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The impact of nursing and pharmacy teams in school, based health programs: Review

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Background: Access to healthcare for adolescents, particularly in the domains of sexual and reproductive health and mental health, remains a critical global challenge. School-Based Health Centres (SBHCs) have emerged as effective venues for providing necessary health services to underserved youth.

Methods: This review systematically analyzed literature from various databases, including PubMed and Cochrane CENTRAL, focusing on studies published from 1990 to 2012. The search utilized keywords related to school-based health care and targeted adolescent health outcomes.

Results: The findings indicate that SBHCs significantly improve access to essential health services, with a notable increase in the utilization of sexual and reproductive health services among female students. However, access for male students remains limited. The presence of SBHCs has been associated with higher rates of preventive healthcare utilization, including screenings for sexually transmitted infections and mental health support. Despite these benefits, many adolescents still report unmet health needs, particularly in mental health care.

Conclusion: The integration of nursing and pharmacy teams within SBHCs is crucial for enhancing service delivery and addressing the health needs of adolescents. Continuous evaluation and adaptation of these programs are necessary to optimize their effectiveness and ensure equitable access to healthcare services for all students. Future research should focus on identifying barriers to service utilization and developing strategies to engage underrepresented populations.

Keyword: School-Based Health Centers, adolescent health, nursing teams, pharmacy teams, healthcare access

1. Introduction

Access to healthcare, particularly for teenagers, is a vital policy aim in several nations, notably concerning sexual and reproductive health and mental healthcare [1,2]. In 2009, individuals aged 15 to 19 constituted 41% of all new HIV infections worldwide and over half of other sexually transmitted infections (STIs). Globally, it is estimated that 11% of annual births occur to teens [3,4]. Mental health issues are projected to impact 10% to 25% of teenagers worldwide, however, their mental healthcare is often overlooked. Sexual and reproductive health treatments, along with mental healthcare services, must be readily available to teenagers, and the obstacles to access must be overcome.

At the onset of the 20th century, social activists spearheaded initiatives to address the needs of youth in underprivileged communities by delivering health and social services via educational institutions, although such services were frequently rendered through voluntary efforts and seldom formally integrated into broader health systems [5]. The motivation to provide these services developed over time from the recognition that the health condition of young people is intricately linked to their educational attainment and from the need to deliver an accessible, consumer-focused service [6-8]. The benefits of using schools as venues for healthcare services are evident: schools are frequented by the majority of young people, they are accessible to families, they can provide comprehensive and non-stigmatizing health services, and they can establish connections between schools and communities [9].

In recent years, official health services have been established inside schools, creating a 'one-stop-shop' that offers a full, integrated preventive health service, including medical, nursing, and mental healthcare for youth [10, 11]. This healthcare delivery approach has gained prominence specifically in the United States. In 2008, the National Assembly on School-Based Health Care (http://www.nasbhc.org) identified almost 2,000 school-based healthcare (SBHC) programs operating nationwide. Nonetheless, despite their prevalence in the US, service provision remains inconsistent, with care extended to around 2% of young individuals enrolled in educational institutions [12]. Evidence indicates that SBHC is prevalent in the UK, including only nursing care; nevertheless, these services are inequitably dispersed and results are seldom recorded [13]. Concerning other nations, especially medium and low-income countries, there is almost an absence of verified information. South Africa is now undertaking the development of SBHC as a component of its primary healthcare re-engineering initiative [14].

Referred to as 'school-based health care (SBHC)', 'school-based health clinics', or 'school-based health centers' (SBHCs), this method of healthcare delivery is regarded as one of the most effective strategies for providing comprehensive primary and preventive health services to youth, particularly those typically underserved by health services [15–17]. While they often do not engage with young individuals who have already disengaged from education, are homeless, or jailed, data suggests they help mitigate school dropout rates and the emergence of dangerous behaviours.

SBHC seeks to deliver fundamental primary care services, address obstacles such as transportation challenges, insufficient community resources, and inconvenient locations or scheduling systems, and can also engage with various health determinants, including public health initiatives and environmental modification strategies [18-21]. Provision may range from fully equipped, permanently staffed centres with medical, nursing, and auxiliary personnel to clinics providing nursing services for only a few hours weekly [22-26].

