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THE EFFECTIVENESS OF NURSING INTERVENTIONS IN PROMOTING HEALTHY LIFESTYLES AMONG YOUNG PEOPLE: AN EVIDENCE-INFORMED NARRATIVE REVIEW AND IMPLEMENTATION FRAMEWORK

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ABSTRACT

Background: Adolescence and emerging adulthood are formative periods for physical activity, nutrition, tobacco-related decisions and psychosocial wellbeing. Nurses working in educational and primary-care settings have repeated opportunities to identify modifiable risks and support realistic behaviour change. Objective: To evaluate published evidence on nursing involvement in healthy-lifestyle promotion among young people and develop a practical, measurable nursing-intervention framework. Methods: A targeted narrative synthesis of 18 scientific and institutional sources available through 12 November 2026 was undertaken, including systematic reviews, randomized trials, implementation research and World Health Organization guidance. No new participants or patient-level observations were recruited. Results: A systematic review of seven school nurse-involved physical-activity interventions found that five reported improvement in at least one outcome. In a school nurse-delivered smoking-cessation trial, self-reported 30-day abstinence was 18% versus 2% at six weeks and 24% versus 5% at three months; these early gains should not be generalized to long-term cessation. Evidence for weight-management counselling, school nutrition environments and mental-health support was promising but heterogeneous and often involved multidisciplinary delivery. An original five-step nursing care pathway, a 12-week implementation schedule and an indicator-based evaluation matrix are proposed. Conclusion: Nursing interventions can strengthen youth health promotion when individualized counselling is integrated with family, school and community supports. Sustainable effectiveness requires standardized measurement, attention to equity and follow-up extending beyond immediate post-intervention outcomes. The proposed framework is conceptual and awaits prospective evaluation.

Keywords: nursing intervention; healthy lifestyle; adolescents; young adults; health promotion; school nursing; motivational interviewing; physical activity; nutrition; smoking cessation; implementation.

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INTRODUCTION

The formation of healthy behaviour during adolescence has consequences that extend beyond school completion and into early adult life. Physical inactivity, low dietary quality, tobacco exposure and persistent psychosocial stress are influenced by personal choices but also by household resources, school conditions, peer groups and the local environment. Consequently, the term "healthy lifestyle" should not be reduced to a list of instructions that young people are expected to follow independently. It denotes a dynamic set of behaviours that require knowledge, opportunity, social support and access to appropriate services. The World Health Organization (WHO) reported in November 2026 that its global assessment of more than 3.2 million adolescents aged 11–17 years found that only 14% reported at least 60 minutes of moderate-to-vigorous physical activity on all seven days of the preceding week, whereas approximately one quarter reported no such day [1]. Earlier pooled surveillance showed insufficient physical activity among 81.0% of school-going adolescents worldwide in 2016, with a higher proportion among girls [2]. Although these indicators have different definitions and reference periods and must not be interpreted as a single time series, both underscore the scale of the prevention challenge.

WHO physical-activity guidance and the WHO–UNESCO Health-Promoting Schools standards position sustainable behaviour change as a joint responsibility of individual learners, health professionals, educational institutions and supportive environments [3,4]. A school nurse or primary-care nurse can contribute through early identification, culturally appropriate counselling, health literacy support, coordination of referrals and repeated follow-up. These activities are particularly relevant when young people prefer accessible, confidential discussions instead of infrequent specialist appointments. Nevertheless, the availability of a nurse does not, by itself, demonstrate an effective intervention: clinical content, training, delivery fidelity, communication quality and environmental conditions influence whether information is translated into behaviour.

Recent reviews provide a more refined picture of this role. Francis and colleagues synthesized 20 nurse-involved school policy, systems and environmental interventions targeting nutrition or obesity prevention, documenting improvements across some anthropometric, knowledge and attitudinal outcomes but heterogeneous designs and targets [5]. Longobucco and colleagues identified seven studies of physical-activity promotion involving nurses and exercise-related professionals [6]. A further review of primary-school nursing activities assembled 19 studies, including randomized and nonrandomized evidence, while emphasizing the need to evaluate the contribution of specific nursing actions rather than attributing all observed effects to a single professional group [7]. These findings make it important to distinguish directly nurse-delivered counselling from broader health-promoting programmes in which nurses are only one of several contributors.

