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Community Health Agents in the Family Health Strategy: 30 years of resistance and achievements

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Abstract *This article analyzes the trajectory of Community Health Agents (CHAs) in the Family Health Strategy over its 30 years, highlighting their role in consolidating Primary Health Care (PHC) within Brazil's Unified Health System (SUS). It aims to understand how public policies shaped their work, training, and professionalization, and the challenges faced. Using a historical-critical approach, it combines document analysis (laws, ordinances) and literature review, aligned with Comprehensive PHC and social determination of health frameworks. Key findings: (1) CHAs evolved from an occupation to a regulated profession with legislative achievements; (2) their work faces tensions between bureaucratic and community roles, aggravated by the decrease in their presence within the teams, harming comprehensive PHC; and (3) they confront violence, socio-environmental crises, and misinformation. Despite the adversities, CHAs have established themselves as essential workers for the Unified Health System (SUS), which is crucial for territorialization, community orientation, and multidisciplinary work, whose future depends on the direction that will prevail in the conduction of PHC in Brazil.*

Key words *Primary Health Care, Community Health Agents, Health Policy, Healthcare Work Process*

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Introduction

When addressing the thirty years of the Family Health Strategy (FHS) as a model for the development of Primary Health Care (PHC) in Brazil, it is important to highlight the particularities that distinguish it from the international experiences that influence it and to locate the role of Community Health Agents (CHAs) in these distinctions. It is important to note that the Brazilian model adheres to the guidelines disseminated since Alma-Ata and renewed by Starfield[1], whose contributions, especially the definition of the attributes specific to PHC, were widely disseminated and adopted in the configuration of policies and the organization of services of so-called PHC in the Unified Health System (SUS). Among its distinctive aspects, three structuring axes of the FHS stand out: the perspective of territorialization, community orientation, and the horizon of multidisciplinary work.

The territorialization[2] practiced in the FHS is not limited to an organizational mechanism for distributing responsibilities, resources, services, and teams to the population, configuring what are conventionally called areas of coverage. More than that, it reflects the concept of the social determination of the health-disease process, recognizing the territory from the perspective of the relationships established, the experiences, the cultural practices, and the micro-relations of power that constitute the production of life in the territory, in constant interaction and movement.

Community orientation[3] is intrinsically related to this concept of territorialization and implies recognizing the importance of popular participation in PHC. This means planning and constructing health actions and services in a participatory manner, creating spaces and strategies for mobilization and dialogue with the people living in the covered territories in order to understand their living conditions, relationships, and health needs. It evokes the idea that there are knowledge and ways of life that need to be understood in order to produce the best health care, one that brings people together, enabling the creation of bonds and the continuity of care.

The perspective of multidisciplinary work derives from the perception of the complexity of the health-disease process, from the understanding that the various dimensions that shape human life – biological, cultural, environmental, relational, social, political, affective, and sensitive – produce the conditions under which we become ill, receive care, recover from health, and die. It points to the need to develop a process of attention and care that brings together and articulates the different knowledge and multidisciplinary practices that must be brought together to respond to health needs in PHC.

These are core aspects of the concept of comprehensive PHC that connect directly with the work of the CHAs. More clearly, in PHC, territorialization and community orientation depend largely on the work of the CHAs. They are involved in the territorialization process from the onset, participating in mapping, diagnosis, and registration, and continue to keep this process alive by updating information and contacts. This is possible through their regular presence in the territory and the bond they establish with the people they support, as well as the mediation they provide between them and other professionals. It is worth remembering that, often, the presence of other professionals in the territory requires the support of CHAs, who are familiar with the space and local dynamics. Community mobilization continues to be a policy mandate for these workers and is part of their history of work.

Regarding multidisciplinary work, CHAs help other professionals build a more sensitive and comprehensive understanding of the particularities of individuals, families, and communities. They do this through a doubly qualified perspective: through the shared life with the people in the territory, and through the knowledge acquired in the health field. They bring visibility to problems of various kinds, which would not otherwise be apparent to people during visits to services. These situations require relationships of trust and complicity that develop through continued contact and access to private living spaces, especially during home visits (HV).