Despite the existence of literature on school health services in general, encompassing comprehensive services situated within schools, specialized adolescent health services, school-linked services at local health centres catering to multiple schools, and various outreach services, there appears to be no known review specifically addressing the role of school-based healthcare, defined as services located on school premises and serving the student population. We aimed to evaluate the data about the impact and cost-effectiveness of SBHC on adolescent sexual and reproductive health, as well as mental health, which are critical problems during this developmental stage. We aimed to evaluate the efficacy of SBHC, examine variables affecting youth use of SBHC, and delineate relevant contextual elements that facilitate or hinder the creation of SBHC.

2. Methods

Databases including Pubmed, Psychinfo, Psychnet, Cochrane CENTRAL, and Web of Science were queried for English-language publications from January 1990 to March 2012, utilizing the search terms ‘School-based health care’, ‘School-based health service’, ‘School-

based health clinic', and 'school-based health centre', supplemented by the subterms: adolescents, youth, high schools, health, prevention, HIV, mental health, reproductive health, and sexual health. We opted not to examine research before to 1990, since we aimed to assess models of SBHC relevant to contemporary health system delivery.

3. Health clinics in schools and the psychological wellness of adolescents

Notwithstanding the relatively established history of SBHC in North America, there exists a surprising paucity of substantial scientific data about its efficacy in relation to sexual, reproductive, or mental health outcomes. No randomized controlled trials are known, and the outcomes of research using a comparison group have been inconsistent. Nonetheless, several researches have shown that students get more concentrated preventive healthcare. Ethier and colleagues [27] discovered that girls attending schools with school-based health centers exhibited higher odds of reporting receipt of pregnancy or disease prevention care (adjusted odds ratio, AOR=1.68, 95% CI, 1.16 to 1.80), utilization of hormonal contraceptives during their last sexual encounter (AOR=1.68, 95% CI, 1.24 to 2.28), and a greater likelihood of being screened for sexually transmitted diseases (STDs) (AOR=1.85, 95% CI, 1.43 to 2.40). Moreover, female students at institutions with School-Based Health Centres (SBHC) had a higher likelihood of using emergency contraception during their most recent sexual encounter (AOR=2.1, 95% CI 1.08, 4.22). Nonetheless, access to SBHC did not affect boys' receipt of reproductive healthcare. Kirby [22] presented inconclusive results about the impact of SBHC on sexual and reproductive health outcomes in six intervention schools relative to four matched comparison schools. In summary, there was no data indicating that SBHC decreased the pregnancy rate.

Nevertheless, the schools provided somewhat different offerings. For instance, merely three out of the six 'intervention' schools offered contraceptives on-site, and only one of these institutions indicated a statistically significant increase in contraceptive use during the last sexual encounter among its students compared to the control school (boys, 78% vs. 61%, p <0.001; girls, 75% vs. 60%, p <0.001). The integration of SBHC with an in-school instructional initiative cantered on HIV in a neighbourhood with elevated incidence resulted in a significant increase in reported condom use at a different school (boys 61% vs. 41%, p <0.001). The authors propose that addressing concerns prioritized by unique school communities may be more beneficial than a uniform strategy to providing. Nonetheless, this complicates the comparison of school programs and the assessment of the overall efficacy of SBHC. The research by Kisker and colleagues [28] examined the results of kids from 19 US schools with school-based health clinics funded by a specific agency to a nationally representative sample of students. They presented heterogeneous and incongruous results. For instance, they propose that SBHC may have diminished the initiation of sexual activity (67% vs. 70%, P=0.05), yet SBHC students exhibited a lower likelihood of contraceptive use at last intercourse compared to the nationally representative sample (75% vs. 80%, P=0.05), with no discrepancies in pregnancy rates (25% vs. 25%). They found that SBHC had decreased the proportion of students who had contemplated suicide (21% vs. 22%, P=0.01), but there was no change in the rates of those who had tried suicide compared to the national sample. A potential reason for these conflicting results is that significant methodological difficulties existed in the research, since the comparison students may have had access to SBHC, hence failing to serve as a genuine comparison group.