An additional challenge is the frequent mismatch between short-term improvements and sustained behavioural change. Tobacco-cessation trials illustrate how favourable early differences can diminish with longer follow-up [8,9]. In weight-management programmes, effects may depend on family involvement, motivational support, multidisciplinary teams and baseline risk [10–12]. Mental-health support likewise requires sensitive identification

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and referral pathways rather than assuming that general health education is sufficient for every participant [13,14]. Against this background, the aim of the present article is to critically synthesize evidence on the effectiveness of nursing interventions for healthy-lifestyle promotion in youth and to propose a pragmatic, measurement-oriented intervention framework that can be adapted to educational and primary-care settings. The contribution of this article is a structured interpretation and implementation model, not the presentation of an original clinical trial.

MATERIALS AND METHODS

This article was prepared as a targeted narrative evidence review combined with original methodological synthesis. Relevant literature was identified by searching or checking PubMed-indexed publications, full-text research articles, systematic reviews and institutional guidance related to school nursing, adolescent health promotion, smoking cessation, physical activity, nutrition, obesity prevention, motivational interviewing, mental wellbeing and implementation science. Search concepts included “school nurse intervention”, “adolescent healthy lifestyle”, “nurse-led physical activity”, “nursing obesity prevention”, “school nurse smoking cessation”, “motivational interviewing adolescent” and “health-promoting schools”. The reference set was finalized using material available through 12 November 2026 and comprises 18 cited sources [1–18]. The selection prioritized direct nursing interventions, quantitative outcome reporting, relevant systematic evidence and methodological guidance. The retrieval was purposive and not exhaustive; no registered protocol, dual-reviewer screening or formal meta-analytic pooling was undertaken.

Eligibility for substantive synthesis was defined conceptually: school-aged adolescents or young people in early adulthood, interventions applicable to nursing or school-health practice, identifiable behavioural or health-related outcomes, and an interpretable study design. Trials in younger children were considered only to inform potentially transferable counselling components, not as direct evidence for older adolescents or university students. Evidence was stratified into three categories: interventions directly delivered by school or clinical nurses; multidisciplinary interventions involving nurses; and wider school-based programmes that illustrate implementation mechanisms but cannot establish nurse-specific efficacy. Published sample sizes, effect estimates and follow-up durations were extracted only when explicitly available in the source. The same result was not treated as a second independent finding merely because it appeared in a review and an underlying trial.

The analytical approach assessed each domain according to the behavioural target, delivery setting, nurse-specific contribution, direction of reported change, durability, methodological limitations and feasibility of measurement in routine care. To avoid inappropriate quantitative synthesis, differences between study designs, control conditions and outcome definitions were preserved. The illustrative graphics in this article therefore reproduce either the published count of studies within a single review or the reported outcome percentages from one randomized trial; they do not represent newly collected data or a pooled effect estimate. The proposed nursing pathway was designed using principles

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of capability, opportunity and motivation from the Behaviour Change Wheel, together with a distinction between clinical outcomes and implementation outcomes such as acceptability, feasibility, fidelity and sustainability [17,18].

No research participants were enrolled, no private health records were accessed and no interventions were administered in preparing this review. Ethics approval and participant consent were therefore not applicable. The author-developed 12-week schedule, care pathway and indicator matrix presented below are a prospective implementation proposal and must not be represented as a completed experiment or a validated effectiveness instrument. Any future prospective evaluation would require institutional approvals, youth safeguarding procedures, appropriate consent or assent, and clearly specified analyses before data collection.

RESULTS

The evidence indicates that nursing-related health promotion should be assessed at more than one level. A favourable change in knowledge can confirm that information was received but does not demonstrate greater physical activity or sustained smoking abstinence. Likewise, successful programme delivery is an implementation outcome, not direct evidence of improved health. Across the reviewed literature, stronger inferences arise when interventions define a clear behavioural objective, deliver repeated contact and collect outcomes at prespecified time points. Table 1 summarizes selected findings that are relevant to nurses while maintaining the distinction between nurse-led, nurse-involved and wider school interventions. The table is intentionally selective and should not be interpreted as a complete systematic evidence inventory.

