ICN code: 10050920)	4.3	5	83.3	0.9	20.9	5.6	INC
Referring to nutritionist (ICN code: 10046788)	4.7	5	100	0.5	*10.4*	0	INC
4.2.4. Consumption of addictive substances							
Teaching about drug abuse (ICN code: 10044916)	4.3	4	88.9	0.7	15.8	0	INC
Teaching about substance abuse (ICN code: 10024639)	4.4	5	88.9	0.7	15.9	0	INC
Teaching about alcohol abuse (ICN code: 10044900)	4.4	4	100	0.5	*11.5*	0	INC
Teaching about smoking cessation (ICN code: 10038647)	4.6	5	100	0.5	*10.9*	0	INC
Teaching about tobacco use (ICN code: 10038843)	4.4	4	100	0.5	*11.4*	0	INC
Promoting smoking cessation (ICN code: 10050954)	4.6	5	100	0.5	*10.9*	0	INC
Referring to health care provider (ICN code: 10032567)	4.4	5	88.9	0.7	15.9	0	INC
4.2.5. Use of health resources							
Teaching about family process (ICN code: 10036153)	4.3	5	83.3	1	23.8	11.1	INC
Teaching about health service (ICN code: 10050965)	4.7	5	100	0.5	*9.8*	0	INC
Promoting social support (ICN code: 10024464)	4.6	5	100	0.5	*10.9*	0	INC
Promoting effective family process (ICN code: 10036084)	4.7	5	100	0.5	*9.8*	0	INC
Providing social support (ICN code: 10027046)	4.6	5	94.4	0.6	*13.5*	0	INC
Referring to community service (ICN code: 10038385)	4.6	5	94.4	0.6	*13.2*	0	INC
Referring to support group therapy (ICN code: 10024558)	4.4	5	83.3	0.8	17.7	0	INC
Referring to occupational therapy (ICN code: 10026415)	4.4	5	83.3	0.8	17.7	0	INC

Nota. Me = Mean; *Md* = Median; CVI = Content Validity Index; SD = Standard deviation; CV = Coefficient of variation; INC = Consensus to include the item; EXC = Consensus to exclude the item.

Table 4

Results of the quantitative analysis of Round 2

Item	Me	Md	CVI (%)	*D*	CV (%)	% of answers 1 or 2	CONSENSUS
1. Structure of the intervention							
1.1. Strategies of the educational intervention							
Group sessions	4.3	4	88.9	0.8	19.3	5.6	INC
1.2. Type of contacts to be established							
Home visit	4.2	4	83.3	0.7	17	0	INC
Text messaging (SMS/email)	3.8	4	83.3	1	25.7	11.1	INC
1.3. Number of sessions/contacts							
4-8 sessions/contacts	4.3	4	88.9	0.8	19.3	5.6	INC
8-16 sessions/contacts	2.3	2	5.6	0.9	*38.9*	66.7	EXC
1.4. Duration of sessions/contacts							
NEW: 15-30 minute sessions/contacts (if individual)	4.3	4.5	88.9	0.8	19.4	5.6	INC
NEW: 30-45 minute sessions/contacts (if individual)	2.7	2	33.3	1.3	*47.1*	55.6	EXC