4. Access to and consumption of services

A significant portion of the data for SBHC has originated from descriptive studies that have investigated service access and usage, with the bulk of retrieved articles focusing on these aspects. Data indicates that girls predominantly utilize services more than boys [16, 17, 29–38–40]. Furthermore, students reporting significant mental health challenges, including suicidal

ideation, sleep disturbances, and depression, were more inclined to utilize SBHC compared to their counterparts without such difficulties [17, 41, 42]. Several researches indicated that regular users of SBHCs had more mental health needs compared to their counterparts [17, 30, 31, 36, 42], while one study did not corroborate this finding [40]. Jepson and colleagues identified that the predominant reasons for using mental health services were related to pregnancy and sexuality concerns, depression or interpersonal conflict, and violence [36]. Individuals of SBHC were frequently characterized as engaging in higher risk behaviours, such as unprotected sexual intercourse, drug abuse, and suicidal tendencies, compared to non-users of the services [12, 15, 17, 43-47]. Adolescents having access to SBHC got more mental health care than those in schools without SBHC, and there seemed to be a cost efficiency advantage when compared to those not exposed. Consequently, SBHC can effectively engage teenagers with the highest degree of need.

SBHC has been recognized for improving adolescents' access to medical, mental health, and substance abuse services; however, a considerable number of students continue to be underserved, especially regarding mental health care, as many students with access to SBHC still report not seeking the necessary assistance. Consequently, school-based health services do not consistently serve as the main healthcare provider, and children continue to report emergency department visits, although sometimes less often than those without access to SBHC. Consequently, it is essential to explore strategies for implementing SBHC to optimize accessibility and service capacity.

5. Rationale for the use and non-utilization of School-Based Health Centers (SBHC)

Several researches investigated the rationale for the use and non-utilization of school-based healthcare. The predominant cause for non-utilization was students' belief in their own health, leading them to feel that school-based health services were unnecessary; moreover, having a personal physician and, to a lesser extent, worries about confidentiality and parental disapproval were contributing factors [15, 31, 34, 40]. The primary reason cited for use was ease of access [31, 34]. Ninety-one percent of students believed they received the desired service, and 92% expressed varying degrees of satisfaction with the services provided. Mental health services, reproductive health services, and medical services were the predominant reasons for using SBHC [37, 40, 47], and a significant percentage of sexually experienced students said they would use SBHC for reproductive health and STI services when offered [34]. Furthermore, these services primarily attracted female students from lower socioeconomic backgrounds and those who inconsistently utilized contraception [34], underscoring the capacity of SBHC services to engage adolescents deemed 'high risk,' who would gain the most from such preventive and early interventions.

Although adults involved in planning SBHC may prioritize pregnancy prevention, it is as essential to address the needs of young people, which often include discussions about physical changes, relationships, family dynamics, and psychological well-being [47]. UK research examining use trends, attendance motivations, and perceptions of services in 16 high schools revealed that the service appealed to typically marginalized students, including males, those with lower academic abilities, and those engaged in sexual activity at earlier ages [23]. A comprehensive array of sexual and reproductive health services was implemented. Barriers accessing services included shame, cultural concerns, and apprehensions over confidentiality. Alternative methods must be identified to engage non-users, especially males [47]. A notable proportion of respondents in the UK research indicated that they primarily sought assistance from friends and family, underscoring the potential benefits of peer support and counselor training initiatives [23].

6. Contextual factors

Billy and colleagues [44] examined contextual factors affecting the provision of SBHC and found, as anticipated, that U.S. states with regulations supporting school-based programs and kids with health-related risks were more

inclined to provide such services. The availability of accessible healthcare facilities in the local community sometimes hindered the provision of school-based health services, with more wealthy towns often offering School-Based Health Centres (SBHC) more frequently than their less affluent counterparts. The authors asserted that emphasizing the health issues of students in particular localities might catalyse the delivery of necessary assistance. Well-trained personnel capable of effectively communicating with adolescents, robust referral mechanisms, sufficient follow-up treatment, and coordination between healthcare providers and educational institutions may enhance service delivery and efficacy [8].

The significance of planning for the establishment of SBHC cannot be overstated [49]. If local accessible and sensitive services are already present, such a service may be unnecessary. It is essential to investigate sources of both opposition and support within the community. SBHCs are often seen as 'contraceptive clinics' that may promote early sexual activity among youth, leading to limits in school district policies [29]. Nevertheless, such apprehensions lack empirical basis [22]. Nonetheless, planners must be prepared to listen and guarantee the provision of complete services. This may also assist in reducing the stigma associated with attending SBHC for students. Educational and healthcare personnel may oppose the establishment of SBHC owing to the ambiguity of professional boundaries, heightened responsibilities, and greater effort. Establishing a representative advisory board throughout the planning phases for each school is advisable to ensure that the approved SBHC model addresses the specific requirements of the local community, rather than using a uniform approach. An additional crucial factor is to the incorporation of SBHC services into established care systems. The placement of SBHC in underprivileged areas may lead to these centres serving as primary care providers, necessitating excellent coordination of referral systems to other care sources and the establishment of robust collaborations with communities [12, 32, 45].