Table 1. Selected evidence on youth health-promotion interventions and the limits of inference

Source / design	Published finding	Interpretation for nursing practice
Longobucco et al. [6]; systematic review; 7 studies	Five of seven studies improved at least one physical-activity or lifestyle outcome; two did not show statistically significant improvement.	Supports feasibility of collaborative school nursing; heterogeneous outcomes preclude a single pooled effect.
Pbert et al. [8]; school nurse RCT; 71 schools	Self-reported 30-day smoking abstinence: 18% vs 2% at 6 weeks; 24% vs 5% at 3 months.	Direct nurse-delivered evidence for short-term cessation; self-report and limited follow-up warrant caution.
Pbert et al. [9]; nurse RCT; 35 schools	Intervention participants more likely to report abstinence at 3 months (OR 1.90); no overall 12-month difference.	Maintenance support and subgroup responsiveness are essential.

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Source / design	Published finding	Interpretation for nursing practice
Köse and Yıldız [10]; RCT; 64 adolescents	A 6-month motivational-support programme including messages and family education improved several weight and wellbeing outcomes.	Supports individualized nursing encouragement; smaller trial and multiple components limit attribution.
Luque et al. [12]; cluster RCT; 44 care teams	Pediatrician–nurse plus dietitian-supported motivational interviewing reduced BMI z-score more than standard care (adjusted B −0.11).	Shows multidisciplinary feasibility; findings are for 8–14-year-olds, not university cohorts.
Francis et al. [5]; systematic review; 20 studies	Nurse-involved school environment and policy interventions reported improvements in several nutrition-related measures.	Institutional food environments should complement individual health education.
Lekamge et al. [14]; meta-analysis; 28 trials	Whole-school interventions reduced odds of regular smoking and some online harms; most evaluated outcomes showed no significant benefit.	Whole-school results are not nurse-specific and do not establish broad mental-health efficacy.
Lee et al. [15]; Cochrane review; 39 trials	Implementation strategies increased delivery of school health interventions (SMD 0.95; 95% CI 0.71–1.19).	Improving implementation is not equivalent to improving student health; both should be measured.

Physical activity was the most consistently represented behavioural target in reviews of school nursing collaborations. Longobucco and colleagues reported that five of seven included studies showed improvement in at least one relevant outcome; the studies varied in intervention methods, monitoring instruments and behavioural indicators [6]. Figure 2 reproduces this descriptive count. The result should not be converted into a “71% treatment success rate” for individual students, because the unit is the study rather than the participant and the outcome definitions are not interchangeable. The broader review by Francis and colleagues further indicates that nutrition-related school policies and environments can influence what healthy choices are available, although the independent contribution of a nurse is difficult to isolate when multiple professionals and institutions participate [5].

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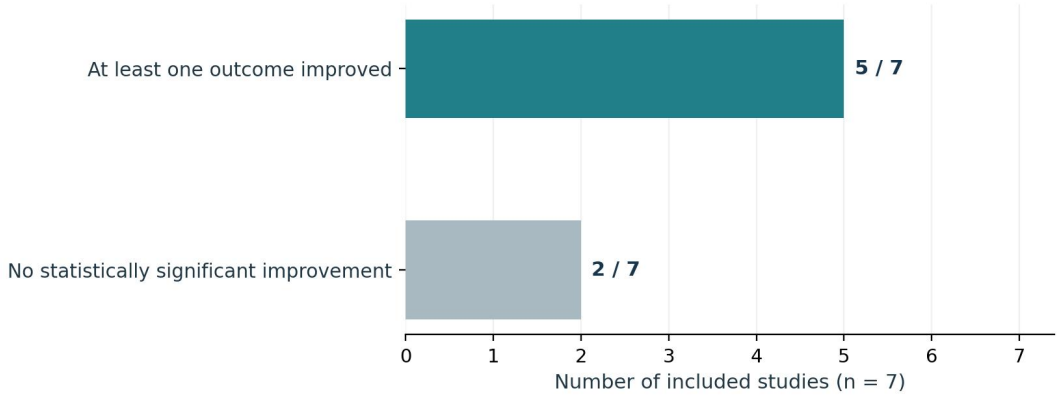


Figure 1. Descriptive outcome distribution among seven nurse-involved physical-activity studies reported by Longobucco et al. [6]. A study was counted as improved if at least one measured outcome improved; this is not an individual-level response rate.