Inventory of the Trajectory of CHAs in Brazilian PHC

CHAs are part of a group internationally known as Community Health Agents, whose attributes vary across the countries that adopt their presence in PHC. They are subject to different requirements, modes of involvement in healthcare, and responsibilities, ranging from prevention and promotion activities to clinical and health education. They can be permanent or temporary, voluntary or professional, with their own activities and/or replacing absent professionals in underserved, more difficult-to-access areas[4,5].

Given this variability, another distinctive feature of Brazilian PHC is the way in which the work of CHAs was established within SUS. They are part of FHS Teams, corresponding to a position in the National Registry of Health Establishments and a profession regulated by Federal Law and regulations from the Ministries of Health and Education.

From a historical perspective, the work of the PHC predates the establishment of the FHS, in its first form, the Family Health Program (FHP), created in 1994, and dates back to 1991, when the CHA Program (CHAP) was created, which incorporates elements of experiences developed in the Northeast, notably the Ceará Health Agents Program, launched in 1987[6].

This program was inspired by ideas disseminated by international organizations and Brazilian government projects to expand health actions and services to the countryside of Brazil, promoting access to populations in underserved areas, with a focus on health education.

From the experiences that preceded the CHAP, one idea is central, justifying the incorporation of agents into public policy: that their sociocultural origin and belonging (or representation) to the territories is a prerequisite for enabling entry, rapprochement, and the building of relationships and bonds between services, health teams, and the population[5,7].

From this perspective, the initial social profile assigned to CHAs and the requirements for access to work were defined: being a resident of the community in which they work, being able to read and write, being available 40 hours a day, with a particular subjective attribute – a penchant for solidarity[8]. Thus, the work of CHAs would be based more on cultural characteristics, tacit knowledge, and subjective disposition, rather than technical expertise and professional training. This concept was corroborated by evidence that important results were achieved on sensitive indicators, such as infant mortality, with health education interventions and measures, such as oral rehydration therapy, breastfeeding promotion, and immunization[5].

The health policy that promotes the work of CHAs must be contextualized within the social policy represented by the Community Solidarity Program (*Programa Comunidade Solidária*), amidst unemployment and recession in the 1990s. Focusing on vulnerable groups, such as women, was part of the policy framework and aimed to promote access to paid work for social groups with precarious, informal, and intermittent work histories. Impoverished working-class women, who assumed leadership and breadwinner roles in their families, were given priority[9].

This history also unfolded amid grassroots social movements, such as the Popular Health Movement (*Movimento Popular de Saúde* - MOPS), in the fight for the country's redemocratization, especially in favor of public health. This political aspect is expressed in the participation of health agents as delegates at the VIII National Health Conference in 1986, which defined principles and guidelines that guided the development of SUS. The report also recommends hiring agents to staff the new system. This was also reflected in the role given to CHAs to promote popular participation, a SUS guideline, present in the guiding documents for the CHAP, FHP, and FHS.

CHAs have spread throughout the country, are present in every municipality[10], and today comprise a workforce of 282,155 people, 81.2% of whom are women[11]. Hence, the use of the female gender in this article. Her professional trajectory was permeated by the effects that the original conception of her social profile projected on her work and her training, as well as by her insertion in health teams, accompanying the expansion of the PHC network.

The scenario we want to characterize, particularly in the FHS, is one of workers who must simultaneously perform their work, legitimize their place in the team, and fight for their professionalization. These characteristics, within the context of a constantly evolving policy, have contributed to the particular vulnerability of the work of CHAs to changes in direction within Brazilian PHC, requiring a constant mobilization of the category. This vulnerability is expressed in changes to the scope and content of their activities, even impacting their presence within the teams. There is an almost immediate relationship between changes in policy and the guidelines defined for their work. Thus, changes in the work of CHAs can be perceived as markers of trends and directions within PHC. This, while presented as a vulnerability, can also be interpreted as an expression of its importance, since any direction intended for PHC, whether directly or indirectly, impacts the work of the agents.

Policies and the work and professional education of CHAs

It is a fact that the institutionalization of CHA work is a product of public policy, and its contours are shaped by the perspectives guiding

the policy. If we ask what constitutes the centrality of CHA work, its strategic core, we will find varied answers over time, but also within the same historical context, revealing ongoing disputes surrounding their work.