NEW: 45-60 minute sessions/contacts (if individual)	2.3	2	22.2	1.1	*48.5*	72.2	EXC
NEW: 15-30 minute sessions/contacts (if in group)	2.1	2	16.7	1.1	*54*	72.2	EXC
NEW: 45-60 minute sessions/contacts (if in group)	4.3	5	83.3	1.3	29.6	16.7	INC
1.5. Frequency of sessions/contacts							
1 session/contact per week	4.5	4.5	100	0.5	*11.4*	0	INC
2 sessions/contacts per week	2.5	2	22.2	1.2	*46*	61.1	EXC
1.6. Start of the intervention							
In the last sessions of treatment	4.3	4	94.4	0.8	17.6	5.6	INC
1.7. Nurses' preparation							
Admit the researcher's supervision	4.3	4.5	83.3	0.9	20.9	5.6	INC
NEW: Promote a debriefing between the nurse and the researcher	4.6	5	94.4	0.8	17.2	5.6	INC
2. Exclusion criteria for participants in the educational intervention							
Being in the palliative phase of cancer	4.2	5	83.3	1.2	30	16.7	INC
Impaired cognitive capacity to make decisions and/or understand the information received	4.4	4.5	94.4	0.6	*13.9*	0	INC
Having had tumor or tissue extraction surgery less than one month ago	4	4	83.3	0.9	22.7	11.1	INC
NEW: Being diagnosed with a decompensated psychiatric illness	4.4	4.5	94.4	0.6	*13.9*	0	INC
NEW: Not being an adult (< 18 years)	3.7	4	66.7	1.4	*38.6*	33.3	-
3. Focuses of nursing practice							
3.1. DOMAIN: Health behavior change							
Health-seeking behaviour (ICN code:10008782)	4.7	5	94.4	0.6	*12.2*	0	INC
Maintaining health (ICN code: 10046580)	4.6	5	94.4	0.6	*13.2*	0	INC
Volition (ICN code: 10020855)	4.4	4.5	94.4	0.6	*13.9*	0	INC
3.2. DOMAIN: Health-promoting behaviors							
3.2.1. Exercise							
Exercise behaviour (ICN code: 10007294)	4.5	5	94.4	0.6	*13.7*	0	INC
3.2.2. Nutrition and diet							
Impulse control (ICN code: 10035700)	4.1	4	83.3	0.8	20.2	5.6	INC
Nutritional intake within normal limits (ICN code: 10051868)	4.6	5	100	0.5	*11.2*	0	INC
Nutritional status (ICN code: 10013419)	4.5	5	94.4	0.6	*13.7*	0	INC
3.2.3. Weight status							
Underweight (ICN code: 10020263)	4.5	5	94.4	0.6	*13.7*	0	INC
Overweight (ICN code: 10013899)	4.4	4	94.4	0.6	*13.8*	0	INC
Weight (ICN code: 10021034)	4.2	4	83.3	0.9	20.6	5.6	INC
3.2.4. Consumption of addictive substances							
Drug abuse (ICN code: 10006346)	3.8	4	83.3	1.1	29.5	11.1	INC
Drug dependence (ICN code: 10041381)	2.7	2	38.9	1.5	*56.1*	55.6	EXC
Drug abuse recovery (ICN code: 10035841)	2.6	2	27.8	1.3	*49.4*	61.1	EXC
Alcohol abuse recovery (ICN code: 10035839)	3	2	44.4	1.5	*48.5*	55.6	EXC
No drug abuse (ICN code: 10028875)	2.3	2	11.1	1.1	*48.8*	55.6	EXC
No substance abuse (ICN code: 10029134)	2.3	2	11.1	1.1	*48.8*	55.6	EXC
No alcohol abuse (ICN code: 10028777)	2.5	2	16.7	1.2	*49.9*	55.6	EXC
No tobacco abuse (ICN code: 10029147)	2.5	2	16.7	1.2	*49.9*	55.6	EXC
Previous tobacco use (ICN code: 10038858)	3.9	4	83.3	1.2	*30.7*	11.1	INC
3.2.5. Use of health resources							
4. Nursing interventions							
4.1. DOMAIN: Health behavior change							
Supporting beliefs (ICN code: 10026458)	4.4	5	88.9	0.7	15.9	0	INC

Note. Me = Mean; *Md* = Median; CVI = Content validity index; SD = Standard deviation; CV = Coefficient of variation; INC = Consensus to include the item; EXC = Consensus to exclude the item.

Table 5

Results of the quantitative analysis of Round 3

Item	Me	Md	CVI (%)	*SD*	CV (%)	% of answers 1 or 2	CONSENSUS
1. Structure of the intervention							
1.1. Strategies of the educational intervention							
Group sessions with a family member	2.8	3	20	0.9	*30.8*	33.3	**N/ CON**
Individual and group sessions with a family member	3.3	4	56.3	1.2	*38.3*	25	**N/ CON**
1.2. Type of contacts to be established							
Video consultation	3	4	47.1	1.4	*45.1*	29.4	**N/ CON**
Flyer/brochure	2.9	3	38.9	1.3	*44.2*	16.7	**N/ CON**
1.3. Number of sessions/contacts							
2-4 sessions/contacts	2.5	3	36.8	1.5	*58.3*	31.6	**N/ CON**
1.4. Duration of sessions/contacts							
30-45 minute sessions/contacts (if in group)	2.7	4	40	1.2	*44.8*	20	**N/ CON**
1.5. Frequency of sessions/contacts							
1 session/contact every two weeks	2.4	3	33.3	1.2	*49.4*	23.8	**N/ CON**
2. Exclusion criteria for participants in the educational intervention							
Not being an adult (<18 years)	2.5	4	47.8	1.3	*51*	13	**N/ CON**
3. Focuses of nursing practice							
3.1. DOMAIN: Health behavior change							
Care plan (ICN code 10003970)	2.2	4	32	1.2	*57.5*	16	**N/ CON**
3.2. DOMAIN: Health-promoting behaviors							
3.2.1. Exercise							
Psychosocial response to instruction about exercise (ICN code: 10022309)	1.7	2	19.2	1.3	*78.9*	30.8	**EXC**
3.2.2. Weight status							
Energy (ICN code: 10006899)	1.7	3	22.2	1.1	*64.7*	22.2	**N/ CON**
Metabolism (ICN code: 10012005)	1.6	3	14.3	0.9	*53.8*	14.3	**N/ CON**
Obese (ICN code: 10013457)	1.7	3	20.7	1.1	*65.4*	17.2	**N/ CON**
Effective weight (ICN code: 10027385)	1.7	4	26.7	1.3	*77.5*	16.7	**N/ CON**

Note. Me = Mean; *Md* = Median; CVI = Content validity index; SD = standard deviation; CV = Coefficient of variation; N/CON = No consensus after three rounds; EXC = Consensus to exclude the item.

