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HEALTH CARE WITHIN THE FRAMEWORK OF THE NATIONAL STUDENT ASSISTANCE PROGRAM IN FEDERAL UNIVERSITIES IN NORTHEASTERN BRAZIL

ATENÇÃO À SAÚDE NO ÂMBITO DO PROGRAMA NACIONAL DE ASSISTÊNCIA ESTUDANTIL EM UNIVERSIDADES FEDERAIS DO NORDESTE DO BRASIL

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ABSTRACT

The National Student Assistance Program (PNAES), created to implement the Student Assistance Policy for Brazilian public higher education undergraduates, establishes 10 areas to be covered. However, Brazil has no national policy to define rules for its implementation, especially regarding health care. Thus, this study aims to map existing student health care actions and their operationalization in Northeastern federal public universities. This is a qualitative exploratory research which included eight universities operating exclusively with higher education. Data were collected by an electronic questionnaire and analyzed via content analysis. From the conducted mapping, it seems that all surveyed universities offer health services to their undergraduates, despite the lack of uniformity in health team formation and of consensus on the direction of actions. The surveyed institutions often offer health services only to PNAES beneficiaries. Moreover, results show difficulties in the communication and integration of the services offered with the local health system and that these institutions form partnerships with internal and external bodies to meet the demand for health services.

Keywords: Education Higher. Students. Health. Public Policy.

RESUMO

O Programa Nacional de Assistência Estudantil (PNAES), criado a fim de efetivar a Política de Assistência Estudantil aos graduandos do ensino superior público brasileiro, estabelece dez áreas a serem atendidas. No entanto, inexiste uma política nacional que defina normas para sua execução, sobretudo, em relação à área de atenção à saúde. Nesse sentido, este estudo tem como objetivo mapear as ações de atenção à saúde estudantil existentes nas universidades públicas federais da região Nordeste, bem como sua operacionalização. Trata-se de uma pesquisa exploratória, de abordagem qualitativa, que incluiu oito universidades, atuantes exclusivamente com atividades de ensino superior. Os dados foram coletados por questionário eletrônico e analisados pela técnica análise de conteúdo. A partir do mapeamento realizado, verifica-se que todas as universidades pesquisadas oferecem serviços de saúde aos graduandos, apesar da desuniformidade na formação das equipes e da ausência de consenso acerca do direcionamento das ações, sendo comum nas instituições pesquisadas a oferta de serviços de saúde somente aos beneficiários do PNAES. Além disso, os resultados evidenciam que há dificuldades na comunicação e integração dos serviços oferecidos com o sistema de saúde local e as instituições realizam parcerias com órgãos internos e externos visando atender a demanda por serviços de saúde.

Palavras-chave: Educação Superior. Estudantes. Saúde. Política Pública.

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1 INTRODUCTION

Brazilian higher education, initially dominated by the elite, emerged after other European or Spanish American countries (VASCONCELOS, 2010). As it grew, public universities experienced an expansion and democratization of access which inserted a more vulnerable public in their undergraduate courses (ASSIS et al., 2013; SAINTS; MARAFON, 2016).

The National Student Assistance Program (PNAES) emerged in this scenario to support student assistance actions in federal higher education institutions (FHEI) in Brazil and favor students' permanence and study completion, especially those in worse socioeconomic conditions (BRASIL, 2010).

The Program establishes 10 areas to be implemented in the daily life of these institutions, which must define the areas and actions they will perform based on decisions from their collegiate and student-support bodies (ALMEIDA; OLIVE TREE; SEIXAS, 2019). Thus, not all federal institutions develop actions in all spheres of the Program (DUTRA; SANTOS, 2017; SOUZA; COAST 2020).

Vargas and Heringer (2017) analyzed permanence policies in Brazil, Chile, and Argentina and found that these countries directly invested in students in the form of scholarships and grants aimed at covering expenses with university life. Although financial issues are fundamental, several factors can influence students' permanence, and it is relevant to observe other conditions which can interfere in academic education. Furthermore, studies have shown that young university students show a greater prevalence of diseases, indicating the influence of the university environment as a predominant factor for these illnesses (BASTOS et al., 2019; DANTAS et al., 2017; MONTEIRO et al., 2019).