Direct evidence for a nurse-delivered intervention is particularly clear in adolescent smoking cessation, although the durability of its impact is more uncertain. In the 2006 randomized trial conducted by Pbert and colleagues across 71 high schools, a four-session, one-to-one nursing intervention was associated with higher self-reported 30-day abstinence at six weeks (18% versus 2%) and at three months (24% versus 5%) compared with usual care [8]. In a subsequent randomized study including 1,068 adolescents across 35 high schools, intervention participants had higher self-reported odds of abstinence at three months (OR 1.90, 95% CI 1.12–3.24), but the overall between-group advantage was no longer evident at twelve months [9]. These trials suggest that brief, structured counselling delivered by nurses can generate near-term behavioural change, but should be accompanied by relapse prevention and longer follow-up. Figure 2 shows only the published self-reported percentages from the 2006 study; the two time points and comparator groups must not be treated as outcomes from the present review population.

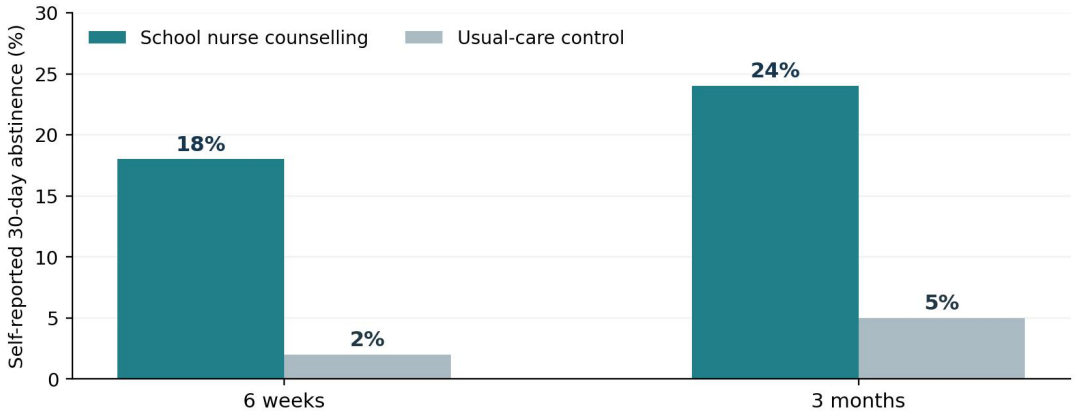


Figure 2. Self-reported 30-day smoking abstinence from the 2006 randomized school nurse-delivered intervention trial by Pbert et al. [8]. Percentages are taken from that trial; no new patients were studied for the present article.

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Weight-related evidence also points toward the value of repeated, personalized support, especially when family context is addressed. In a randomized trial involving 64 adolescents with overweight or obesity, Köse and Yıldız assessed a motivational programme with interviews, reminder messages and parental education over six months; intervention participants experienced improvements in body-mass and several wellbeing-related outcomes relative to baseline and/or controls [10]. In the Obemat2.0 cluster trial, the intervention was delivered by pediatrician–nurse teams with dietitian workshops and written educational support for children aged 8–14 years. The model-adjusted difference in BMI z-score reduction was −0.11 (95% CI −0.20 to −0.01) relative to standard care [12]. These findings should not be extrapolated directly to healthy older students or interpreted as evidence that messaging alone caused weight reduction. Robbins and colleagues also studied the feasibility of combining school and home approaches to adolescent physical activity and eating behaviour, highlighting the practical relevance of multi-setting contact rather than relying on isolated classroom lessons [11].

Mental wellbeing emerges as a necessary component of healthy-lifestyle counselling, but the available evidence requires careful discrimination. A 2026 integrative review organized school-nurse mental-health support around accessibility, person-centered encounters, individualized strategies and attention to sleep [13]. Such elements support identification, trust and referral, but are not equivalent to proof that routine counselling treats depression or anxiety. An updated whole-school meta-analysis involving 28 studies showed reductions in some risk outcomes, including regular smoking (OR 0.69), cyberbullying (OR 0.75) and cyber-aggression (OR 0.63), yet found no statistically significant effect in most other pooled outcomes, including several mental-health measures [14]. The COPE Healthy Lifestyles TEEN cluster trial demonstrated positive outcomes from a cognitive-behavioural, physical-activity-enhanced curriculum, but its classroom sessions were teacher-delivered rather than a direct test of nurse-only practice [16]. It therefore informs the organization of multi-domain sessions but cannot substantiate a nurse-specific treatment effect.