To understand these answers, it is necessary to examine both the policy discourse (normative and guiding documents) and the reality of CHA work and perspectives. The documentary corpus on which this article focuses consists primarily of Ordinances and Technical Notes, Decrees, Bills, Federal Laws, Reference Frameworks, and Curricular Guidelines that focus on the work and training of CHAs. These documents are highlighted in bold in Chart 1, which presents the main normative documents and facts that influenced the formation of CHA work and training, as well as their political struggle.

Some expectations and responsibilities that remain in policy discourse are becoming unfeasible in reality, due to changes in the approach to care and work management. This is the case, for example, with encouraging community participation, which has been overlooked in the agents' daily work, even though it remains among their responsibilities in the 2017 PNAB[12].

A tension is evident here between two dimensions of CHA work. One is related to the growing trend toward the standardization of activities, coupled with objectives for monitoring, controlling, and evaluating work, aligned with the logic of performance targets that serve the purposes of managerialist management, increasingly dominant in the public sector and pressured by the logic of measurability. Another dimension is linked to the dynamics of interaction with the subjects of the care and care process, which refers to the recognition of the uniqueness of people, the environment, and the community, that is, the experiences lived in the territory. This second dimension structures the perspective of emancipatory health education, which implies the understanding and shared production of knowledge, distinguishing it from traditional health education that reproduces the model of knowledge transmission.

It is in this second dimension that the criticism of CHA work are found. Widely recognized as a "link" or "bridge" between teams, health services, and the population, to whom the role of promoting access to health and cultural mediation is delegated, the agents have formed their own vision of their work, in their relationship with the people they serve and with whom they share life in the territory. In this process, they have become involved in the responsibility of promoting the right to health by enabling the population's health needs to be met, and this is the focus of their complaints. The agents resent the difficulty in promoting access to health services, especially regarding needs that go beyond PHC. They also feel uncomfortable seeing their work time increasingly taken up by tasks they identify as bureaucratic and administrative in nature. In this sense, the workers' criticism is directed at the lack of time dedicated to the area, where they should be carrying out health education activities, especially in home visits, under conditions that allow for listening and dialogue[7,13].

In short, it is understood that the CHAs see themselves as workers who should guarantee the right to health, whether by facilitating access or by practicing health education. Health education requires an understanding of reality and the construction of knowledge in multiple ways, starting with a knowledge they need time to learn or develop; from a knowledge they need to recognize in others; and recognizing that this only materializes through meetings. These meetings are generally with the people they serve, but also with other professionals on the team, in a collective processes of discussion about the daily reality of work.

This presents a problem that is not limited to CHAs, but rather has been highlighted by other workers on FHS teams, identifying a common situation in the Brazilian PHC work process. This involves the depletion of collective moments dedicated to case discussions, sharing of experience, identifying challenges, and developing joint strategies and a common work agenda. Conversely, these spaces have been taken over by administrative agendas, monitoring, evaluating, and reporting on work, with few opportunities for other types of interaction[7,13].

This situation has recently worsened with the decrease in the number of CHAs on teams and the formation of teams without them, reducing the capacity to contribute to territorialization, community guidance, and multidisciplinary work.

Teams with few or no CHAs: uncharacterized work and overload

The minimum composition of the Family Health Program (FHP) was established as: physician, nurse, nursing technician or assistant, and CHA. Prior to the 2017 National Health Policy (PNAB)[12], the 2006[14] and 2011[15] versions of the PNAB defined the number of CHAs per

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Chart 1. Main milestones of inflection in the work of CHA in the SUS.