In this sense, universities should act as health promoting agents, fostering healthy environments supported by health prevention and promotion. However, PNAES lacks specific rules to ensure that educational institutions implement health actions. The absence of policies or guidelines determining how health actions should take place can cause various losses to students, including impairing their permanence in higher education, since actions can become ineffective and insufficient, hindering access to students.

Thus, seeking to subsidize future public policies which can fill this important gap in Brazilian higher education and considering that the Brazilian Northeast concentrates a large

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number of socioeconomically vulnerable students, this study aims to map student health care actions and their operationalization in Northeastern federal public universities.

2 THEORETICAL FRAMEWORK

PNAES, responsible for implementing a student assistance policy in Brazilian higher education, proposes ten areas of activity, namely: housing, food, transportation, health care, digital inclusion, culture, sport, day care, pedagogical support, and access, participation, and learning of those with disabilities, global development disorders, high skills, and giftedness (BRASIL, 2010). It establishes that FHEI will receive resources to implement assistance actions according to their strategic research, teaching, and extension areas, specificities, and those meeting the needs of student bodies.

According to Bleicher and Oliveira (2016), even with the PNAES Decree, Brazil still lacks goals to be met and mechanisms to evaluate the program. For them, although PNAES predicts "health care" as one of its areas, few managers assumed the need for a change to gear its actions toward health promotion and prevention and service integration with the Unified Health System (SUS) within the municipal health network. Moreover, many universities prioritize the distribution of financial assistance and the offering of health services, such as psychological, medical, dental, and nutritional support to assist students. However, this offer lacks a policy regarding the format in which students receive services.

Data from the V research on FHEI (FONAPRACE, 2019) students' profile (to portray the socioeconomic and cultural profile of undergraduate students in Brazilian FHEI), showed that physical and mental health issues relate to academic difficulties, which may result in poorer students' permanence in higher education. As the VIII National Health Conference defined it, in a broad sense, health stems from food, housing, education, income, environment, work, transportation, employment, leisure, freedom, land access and possession, and access to health services (BRASIL, 1986).

Regarding health care, another relevant aspect raised by FONAPRACE (2019) refers to undergraduates' search for medical care, including preventive care. When students were asked whom or what equipment they sought if they needed medical care, 53.6% answered that they resorted to the public health network; 35.6%, the private network via health plans; 4.1%, the private network without health plans; 2.7%, university health services; and finally, 1.2%, friends or family's informal help.

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Another mentioned datum was the increase in leaves of absence due to health, which increased from 12.4% in the 2014 IV Forum Survey to 17.2% in the last one in 2018. The growth of this index may point to worsening permanence in the last four years and indicates the need for further studies to specify this diagnosis and new public policies to cope with it (FONAPRACE, 2019).

When studying away from home, university students need assistance to address their socioeconomic issues (i.e., food, housing, and transportation) and emotional issues (distance from their families, cultural shock, teachers' demands, and possible health challenges) (RECKTENVALD; MATTEI; PEREIRA, 2018). Student assistance is a fundamental and necessary action to maintain students in higher education, especially socioeconomically vulnerable ones (OLIVEIRA; PONCIANO; SANTOS, 2020).

According to Assis and Oliveira (2010, p. 167), offering care means addressing the personal aspects of students' lives, i.e., their physical, mental, and emotional health, food, and financial, survival, working, study, and housing conditions; in short, the precarious way of life of a significant portion of the university community. The authors claim it is essential to seek institutional exits to implement student assistance policies which meet these demands and respect and promulgate their right to assistance and the social commitment of universities.

3 METHODOLOGICAL PROCEDURES

This is a qualitative exploratory research conducted in Brazilian Northeastern federal universities in April 2021. This region was chosen since it has large percentages of poorer students and has led the internalization of higher education in the country, recording the largest increase in number of *campi*, reaching 200% in 2002 (BRASIL, 2015; OLIVEIRA et al., 2020). Camargo and Araújo (2018) stated that, of the 16 federal universities created between 2003 and 2014, eight were in the Brazilian North and Northeast. Currently, the Northeast has 20 federal universities.