In addition to observable health indicators, the reviewed literature emphasizes the central role of implementation quality. A 2024 Cochrane review of 39 randomized or cluster-randomized trials reported that school implementation strategies probably increase delivery of health-promoting policies or practices (standardized mean difference 0.95; 95% CI 0.71–1.19), but highlighted heterogeneity and methodological limitations [15]. The practical implication is that staff preparation, institutional endorsement, standardized materials and reminders must be evaluated separately from student health results. Building on this distinction, the present synthesis proposes a five-stage pathway consisting of assessment, shared goal setting, intervention delivery, structured follow-up and multidimensional evaluation. Figure 3 depicts an original educational model, not a validated clinical algorithm. In routine nursing practice, repeated cycles may be more useful than a one-off educational session because they allow the plan to be updated when motivation, resources or health needs change.

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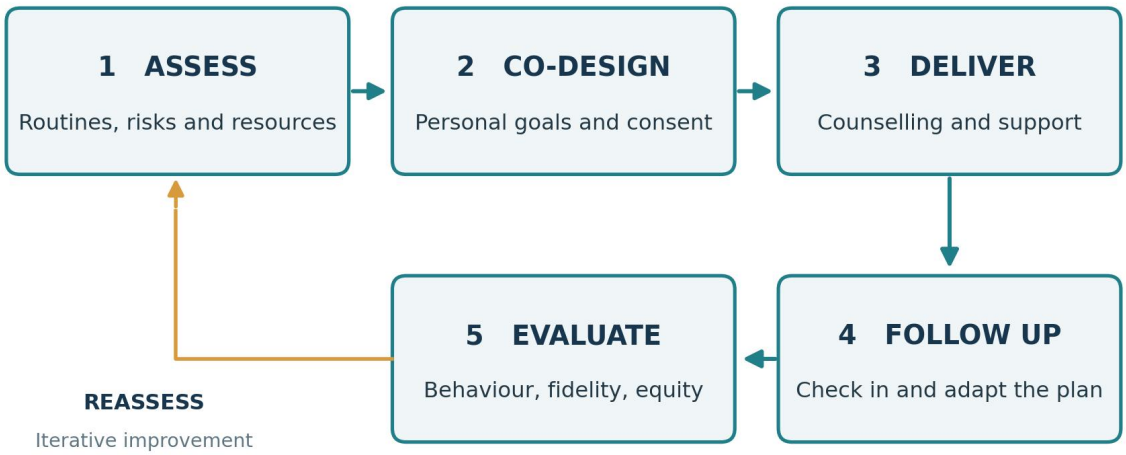


Figure 3. Proposed five-stage nursing intervention cycle for healthy-lifestyle promotion among young people. Original conceptual diagram based on behaviour-change and implementation principles [17,18]; effectiveness has not been prospectively tested.

Table 2. Proposed nurse-coordinated intervention components for youth healthy-lifestyle promotion

Priority domain	Nursing actions and partners	Measurable short-term outcome
Physical activity	Assess current activity and access; agree on enjoyable, realistic movement goals; connect learners with physical-education staff and safe opportunities.	Activity days per week, average minutes of moderate-to-vigorous activity, sedentary time [1–3,6].
Nutrition and hydration	Brief food-pattern assessment; age-appropriate meal and beverage education; referral for complex dietary needs; coordinate with campus or school catering.	Diet-quality questionnaire, regular meal pattern, sugary-drink frequency [4,5].
Tobacco/vaping prevention	Nonjudgmental screening; brief motivational counselling; support a quit plan when appropriate; connect to cessation services.	Self-reported tobacco/vape use and biochemically verified abstinence when feasible [8,9].
Stress, sleep and wellbeing	Confidential check-in; practical sleep and stress education; validated screening when indicated; timely specialist referral.	Self-reported sleep regularity; wellbeing score; referral completion [13,14].
Behaviour-change maintenance	Collaborative SMART goals, self-monitoring, brief follow-up messages, optional family or peer support.	Goal attainment, follow-up attendance, maintenance at 3–6 months [10–12,17].