Government	Year	Fact, normative document or legislation
Sarney	1987	Launch of the Ceará Community Health Agents Program (CHAP).
Collor de Melo	1991 1992	Launch of the National Community Health Agents Program (NCHAP), renamed the Community Health Agents Program (CHAP).
Itamar Franco	1994	Launch of the Family Health Program (FHP).
	1994	Creation of the National Confederation of Community Health Agents (CONACS) - strengthens the national movement to organize community health agents.
Fernando Henrique Cardoso	1996	Ordinance 2,203/MS/1996 - NOB/96 - creates the fixed PHC Program and the variable PHC Program, with incentives for the adoption of the CHAP and FHP, assuming the role of a strategy for the PHC model.
	1997	Ordinance No. 1,886/MS/1997 - approves the standards and guidelines for the CHAP and FHP and defines CHA responsibilities.
	1999	Decree No. 3,189/1999 - establishes the guidelines for the practice of CHA and provides other provisions.
	2002	Ministry of Health Document: Modality for Recruiting Community Health Agents (CHAs): a tripartite pact - provides guidance on hiring methods, introducing the modality through OSCIP (Law 9,790/1999 - third sector law) with rights under the Consolidation of Labor Laws (CLT).
	2002	Law No. 10,507/2002 - establishes the profession of CHA and establishes the mandatory completion of a basic qualification course.
Lula da Silva	2003	The National Seminar on the Policy for Reducing Precarious Work in the Unified Health System (SUS) is held – CHAs are one of the workers in focus.
	2003	Investigative Proceeding No. 160/2003, instituted by the Public Ministry of Labor, to investigate the hiring practices of CHAs, due to reports of precarious employment.
	2003	Ordinance No. 2,430/GM/MS/2003 – creates the National Interinstitutional Committee for Reducing Precarious Work in the Unified Health System (SUS).
	2004	Publication of the Curricular Reference for the Community Health Agent Technical Course – MS/MEC – serves as the basis for the category's technical training in three stages, with the tripartite agreement limiting it to the first stage.
	2006	Document of the National Program for the Reduction of Precarious Work in the Unified Health System (SUS): Simplifies SUS: questions & answers - National Interinstitutional Committee for the Reduction of Precarious Work in the Unified Health System (SUS).
	2006	Constitutional Amendment 51/2006 – creates the public selection process for CHAs and Endemic Disease Control Agents.
	2006	Provisional Measure 297/2006 – repeals Law 10,507/2002.
	2006	Law 11,350/2006 – regulates the profession, establishes a direct link with states and municipalities via the Consolidation of Labor Laws (CLT), and provides for initial and continuing education, maintaining the provisions of Law 10,507.
	2006	Bill 270/2006 – proposes a minimum wage for CHAs and Endemic Disease Control Agents.
Dilma Roussef	2014	Law 12,994/2014 – establishes the minimum wage and the guidelines for the Career Plan for CHAs and Endemic Disease Control Agents.
	2015	Decree 8,474/2015 – regulates the minimum wage for CHAs and Endemic Disease Control Agents.
	2015	Technical Note No. 09/2015 from the Secretariat of Social Security Policies/MPS on the legal employment regime and the social security regime for CHAs and Endemic Disease Control Agents.
	2015	Published by the SGTES/MS of the Health Agents' Regularization, Work Qualification, Education, and Appreciation Plan (CHA and Endemic Disease Control Agents).
	2015	Ordinance No. 243/MS – establishes the Introductory Course for CHAs and Endemic Disease Control Agents and its content.
	2015	Protocol No. 009/2015 of the National Permanent Negotiation Board of the Unified Health System (SUS) – establishes the guidelines for the National Decent Work Agenda for SUS Workers. Ordinance 958/2016/MS - amends Annex I of Ordinance No. 2,488/2011 - removes the CHA from the minimum FHS team, whose presence becomes optional and interchangeable with the nursing technician.
	2016	Law 12,994/2014 – establishes the minimum wage and the guidelines for the Career Plan for CHAs and Endemic Disease Control Agents.

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team, based on the number of people under the responsibility of each CHA and each team. The calculation parameters were as follows: the maximum number of people per CHA (n=750)

Chart 1. Main milestones of inflection in the work of CHA in the SUS.