Northeastern federal universities which only offered higher education activities were included in this study, considering that PNAES resources are primarily intended for higher education students. To collect data, an electronic Google Form questionnaire was sent to all universities which agreed to participate in this study and had previously filled out informed consent forms. The participating institutions were labeled FU (Federal University) from 1 to 8.

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Our electronic questionnaire focused on questions about the areas recommended by PNAES, especially health care. Managers were invited to describe the areas of the program served by their institutions, the health actions and services offered to undergraduate students, the composition of their health teams to care for students, the difficulties and potentialities for carrying out health actions and services, and the means of communication between the university and the local public health network regarding student care. Our collection instrument was previously tested and, soon after, the adequately adjusted. The manager who participated in the pre-test was excluded from our sample.

Content analysis (BARDIN, 2016) was used to describe our data and its elements were defined a posteriori. Content analysis followed the three stages in Bardin (2016): (i) pre-analysis, in which the available literature on the studied phenomenon was "floating read," (ii) material exploration, which enabled the definition of our analysis categories, and (iii) data treatment, which enabled us to discuss and establish the relation of empirical data with theory.

Analysis of the collected data enabled us to establish three categories: 1) offer and access to health services, addressing the characteristics of the surveyed institutions regarding the developed health actions; 2) difficulties in communicating and integrating services with the local health system; and 3) partnerships to meet the demand for health services.

This study was approved by the Research Ethics Committee at Universidade Federal Oeste da Bahia, under opinion no. 4.602.330.

4 RESULTS

We sent our electronic questionnaire to the 10 institutions which agreed to participate in this study. Of these, eight answered the online instrument, which represents 40% of the northeastern federal universities.

All participating universities have pro-rectories to specifically deal with student assistance and affirmative action issues and between 3,417 and 32,991 enrolled students (Chart 1). The history of student assistance in these universities showed that the institutions which provided assistance actions before the creation of PNAES offered services that limited themselves to food and residency. They provided other forms of assistance only after the emergence of the Program.

4.1 HEALTH SERVICE OFFER AND ACCESS

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Mapping health actions and services in the surveyed institutions showed the areas PNAES served, the offered health services and actions, the number of provided services, and their coverage. Regarding these areas, all participating universities reported carrying out actions in at least two of them and three universities, that they met all 10 PNAES areas (Chart 1).

Chart 1 Mapping of health actions and services in the surveyed institutions

Institution / Number of students	PNAES areas served	Existing health actions and services	Number of students served per month	Coverage of health actions and services
FU*1 / 26,000	Housing; Feeding; **Health care;** Digital inclusion; Culture; Sport; Pedagogical Support; Access, participation and learning of students with disabilities, global development disorders, high skills, and gifted students	Integrated Student Health Care Program; Dental card; Medical care; Psychological care; Physical Activity, Sport, and Leisure Program	1092 referrals to the University Hospital; 606 dental services; 1066 psychological services	Targeted at all students
FU2 / 3,417	Housing; Feeding; **Health care;** Digital inclusion; Culture; Sport; Pedagogical Support; Access, participation and learning of students with disabilities, global development disorders, high skills, and gifted students	Psychology; Psychiatry; Quality of Life	57 psychological visits; 20 psychiatric visits	Targeted at all students
FU3 / 9,215	Housing; Feeding; **Health care;** Digital inclusion; Culture; Sport; Pedagogical Support; Access, participation and learning of students with disabilities, global development disorders, high skills, and gifted students	Psychology; Nutrition; Dentistry	50 sessions (the Institution did not inform the offered services)	Targeted at all students, except dental care
FU4 / 19,634	Housing; Feeding; **Health care**; Digital inclusion; Culture; Sport; Day care, Access, participation, and learning of students with disabilities, global development disorders, high skills, and gifted students	General practitioner; Psychiatry; Psychology; Nutritionist; and Administrative Assistant	200 sessions (the Institution did not inform the offered services)	Targeted at all students
FU5 / 3,682	Feeding; **Health care**; Digital inclusion	Psychology; Nutrition	68 sessions (the Institution did not inform the offered services)	Geared to socioeconomically vulnerable students, except