Discussion

Based on their interaction and answers, the experts validated aspects related to the content and structure of the educational nursing intervention, producing relevant data that will allow designing an intervention protocol. Concerning the structure, the experts analyzed aspects related to the intervention strategies, the types of contacts to be established, the moment to start the intervention, the number, duration and frequency of sessions, and the preparation of the nurses who will implement the intervention. The participants agreed that the intervention under discussion should include 4 to 8 individual sessions (1/week), with a family member, and/or group sessions, preferably face-to-face, at the institution or at home. The intervention can be implemented through telephone contacts and/or text messages. Given that living beyond cancer is a highly personalized experience, the inclusion of a family member highlights the key role of the family in managing the health/illness process, promoting holistic interventions, and avoiding self-isolation (Young et al., 2020). The literature often points to group interventions in this area (Meraviglia et al., 2013), promoting adherence to health-promoting behaviors resulting from peer-to-peer sharing. Likewise, the use of new technologies is mentioned in the follow-up and involvement of survivors (Eakin et al., 2015; Young et al., 2020), especially regarding the promotion of motivation for behavioral change. This strategy reinforces the use of Nola Pender's (2015) Health Promotion Model (HPM). The HPM focuses on the factors influencing healthy behaviors, but it also has the advantage of being a guide to explore the complex biopsychosocial process that motivates individuals to engage in health-promoting behaviors and keeps them committed to following a plan of action (Pender, 2015). As for the participant exclusion criteria, the following conditions were considered: being in the palliative phase of cancer and having had a tumor and/or tissue extraction surgery less than one month ago. This decision may be related to the fact that the palliative and postoperative phases overburden survivors with different needs. This option is framed within WHO (2020) guidelines that call attention to distinguishing between survivorship care and palliative care. This organization assumes that the different types of care should be integrated into

broader health services but with a clear division between them, with clear communication and an unambiguous definition of their goals, to improve the interventions' overall outcomes and efficiency. The participants did not include some exclusion criteria, especially the criteria that excluded survivors with disease progression and those who were still in the treatment phase, which may be related to the existence of multiple definitions of survivorship in the literature (León-Salas et al., 2020) and the use of broader definitions by the experts, promoting the inclusion of more participants rather than their exclusion. The experts' opinion may have been conditioned by the lack of a definition of survivor. As regards the content, its discussion is difficult due to the lack of interventions or intervention programs in the literature using the ICNP® and that may be comparable. However, given the high number of focuses of nursing practice and nursing interventions that reached expert consensus, its use seems unanimous, especially due to its replicability and major impact on professional practice and nursing care documentation. This option is aligned with WHO guidelines, which accepted the ICNP® to describe the domain of nursing practice as an essential and complementary part of health services. Given the heterogeneity and multiplicity of the focuses of nursing practice and nursing interventions analyzed by the experts, the following domains were discussed: Health behavior change and Health-promoting behaviors. These approaches were validated by the experts due to the high number of focuses of nursing practice and nursing interventions that reached consensus for inclusion (110 items) and the fact that no expert suggested changes to their content in the section dedicated to this purpose in the questionnaires. These domains are in line with those used by Meraviglia et al. (2013) and Eakin et al. (2015). On the one hand, they focus the intervention on enhancing knowledge and health-promoting behaviors, emphasizing responsibility for health, stress management, physical activity/exercise, nutrition, interpersonal relationships, substance use, and spiritual growth, and, on the other hand, they highlight the survivors' motivation, meanings, attitude, involvement, and self-efficacy to engage in health-promoting behaviors. It seems unanimous that interventions comprised of self-management goals and focused on individualized care lead to more benefits (Young et al., 2020).

This study has expectable limitations related to the method. Due to the heterogeneity of available evidence, it was impossible to obtain robust evidence on the consensus criteria or the number of experts to participate in the study. The selection of the modified e-Delphi technique, which meant that Q1 consisted of a set of pre-selected items, may have imposed limitations on the experts' freedom; however, the fact that they could suggest new items and justify their decisions may have reduced this bias.

Conclusion

Having had a cancer, even when successfully completing the treatments, imposes a new health condition to survivors. The experts' opinion analyzed in this study is extremely important in designing a complex educational intervention to promote health behaviors. The consensus reached by the experts adds robustness and consistency to the educational nursing intervention under development and allows drawing guidelines for standardized care plans and designing a holistic intervention grounded on the knowledge of the nursing discipline and based on a standardized language. The aspects validated by the experts will improve cancer survivors' health-promoting behaviors and, consequently, their quality of life. The analysis of the 187 items produced reliable indicators to outline the structure of the educational intervention and move forward to test its applicability, effectiveness, and replicability, possibly in a pilot study. This research reinforces the relevance of nurses' autonomous practice, provides a response to survivors' needs, and aligns with the national and international demand for this type of programs/interventions.

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