Government	Year	Fact, normative document or legislation
Temer	2016	Revocation on June 9, 2016, of Ordinance 958 of May 2016.
	2016	Bill - PL 6,437/2016 - Amends Law 11350 regarding the duties, training, and rights of CHAs and Endemic Disease Control Agents.
	2017	Ordinance MS/GM No. 2,436/2017 (PNAB 2017) - Approves the National Primary Care Policy (PNAB). It does not specify a minimum number of CHA/FHS teams; it alters their duties, incorporating nursing practices and Endemic Disease Control Agent actions; it facilitates adherence to the traditional PHC model, creating incentives for PHC teams (teams without CHAs).
	2018	Law 13,595/2018 - Amends Law No. 11,350/2006 - reformulates the duties, working hours, working conditions, and level of professional training; indicates technical and continuing education and transportation compensation for CHAs and Endemic Disease Control Agents.
	2018	Ordinance 83/2018 – establishes the Technical Training Program in Nursing for Health Agents (Profags) - not implemented.
Bolsonaro	2019	Ordinance No. 2,979 - Previne Brasil Program - new PHC financing model - emphasis on registration, intensifies the work of CHAs, and adopts performance indicators that do not favor health education.
		Ordinance No. 2,539/MS/2019 - establishes the PHC team, which can be staffed without CHAs, consisting solely of a physician and a nurse, and makes the workload of these professionals more flexible.
	2020	Publication of new guidelines for technical training - "Community Health Agent (CHA) Technician: guidelines and guidance for training."
	2020	Ordinance No. 3,241/2020 - establishes the Health with Agent Program.
	2021	Technical Note No. 546/2021 - CGFAP/DESF/SAPS/MS - specifies the legislation regulating the activities of CHAs, the type of employment relationship, and the rules governing the registration of these professionals in PHC facilities.
	2022	Constitutional Amendment No. 120/2022 - establishes the financial responsibility of the federal government in the remuneration policy and recognition of CHAs and Endemic Disease Control Agents, establishing that the minimum wage cannot be less than two minimum wages, including unhealthiness and special retirement benefits.
	2022	Publication of the first call for applications for the Health with Agent Program – a nationwide offer of technical training for CHAs and Endemic Disease Control Agents in a distance learning format, with support from CONASEMS.
Lula da Silva	2023	Law No. 14,536/2023 - amends Law No. 11,350/2006 to consider CHAs and Endemic Disease Control Agents with regulated professions for the specified purpose.
	2024	More Health with Agent Program - second wave of training for the Program.
	2024	Ordinance GM/MS No. 3,493/2024 - establishes federal co-financing of the PHC minimum wage, with an emphasis on complete and up-to-date registration and monitoring of the population.

Source: Authors, based on a previously published chart[19].

and CHAs per team (n=12), in relation to the recommended number and the maximum number of people per team (3,000 and 4,000, respectively); a calculation that indicated at least four CHAs per team.

As of the 2017 National Health Policy (PNAB)[12], a minimum standard for CHAs per team is no longer established, and teams without these workers (PHC teams) are permitted. Ordinance 2,539/2019[16] standardizes these teams, naming them PHC Teams and indicating the possibility of them being composed of only a doctor and a nurse. This Ordinance, regarding the composition of the so-called PHC Teams, does not mention CHAs, nor nursing technicians and assistants. The prevalence of a narrow conception of clinical practice is evident, strongly guided by the biomedical, medicalizing, individual, and care perspective, based on pathologies and procedures, which suppresses the relational and social dimensions of the health-disease process and deprives CHAs of their ability to resolve problems.

This has resulted in a decrease in the presence of CHAs on teams and the observation of teams without CHAs in Brazilian PHC. A study by Morosini *et al.*[17] found that in four of the five Brazilian capitals studied – Porto Alegre, Recife, Rio de Janeiro, and Salvador – FHS teams had only one or two CHAs. The most prominent cas-

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es were Salvador and Porto Alegre. Both municipalities have PHC teams and FHS teams. In Salvador, which has 106 PHC teams, 93.4% of these teams had no CHAs. Of the 369 FHS teams in this municipality, 45.5% had up to three CHAs; 54.4% had four or more CHAs, with the highest concentration being in the four-CHA range per team. A particularly significant finding was that, of the total number of PHC teams in Salvador, 165 teams (34.7%) had only one or no CHAs.

In Porto Alegre, PHC teams accounted for 28% of all PHC teams, and there was a significant presence of teams without CHAs, corresponding to 29.3% of the total number of teams, 85.2% of which were PHC teams and 7.8% of which were FHS teams. It was also found that 78.2% of teams in the range equivalent to teams operating with one or no CHAs, and 98.9% of the total teams in the capital of Rio Grande do Sul were found with up to three CHAs[17].

In a study by Freire[18], data from the e-gestor platform showed a decline in the number of CHAs in all regions of the country, with the most significant reductions found in the South, Midwest, and Southeast regions. The authors also note that cities with a higher HDI, larger populations, and greater inequality tend to be more likely to experience a decline in the number of CHAs. It is understood that less stable hiring methods that facilitate the dismissal of these workers should also be considered.