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				collective activities
FU6 / 32,991	Housing; Feeding; **Health care**; Digital inclusion; Culture; Sport; Day care, Access, participation, and learning of students with disabilities, global development disorders, high skills, and gifted students	Psychology	40 sessions (the Institution did not inform the offered services)	Geared to socioeconomically vulnerable students
FU7 / 10,529	Housing; Feeding; **Health care;** Digital inclusion; Culture; Sport; Pedagogical Support; Access, participation and learning of students with disabilities, global development disorders, high skills, and gifted students	Psychology	Not reported	Geared to socioeconomically vulnerable students
FU8 / 25,639	Housing; Feeding; **Health care;** Digital inclusion; Culture; Sport; Pedagogical Support; Access, participation and learning of students with disabilities, global development disorders, high skills, and gifted students	General practitioner; Dentistry; Psychology	800 sessions	Geared to socioeconomically vulnerable students

Source: Prepared by the authors (2021). *FU = Federal University.

Regarding the health services and actions offered, the eight surveyed universities offer at least one health service to undergraduate students, and all provide psychological care. Unlike psychology services, only two and three universities offer psychiatric and dental care, respectively. We found that each institution has its own way of composing their health teams to care for students. FU4, for example, reported that its team consists of a general practitioner, a psychiatrist, five psychologists, a nutritionist, and an administrative assistant, whereas FU6 has only a psychologist (Chart 1).

Also, seven universities claim that a limited number of professionals make up their health teams (FU2, FU3, FU4, FU5, FU6, FU7, and FU8), which may hinder actions and services. The FU2 manager pointed out that “Given limitations of personnel and the areas of training of the health professionals making up the team, actions are currently more focused on mental health care and on health prevention and promotion” (FU2). The UF7 manager stated that

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> Considering that we only offer psychology care, follow-ups occur by psychological care shifts offering immediate care […]. Unlike psychotherapy, this is a short-term service which enables a limited number of sessions with the professional (FU7).

Another relevant datum is the variety of students served by university health actions and services. Even considering the varying number of enrolled students and professionals making up the health teams in each institution, note that the three universities with the highest number of served students (FU1, FU4, and FU8) have similar characteristics, such as partnerships with internal institutional sectors (e.g., the FU1 university hospital) and exclusive sectors to deal with students' health issues (as in FU4 and FU8). Regarding forms of access to health services and actions, we found that each institution has its own norms, usually unlike each other. Forms of access ranged from simpler norms, such as "Spontaneous demand via e-mails and other forms of direct contact with professionals" (FU2), to more defined standards, as described by FU4:

> Students send an e-mail to the division informing some specific data and the type of care they want (mental health, medical clinic) and after the information is checked, they receive a form to fill out with instructions and information on the service. Then, students are placed in a service spreadsheet so professionals can make appointments (FU4).

Regarding health service and action coverage, in half of the surveyed universities, health services are primarily geared to students with proven socioeconomic vulnerability, as the FU6 manager highlights: "[Health care services] are exclusive to assisted students because we do not have a team to care for every student body" (FU6). Overall, four universities claimed allocating health actions to all students, as FU1 manager stated: "Services are directed to all students, that is, they are independent of socioeconomic vulnerability, according to the SUS universality principle" (FU1). We also found that the universities with the most professionals in their health teams and greater service and action offer provide health care for all their students.

In total, five universities (FU2, FU3, FU4, FU5, and FU8) reported offering collective health actions, as mentioned by FU2: "[…] health care for students has also focused on carrying out collective interventions, mainly directed to emerging mental health demands related to the particularities of each course" (FU2).

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4.2 DIFFICULTIES IN COMMUNICATING AND INTEGRATIING SERVICES WITH THE LOCAL HEALTH SYSTEM

We found difficulties in communication and integration of health services between the universities and the local public health network. Among the raised questions, we highlight the absence of follow-ups for referrals by the institution; ignorance about the functioning of the public health network by the professionals in the institutions; difficulties referring students to the local public health network, and the refusal of the public network to accept university professionals' referrals (Chart 2).