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Priority domain	Nursing actions and partners	Measurable short-term outcome
Healthy environment and equity	Map financial, safety, mobility and accessibility barriers; work with education staff to improve opportunities.	Participation by subgroup, access barriers addressed, programme reach and fidelity [4,5,15,18].

The proposed programme is intentionally multi-domain but not maximalist. Assessment should identify one or two high-priority behaviours with the greatest relevance to each participant, rather than requiring all young people to undertake identical diet, exercise and mental-health tasks. The nurse should translate a broad risk into a specific action that is feasible within the learner's circumstances—for example, substituting a personally acceptable active commute, identifying an affordable balanced food option or scheduling an appropriate cessation follow-up. Shared decision-making and non-stigmatizing language are particularly important when discussing weight, tobacco use or emotional distress. Family and peer involvement may improve continuity when requested and appropriate, but should not compromise adolescent confidentiality or informed participation [10,13,17].

Table 3. Illustrative 12-week nursing implementation schedule (proposed, not tested)

Timeframe	Intervention process	Implementation verification
Weeks 1–2	Secure institutional agreement; train nurses; conduct voluntary baseline assessments; identify risk and protective factors.	Consent/assent process; referral map; baseline measurement completeness.
Weeks 3–4	Agree one or two personal goals; deliver individual or small-group counselling; provide accessible educational materials.	Documented goal plans; counselling checklist; participant acceptability.
Weeks 5–8	Conduct brief follow-up; adjust goals; coordinate physical-activity, nutrition and smoke-free environmental supports.	Contacts completed; intervention fidelity; barriers and adaptations.
Weeks 9–12	Reassess behaviour indicators; identify relapse risks; reinforce achievable next steps; arrange referral if indicated.	Repeat measures; adverse events; follow-up plan and retention.
Months 3–6 after programme	Optional longer-term monitoring to test sustained change, school transition and service uptake.	Maintenance indicators, attrition and subgroup differences.

A rigorous evaluation should separate programme reach and delivery from participant-level outcomes. A knowledge test may be suitable as a secondary learning indicator, but verified tobacco abstinence, measured activity and meaningful functional wellbeing are better aligned with claims of clinical effectiveness. Conversely, when objective

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instruments are unavailable, self-reported measures can be used if the tool and recall period are specified and its limitations acknowledged. Measures should be age appropriate, culturally comprehensible and feasible in low-resource educational settings. Table 4 provides a recommended indicator matrix. It identifies what should be recorded in a future study; no baseline or follow-up values are supplied because none were collected for this review.

Table 4. Suggested monitoring and evaluation matrix for a future controlled study

Indicator / level	Operational definition and collection method	Time point / interpretation
Reach and representativeness	Eligible and enrolled learners; attendance and uptake by age, gender and resource constraints.	Baseline, each session; test unequal access.
Physical activity	Days meeting age-appropriate activity target; optional accelerometer or validated activity tool.	Baseline, 12 weeks, 6 months; report instrument.
Dietary habits	Frequency of sugary drinks, fruit/vegetable consumption and skipped meals using a standardized recall window.	Baseline, 12 weeks, 6 months; avoid unsupported causal attribution.
Tobacco/vaping	Past-30-day use and quit attempts; where practical, biochemical validation for smoking cessation.	Baseline, 12 weeks, 6 months; report self-report separately.
Wellbeing and sleep	Brief validated age-appropriate wellbeing scale; sleep-duration and regularity questions.	Baseline, 12 weeks, 6 months; referral if screening indicates risk.
Service and implementation	Intervention dosage, adherence to counselling checklist, referrals completed, satisfaction.	Ongoing; distinguish delivery from health outcomes.
Safety and equity	Confidentiality incidents, distress/referral needs, unintended harms and subgroup differential effects.	Ongoing; predefine escalation and safeguarding procedure.

4. DISCUSSION

The principal conclusion emerging from the selected evidence is that nursing intervention effectiveness is conditional rather than universal. Nurses can deliver structured, accessible counselling and coordinate supportive environments, but the observed benefit depends on the behaviour targeted, the intensity of contact, the population and the way outcomes are measured. The smoking studies provide direct evidence that a small number of nurse-led sessions can improve short-term cessation among adolescents interested in quitting [8,9].