The financial source for SBHC requires attention due to the enduring demands of teenagers in educational institutions. In the majority of the documented research, money was mostly sourced from the government. Guo and colleagues [46] evaluated the cost-benefit of SBHC using a quasi-experimental repeated measures method, including data from medical assistance claims and parental reports. They determined that SBHC was economically advantageous within the medical assistance framework and contended that it also benefits society by diminishing health inequality gaps.

7. Conclusions

SBHC seems capable of delivering services to often underprivileged youth, especially in the realm of mental health care. Nevertheless, there is an urgent need for additional rigorous study about the efficacy of SBHC on sexual, reproductive, and mental health outcomes, particularly focusing on the factors that promote service use among young individuals and the barriers that deter others, especially males, from using these services. Meticulous preparation and cooperation with youth, parents, and local communities are obviously essential. School-based health services may not serve as the primary source of healthcare due to their restricted coverage of schools, limited services offered, and operational hours (i.e., closed on weekends and holidays). Health policymakers must ensure a seamless integration with conventional healthcare delivery systems. School-based health services should ideally serve as a supplementary resource and not replace existing community health resources [37].

The existing data on the efficacy of SBHC on adolescent sexual, reproductive, and mental health is both significantly constrained and ambiguous. If further research can establish the basic requirements for comprehensive SBHC services and determine effective interventions using proper and rigorous procedures, it may provide a viable solution for addressing critical adolescent public health concerns. However, until that point, despite intuitive and anecdotal reasoning suggesting its efficacy, we lack the data to confidently assert its usefulness.

8. References

1. Ralph L, Brindis C. Access to reproductive healthcare for adolescents: establishing healthy behaviours at a critical juncture in the lifecourse. Curr Opin Obstet Gynecol. 2012;22(5):369-374.
2. World Health Organization. Caring for children and adolescents with mental disorders: Setting WHO directions. Geneva: WHO; c2003.
3. UNAIDS. Securing the future today: Synthesis of strategic information on HIV and Young People. Geneva: UNAIDS; c2011.
4. World Health Organization. Young people: health risks and solutions. WHO Fact sheet N°345. Geneva: WHO; c2011.
5. Merikangas KR, He J-P, Burstein M, Swanson SA, Avenevoli S, Cui L, *et al*. Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication--Adolescent Supplement (NCS-A). J Am Acad Child Adolesc Psychiatry. 2010;49(10):980-989.
6. Kieling C, Baker-Henningham H, Belfer H, Conti G, Ertem I, Omigbodun O, *et al*. Child and adolescent mental health worldwide: evidence for action. Lancet. 2011;378(9801):1515-1525.
7. Lieu TA, Newacheck PW, McManus MA. Race, ethnicity, and access to ambulatory care among US adolescents. Am J Public Health. 1993;83(7):960-965.
8. Dryfoos JG. Full service schools: revolution or Fad?. J Res Adolesc. 1995;5(2):147-172.
9. Richardson JW. Building bridges between school-based health clinics and schools. J Sch Health. 2007;77(6):337-343.
10. Dryfoos J. Full-service schools: A revolution in health and social services for children, youth and families. San Francisco, CA: Jossey-Bass; c1994.
11. Bruininks R, Frenzel M, Kelly A. Integrating services: the case for better links to schools. J Sch Health. 1994;64(6):242-248.
12. Brindis CD, Klein J, Schlitt J, Santelli J, Juszczak L, Nystrom RJ. School-based health centers: accessibility and accountability. J Adolesc Health. 2003;32(2):98-107.
13. Owen J, Carroll C, Cooke J, Formby E, Hayter M, Hirst J, *et al*. School-linked sexual health services for young people (SSHYP): a survey and systematic review concerning current models, effectiveness, cost-effectiveness and research opportunities. Health Technol Assess. 2010;14(24):1-228.
14. Motsoaledi A. Health Budget Vote Policy Speech presented at the National Assembly by Minister of Health, Dr A Motsoaledi. Cape Town: Parliamentary Monitoring Group; c2011.
15. Balassone ML, Bell M, Peterfreund N. A comparison of users and nonusers of a school-based health and mental health clinic. J Adolesc Health. 1991;12(3):240-246.
16. Anglin TM, Naylor KE, Kaplan DW. Comprehensive school-based health care: high school students' use of medical, mental health, and substance abuse services. Pediatrics. 1996;97(3):318-330.
17. Amaral G, Geierstanger S, Soleimanpour S, Brindis C. Mental health characteristics and health-seeking behaviors of adolescent school-based health center users and nonusers. J Sch Health. 2011;81(3):138-145.
18. Freudenberg N, Ruglis J. Reframing school dropout as a public health issue. Prev Chronic Dis. 2007;4(4):1-5.
19. Kerns S, Pullmann M, Cusworth Walker S, Lyon A, Cosgrove T, Bruns E. Adolescent use of school-based health centers and high school dropout. Arch Pediatr Adolesc Med. 2011;165(7):617-623.