Chart 2 Answers provided by the managers of the surveyed institutions

RESPONSES FROM INSTITUTIONS	
Absence of follow-ups for referrals made by the Institution	"[…]follow-up on whether the service actually occurred is not always provided" (FU*1)
	"There are indeed some difficulties regarding counter-referrals. Services generally do not follow-up referrals. Most of the time, we receive feedback on the situation from the students." (FU3)
Ignorance about the functioning of the public health network by the professionals in the institutions	"[…] We seek contact with the service which can make the referral to understand the flow of entry into the service and pass on guidance to the student" (FU2)
	"[…] Students are instructed to seek the Basic Health Unit (UBS) in their neighborhood to verify which mental health services are offered and what are the procedures to make the appointment" (FU3)
	"When there is a demand for individual admission that exceeds the possibility of service staff […], the recommendation is made for the student to seek a professional outside the institution" (FU5)
Difficulties referring students to the local public health network	"There are difficulties, especially in relation to the students inserted in the University Residency housing program, regarding the primary care network because it works from the territorialization perspective. So, health units refuse to cover the Residency since it is located within the Campus" (FU1)
	"There are no difficulties in communication, although we understand that the demand of the university sometimes represents an overload for the network, considering that many students are a seasonal population in the municipality" (FU7)
Refusal of the public network to accept university professionals' referrals	"The main difficulty identified refers to the refusal of some municipalities to accept direct referral from the educational institution, with the justification that the health professionals in the university would not be inserted in the basic health network" (FU2)
	"[…] We face difficulties offering vacancies for care in some specialties, such as Psychiatry, Psychology, etc." (FU3)
	"When students need other specialists, long-term psychotherapy, and secondary and tertiary care, referrals are directly to UBS (Basic Units) because we do not work with regulation" (FU8)

Source: Prepared by the authors (2021). *FU = Federal University.

In total, two universities reported that the healthcare providers in the institution, after referring students to the municipal public health network, generally received no return or

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counter-referral from the agency, as stated by the FU1 manager. FU3 claims receiving referrals only from students who entered the basic network service (Chart 2).

University healthcare providers seem to be unsure of the functioning of the local public health network. According to a FU2 report, when students need care from SUS, the professional in the institution seeks contact with the municipal health network to check the availability of professionals in the required area and assess how students will access the needed service (FU2). For the FU8 manager, ignoring the functioning of the public health network is an important difficulty since it reduces students' chances of professionals outside the institution welcoming them (FU8).

Regarding the difficulty the institution evinced to refer students in university housing to the primary care network, the responses of two participating universities (FU1 and FU7) show territorialization problems. For FU1, regarding access to SUS services, difficulties mainly include students in the housing program since, as residences are within the campus, health units refuse to carry out their coverage (FU1). UF7, on the other hand, understands that institutional demands (students in need of public health services) overloads the network, stressing that many constitute a seasonal population for the municipality (FU7).

Another difficulty regarding students' referral for local health services is that the public network rejects university health professionals' referrals, as the FU2 manager indicated, stating that municipalities reject these referrals since they lie outside the basic health network. For the manager, this forces students to seek basic health units to consult with other professionals and then be referred (FU2).

The FU2 manager also highlighted losses to students due to SUS refusing to accept university referrals, indicating that the longer waiting time disincentives students to continue to search treatment (FU2). FU8 even mentioned that, when students need care from different specialists, they are referred to a UBS since the institution fails to work with the regulation in force (FU8).

4.3 PARTNERSHIPS TO MEET THE DEMAND FOR HEALTH SERVICES

We found that, when possible, universities integrate their actions and health care services with partners inside or outside the institution (Chart 3). Thus, three universities reported partnering with institution sectors outside the student assistance team. The FU2 manager pointed out that the institution has referred medical, dentistry, physical therapy, and

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biomedical services to specialty outpatient and school clinics (FU2). For FU2, an internal partnership with different sectors also discusses activities and campaigns to promote health which can reach a larger number of students, benefiting the institution. Another important point is the partnership between FU1 and its university hospital, enabling highly complex care (FU1).