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The different findings at three and twelve months underscore the danger of treating immediate post-intervention gains as durable health improvements. Similarly, weight-related studies demonstrate the relevance of motivational interviewing and family or interdisciplinary support, but their use of combined interventions makes the unique effect of nursing difficult to determine [10–12]. A credible nursing model should therefore specify which actions are nurse-delivered, which are shared with other providers and which depend on institutional policy.

The conceptual pathway proposed here differs from a standard lecture-centred prevention approach in three ways. First, it begins with individualized assessment of opportunity and motivation rather than assuming that information deficits are the principal cause of unhealthy behaviour. Second, it integrates follow-up with adaptive goal setting so that barriers can be addressed before disengagement becomes permanent. Third, it requires simultaneous documentation of behaviour outcomes and implementation indicators. The Behaviour Change Wheel provides a useful structure for linking knowledge and skills to available opportunities and motivation, while the implementation-outcomes framework prevents high attendance or favourable satisfaction scores from being misinterpreted as evidence of disease prevention [17,18]. These elements are methodologically plausible but require prospective testing in the target context.

The evidence also supports a whole-environment perspective. A student who learns about balanced nutrition but lacks affordable food options may be unable to act on the advice. Similarly, a safe and accessible physical-activity setting may be decisive for adolescents with limited free time or mobility resources. The WHO–UNESCO standards and the review of nurse-involved nutrition interventions emphasize that school or university leadership, educational staff, food services and families share responsibility for creating realistic options [4,5]. Nurses may be particularly effective as coordinators who combine confidential counselling with advocacy for local environmental change. However, a systems-wide intervention must be assessed as such; effects observed in a whole-school programme should not be attributed solely to the nurse, and implementation success must be distinguished from subsequent student health improvements [14,15].

Adaptation to Uzbekistan and comparable Central Asian settings will require attention to educational schedules, availability of trained nurses, bilingual or multilingual communication, confidentiality norms, referral pathways, differences between urban and rural services and the cost of follow-up instruments. These practical considerations are proposed as contextual requirements, not as findings from a local population study. A feasible initial evaluation could use a cluster-randomized or controlled before-and-after design across comparable educational institutions, with baseline and follow-up measurements collected by trained evaluators. The study protocol should define a primary outcome in advance—such as activity behaviour or verified tobacco abstinence—and include process measures, implementation fidelity and prespecified handling of missing data. If the focus is university students aged 18–24 years, the intervention content and physical-activity thresholds should be adapted to adult guidance rather than copied from evidence on children aged 8–14 or adolescents aged 11–17.

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Several limitations must be emphasized. The present article is a targeted narrative synthesis, not a systematic review, registered meta-analysis or prospective clinical investigation. Its 18 sources were purposively selected and do not establish a complete evidence base. Some reviews concern primary-school children rather than adolescents or emerging adults; some effective curricula were teacher-delivered; and multidisciplinary interventions do not permit nurse-specific causal attribution. The visualized trial findings are derived from an individual historical smoking-cessation study, and the review count summarizes heterogeneous physical-activity outcomes rather than a pooled patient-level benefit [6,8]. Reporting bias, variable self-report accuracy, differences in follow-up duration and contextual heterogeneity further restrict generalizability. Accordingly, the proposed 12-week programme and indicators should be interpreted as a research-ready methodological proposal, not an empirically validated package, a demonstrated effect in Uzbekistan or a substitute for specialist care when medical or psychological needs are identified.

5. CONCLUSION

Published evidence supports a meaningful, though heterogeneous, role for nursing interventions in helping young people adopt healthier lifestyles. Structured counselling can improve short-term cessation-related outcomes, and nurse-involved physical-activity, nutrition and motivational programmes offer feasible methods for promoting beneficial behaviours. However, effects are not uniform, many programmes involve several professional groups and long-term maintenance remains uncertain. The proposed intervention framework combines personalized assessment, collaborative goal setting, brief evidence-informed counselling, supportive school and family environments, structured follow-up and transparent evaluation. Its effectiveness should be tested prospectively with behavioural outcomes, implementation indicators, equity assessment and appropriate safety procedures. The practical priority is not to maximize the number of educational sessions but to establish accessible, measurable and sustainable nursing support tailored to the needs and circumstances of young people.

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