20. Van Cura M. The relationship between school-based health centers, rates of early dismissal from school, and loss of seat time. J Sch Health. 2010;80(7):371-377.
21. Clayton S, Chin T, Blackburn S, Echeverria C. Different setting, different care: integrating prevention and clinical care in school-based health centers. Am J Public Health. 2010;100(9):1592-1596.
22. Kirby D, Waszak C, Ziegler J. Six school-based clinics: their reproductive health services and impact on sexual behavior. Fam Plann Perspect. 1991;23(1):6-16.
23. Ingram J, Salmon D. Young people's use and views of a school-based sexual health drop-in service in areas of high deprivation. Health Educ J. 2010;69(3):227-235.
24. Fothergill K, Ballard E. The school-linked health center: A promising model of community-based care for adolescents. J Adolesc Health. 1998;23(1):29-38.
25. Wright T, Richardson JW, editors. School-based health care, advancing educational success and public health. Washington, DC: American Public Health Association; c2012.
26. Peak GL, Hauser McKinney DL. Reproductive and sexual health at the school-based/school-linked health center: An analysis of services provided by 180 clinics. J Adolesc Health. 1996;19(4):276-281.
27. Ethier KA, Dittus PJ, DeRosa CJ, Chung EQ, Martinez E, Kerndt PR. School-based health center access, reproductive health care, and contraceptive use among sexually experienced high school students. J Adolesc Health. 2010;48(6):562-565.
28. Kisker EE, Brown RS. Do school-based health centers improve adolescents' access to health care, health status, and risk-taking behavior?. J Adolesc Health. 1996;18(5):335-543.
29. Santelli J, Nystrom RJ, Brindis C, Juszczak L, Klein J, Bearss N, *et al*. Reproductive health in school-based health centers: findings from the 1988–99 census of school-based health centres. J Adolesc Health. 2003;32(5):443-451.
30. Harold R, Harold N. School-based clinics: a response to the physical and mental health needs of adolescents. Health Soc Work. 1993;18(1):65-74.
31. Adelman HS, Barker LA, Nelson P. A study of a school-based clinic: who uses it and who doesn't?. J Clin Child Psychol. 1993;22(1):52-59.
32. Allison M, Crane L, Beaty B, Davidson A, Melinkovich P, Kempe A. School-based health centers: improving access and quality of care for low income adolescents. Pediatrics. 2007;120(5):e887-e894.
33. Britto MT, Klostermann BK, Bonny AE, Altum SA, Hornung RW. Impact of a school-based intervention on access to healthcare for underserved youth. J Adolesc Health. 2001;29(2):116-124.
34. Coyne-Beasley T, Ford C, Waller M, Adimora A, Resnick M. Sexually active students' willingness to use school-based health centers for reproductive health care services in North Carolina. Ambul Pediatr. 2003;3(4):196-202.
35. Guo J, Wade T, Keller K. Impact of school-based health centers on students with mental health problems. Public Health Rep. 2008;123(6):768-780.
36. Jepson L, Juszczak L, Fisher M. Mental health care in a high school based health service. Adolescence. 1998;33(129):1-15.
37. Juszczak L, Melinkovich P, Kaplan D. Use of health and mental health services by adolescents across multiple delivery sites. J Adolesc Health. 2003;32(2):108-118.