Chart 3 Answers provided by the managers of the surveyed institutions

RESPONSES FROM INSTITUTIONS	
Partnerships with internal sectors of the Institution	"[…] in relation to health care (Medicine, Dentistry, Physiotherapy, and Biomedicine), the [Institution] has made possible referrals to an outpatient clinic of medical specialties and a school clinic" (FU*2)
	"The referral to the network of high complexity is served by the University Hospital and other units of this complexity level […]" (FU1)
	"The socio-educational campaigns developed by the Psychology Service and in partnership with other university services are for the entire academic community, aiming to produce health education" (FU3)
	"[…] partnerships with other sectors of the institution that have physical education professionals, physical therapists, and nurses were carried out as a way to promote multidisciplinary and specialized actions, such as the preparation of health education materials, talk rounds, lectures, and vaccination campaigns" (FU2)
Partnerships with sectors outside the Institution	"The division of health education neither serves urgency and emergency cases nor cases requiring medical specialties; these are directed to the public health network" (FU4)
	"More severe cases and persistent mental disorders, which require a community approach and the involvement of other professionals in the service, are referred to public psychosocial care policy services" (FU2)
	"Some health promotion services (campaigns, vaccines, etc.) in 2019 were carried out by the outpatient service in partnership with external sectors linked to SUS" (FU5)
	"In cases requiring follow-up in psychotherapy, we discuss with students the possibility of referral to the partner institutions providing the service" (FU2)
	"[when necessary, students are referred to] the psychosocial and health networks of the municipalities in which the Campi of the [Institution] are located, triggering the units according to the served demand" (FU7)
	"The health actions for students are articulated with the psychosocial and health care network of the municipalities which have campi of the [Institution]" (FU7)

Source: Prepared by the authors (2021). *FU = Federal University.

In total, four universities reported partnerships with outside sectors. For their managers, these partnerships aim to assist students in urgent and emergency situations or in cases requiring highly complex services or even the implementation of health campaigns and events within the educational institution. We found these issues, for example, in FU2 manager's answer, which signaled that psychotherapy is directed to partner institutions helping to provide these services (FU2) (Chart 3).

Chart 4 summarizes our main results and shows our analysis categories and elements.

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Chart 4 Main results according to our analysis categories and elements

CATEGORIES	THEMES (ANALYSIS ELEMENTS)
OFFER AND ACCESS TO HEALTH SERVICES	Diversity in the form of supply and access between institutions; actions prioritize mental health; Psychology and Nutrition services are generally offered to all students; dentistry service, when offered, is intended only for beneficiary students; multidisciplinary teams fail to include all services; in most institutions, services are intended only for socioeconomically vulnerable students; collective actions, if existing, serve all interested in participating; in some institutions, services are exclusive to assisted students since they lack a team to serve its entire student body
DIFFICULTIES IN COMMUNICATING AND INTEGRATING SERVICES WITH THE LOCAL HEALTH SYSTEM	Absence of service follow-ups; lack of feedback on the performed care; ignorance about the functioning of the public network; difficulty referring students to the public health network; refusal of the municipality to accept institutional referrals
PARTNERSHIPS TO MEET THE DEMAND FOR HEALTH SERVICES	High complexity care by the university hospital; specialized care is referred to the school clinic; partnerships with internal sectors to develop multidisciplinary activities; partnerships with psychosocial care services; vaccination campaigns carried out in partnership with the local health system

Source: Prepared by the authors (2021).

5 DISCUSSION

This research is unprecedented as it has mapped how federal universities offer health actions. We found an evident scarcity of resources and no standard definition of the served public regarding limited care specialties and professionals. Although the carried out collective health activities enable all students to participate, we found difficulties integrating services with SUS. Finally, student health assistance sectors partner with internal and external agencies to meet their service demands.

The health services FHEI offered are limited in certain aspects, seemingly related to the scarce number of professionals who make up their teams and restricted care specialties. However, we found that the university students' mental health care is prioritized to the extent that all FHEI offered psychological services.

Several studies have showed the magnitude of mental health-related problems among university students. Those which investigated the prevalence, incidence, and characteristics of suicide in university students in several countries worldwide, such as the United Kingdom, highlighted the importance of health services in universities (especially psychological

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counseling) and stressed the need to expand these programs (AKRAM et al., 2020; GUNNEL et al., 2020).

In Brazil, data from V FONAPRACE (2019) showed that, regarding general health, 5.9% of students deemed it as a problem for the proper development of their studies; regarding mental health, 23.7% of the surveyed public claimed impairments to their academic performance due to related problems (FONAPRACE, 2019). Authors who systematically reviewed and meta-analyzed the prevalence and factors associated with anxiety, depression, and suicidal behavior in students found a high prevalence of these factors in university students, implying the need for the comprehensive mental health care of Brazilian undergraduates (DEMENECH et al., 2021).

Student health care should not only concern health professionals but also involve managers, teachers, pedagogues, and social workers, including the entire university (NOGUEIRA-MARTINS; NOGUEIRA-MARTINS, 2018). Moreover, isolated assistance services are unable to solve the problem, requiring a broader change which would involve the university community and society at large. Universities must promote changes to address internal policies, adapting political pedagogical course projects, restructuring curricular dynamics, and modifying educational strategies and evaluation formats (ALMEIDA, 2018).

Within the surveyed FHEI and regarding the public their health actions assist, we found no standardization for the offered services, i.e., some institutions offer health services only to PNAES beneficiaries. However, considering the recent budget cuts, prioritizing health care to the served public may exclude a significant portion of students, including potential beneficiaries and those failing to meet its criteria but who still need health care.

Bleicher and Oliveira's (2016) data reinforce this finding, indicating that PNAES fails to reach all audiences demanding student assistance, of which graduate students constitute an example. We should also stress that the scarce number of healthcare providers may justify the adoption of actions directed only to a specific audience, usually the most vulnerable one, as in this study.

An evinced positive point is the offer of collective health activities since this format encompasses a larger number of students and favors prevention and health promotion practices for all, without exception. Azevedo et al. (2021) also reported the performance of collective health activities. They indicate that these actions not only reach a higher number of

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students but also expand care, considering the cultural, political, social, institutional, and singular aspects experienced by each student who seeks them.

Although universities are organized according to their possibilities to maintain services or actions to support students, the institution is unable to meet all students' health demands by itself. The available social equipment, such as SUS, should meet these questions which go beyond the capacity of the university.

However, we found that the university is considered a single institution lying outside the territory or the health system. The reports show impasses for the continuity of care to students in the municipal health network. The lack of a policy and consensus on the role of the university regarding students' health care hinders societal recognition and, thus, its articulation with SUS, fragmenting health actions and services.

Thus, we assume that the health care services federal public universities offer lack guidance and organization to better meet students' health demands. Therefore, it is necessary to establish structured health services in these institutions to ensure access and meet students' demands, especially given the evinced difficulty of dialogue with SUS.

The potential of the studied institutions shows partnerships with other sectors and health agencies, especially university hospitals, which support student care, particularly highly complex care. However, not all universities have this body. The partnership we found corroborate the findings of Assis et al. (2013), who analyzed student assistance policies in 11 public and private universities in the Brazilian Midwest, Southeast, and South and found that the student assistance sectors in some of these institutions jointly worked with their culture and extension pro-rectories to facilitate the development of actions and meet students' demands.

We believe that the aspects we mapped are valid for FHEI throughout the country since Brazilian universities lack support from a national health policy which would guide health actions in higher education. This lack and the evident heterogeneity in executing and offering health actions can impair the implementation of services in federal public universities.

6 FINAL CONSIDERATIONS

Our results point to the need for a health policy which can support the discussion about the role of health care in universities, directing the position of the institution in this

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context, preventing diversification in the offer of actions, and thus benefiting student education. Moreover, it would favor the contribution of resources, directing it to priority health actions and strengthening this item within PNAES. Thus, it could facilitate the dialogue of FHEI with the health service of the municipalities in which universities are inserted, favoring the communication between managers, and thus ensuring continuity of care. The policy would also articulate health services in municipalities with *campi* and favor students from more internalized locations.

Note that one limitation in this study refers to the fact that we sent our data collection questionnaire to student care managers rather than to healthcare providers, which may have restricted information about services and actions.

Finally, we hope that the information we mapped and discussed contribute to articulating institutional health services with those in local public health networks and offer an important incentive to the implementation of public health policies aimed at university students. We suggest that further studies evaluate the need and adequacy of health care services, especially how they affect undergraduates' lives and their permanence in higher education.

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