38. Kaplan D, Calonge N, Guernsey B, Hanrahan M. Managed care and school-based health centres. Arch Pediatr Adolesc Med. 1998;152(1):25-33.
39. Langille D, Asbridge M, Kisely S, Leblanc M, Schaller E, Lynk A, *et al*. The relationship of sex and risk behaviours to students' use of school-based health centres in Cape Breton, Nova Scotia. Paediatr Child Health. 2008;13(7):605-609.
40. Pastore D, Techow B. Adolescent school-based health care: A description of two sites in their 20th year of service. Mt Sinai J Med. 2004;71(3):191-196.
41. Walter H, Vaughan R, Armstrong B, Krakoff R, Tiezzi L, Mccarthy J. Characteristics of users and nonusers of health clinics in inner-city junior high schools. J Adolesc Health. 1996;18(5):344-348.
42. Weist M, Proescher E, Freedman A, Paskewitz D, Flaherty L. School-based health services for urban adolescents: psychosocial characteristics of clinic users vs nonusers. J Youth Adolesc. 1995;24(3):251-265.
43. Wolk LI, Rosenbaum R. The benefits of school-based condom availability: cross-sectional analysis of a comprehensive high school-based program. J Adolesc Health. 1995;17(3):184-188.
44. Billy JOG, Grady WR, Wenzlow AT, Brener ND, Collins JL, Kann L. Contextual influences on school provision of health services. J Adolesc Health. 2000;27(1):12-24.
45. Bowlan N, Chevalier N, Gullo S, Lawrence L, Hinton Walker P. School-based care: clinical challenges and research opportunities. J Soc Pediatr Nurs. 1996;1(2):64-74.
46. Guo JJ, Wade TJ, Pan W, Keller KN. School-based health centers: cost-benefit analysis and impact on health care disparities. Am J Public Health. 2010;100(9):1617-1623.
47. Szumilas M, Kutcher S, LeBlanc JC, Langille DB. Use of school-based health centres for mental health support in Cape Breton, Nova Scotia. Can J Psychiatry. 2010;55(5):319-328.

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تأثير فرق التمريض والصيدلة في البرامج الصحية المدرسية: مراجعة

الملخص

الخلفية :يمثل الوصول إلى خدمات الرعاية الصحية للمراهقين، خصوصًا في مجالات الصحة الجنسية والإنجابية والصحة النفسية، تحديًا عالميًا بالغ الأهمية. ظهرت المراكز الصحية المدرسية (SBHCs) كأماكن فعّالة لتقديم الخدمات الصحية اللازمة للشباب المحرومين من الرعاية.

المنهجية :حللت هذه المراجعة بشكل منهجي الأدبيات العلمية المتوفرة في قواعد البيانات المختلفة، بما في ذلك PubMed وCochrane CENTRAL، وركزت على الدراسات المنشورة بين عامي 1990 و2012. تم استخدام كلمات مفتاحية ذات صلة بالرعاية الصحية المدرسية واستهداف نتائج الصحة لدى المراهقين.

النتائج :تشير النتائج إلى أن المراكز الصحية المدرسية تعزز بشكل كبير الوصول إلى الخدمات الصحية الأساسية، مع زيادة ملحوظة في استخدام الخدمات الصحية الجنسية والإنجابية بين الطالبات. ومع ذلك، لا يزال وصول الطلاب الذكور إلى هذه الخدمات محدودًا. كما ارتبط وجود هذه المراكز بزيادة معدلات استخدام الرعاية الوقائية، بما في ذلك فحوص العدوى المنقولة جنسيًا ودعم الصحة النفسية. وعلى الرغم من هذه الفوائد، أفاد العديد من المراهقين باستمرار وجود احتياجات صحية غير ملباة، خاصة في مجال الصحة النفسية.

الاستنتاج :يعد دمج فرق التمريض والصيدلة في المراكز الصحية المدرسية أمرًا بالغ الأهمية لتعزيز تقديم الخدمات الصحية وتلبية احتياجات المراهقين. يتطلب تحسين فعالية هذه البرامج تقييمًا مستمرًا وتكيفًا مع الاحتياجات المتغيرة لضمان توفير رعاية صحية عادلة لجميع الطلاب. ينبغي أن تركز الأبحاث المستقبلية على تحديد العوائق التي تحول دون الاستفادة من الخدمات وتطوير استراتيجيات لجذب الفئات غير الممثلة بشكل كافٍ.

الكلمات المفتاحية :المراكز الصحية المدرسية، صحة المراهقين، فرق التمريض، فرق الصيدلة، الوصول إلى الرعاية الصحية.