The 2024 National Census of Basic Health Units (BHUs) indicates that 96.4% of the units have CHAs on their teams; however, 38.5% of these BHUs have some micro-areas without CHAs[10]. Three regions – Midwest (54.8%), South (46.1%), and North (41.7%) – have a higher rate than the national average, revealing that full CHA coverage remains a challenge, as shown in Chart 2. These data are dynamic and should be contextualized in each municipal management cycle.

The removal of CHAs from teams has been accompanied by changes in their responsibilities[19], creating both a situation of overload for the CHAs who remain active and significant changes in the dynamics and content of their activities. These changes occur in two directions: the incorporation of bureaucratic-administrative activities or instrumental support for other professionals, and the incorporation of care-related activities, typical of nursing, in response to pressure for resolution. The latter have been justified by changes in the demographic and health scenario of the Brazilian population, which would call into question the role of these workers in this new context. This most recent debate echoes an earlier one that questions whether CHAs should have responsibilities for middle-class population groups, with higher levels of education and greater access to health goods and services.

While activities classified as bureaucratic are perceived as detrimental to the practice of their work, care-related activities are understood as the recognition of work often carried out informally, meeting community demands, which contributes to legitimizing their work and strengthening bonds with individuals. In this case, the territory, rather than the unit, is referred to as the location where these actions should be performed by CHAs, ensuring that they are not used as a substitute for nursing professionals.

It is important to note that, in the most recent policy changes that seek to refocus PHC on the restoration of the attributes that characterize comprehensive PHC, the new co-financing policy emphasizes complete and up-to-date registration and population monitoring as variables. These are two processes in which CHAs play a key role. What remains to be analyzed is the extent to which the policy is capable of qualifying this monitoring, going beyond the quantitative dimension and incorporating qualitative aspects related to the intersubjective dimension. The fact that the bond is considered to be a component of co-financing and the reduction in the value predicted for PHC teams, compared to the value attributed to FHS teams, allows for a positive expectation.

CHAs on the move: work regulations, job insecurity, and professional training

The organized CHA movement is represented nationally by the National Confederation of Community Health Agents (*Confederação Nacional dos Agentes Comunitários de Saúde* - CONACS) and the National Federation of Community Health Agents and Endemic Disease Control Agents (*Federação Nacional de Agentes Comunitários de Saúde e Agentes de Combate às Endemias* - FENASCE), which have played a key role in securing rights. This is a very significant category in quantitative terms, as regards its presence throughout the country and its capacity for mobilization.

Given these characteristics, the question arises: what made it necessary, after thirty years of work in the FHS, for a Federal Law – Law No. 14,536/2023[20] – to recognize CHAs as health

Chart 2. Coverage of CHAs in teams and micro-areas, regions, and the country, 2024.

CHA Presence and Coverage		Midwest n (%)	Northeast n (%)	North n (%)	Southeast n (%)	South n (%)	Brazil n (%)
In this BHU, do ALL FHS teams have CHAs?	No	192 (6.4%)	456 (2.7%)	133 (3.6%)	413 (3.5%)	308 (5.1%)	1.502 (3.6%)
	Yes	2,785 (93.6%)	16,677 (97.3%)	3,599 (96.4%)	11,419 (96.5%)	5,750 (94.9%)	40,230 (96.4%)
In this BHU, are there any micro-areas discovered by CHAs?	No	1,345 (45.2%)	11,328 (66.1%)	2,174 (58.3%)	7,539 (63.7%)	3,268 (53.9%)	25,654 (61.5%)
	Yes	1,632 (54.8%)	5,805 (33.9%)	1,558 (41.7%)	4,293 (36.3%)	2,790 (46.1%)	16,078 (38.5%)

Source: Census of Basic Health Units - Executive Summary[10] (p.66).

workers? The answer to this question reflects several issues that the category has faced along the way to progressively achieve professionalization. This relates to the idea that professional training, accompanied by increased educational attainment, could distort the social profile attributed to CHAs, causing them to no longer identify with the people they serve, as well as the requirement of community residence and the fact that their training must be promoted through public policy and resources[7].

The requirement of community residence made it impossible to hold a public selection process, a selection tool that does not allow discrimination based on one's place of residence. This requirement was another factor that contributed to the precarious hiring process for CHAs. The argument regarding the loss of community identity was also used against CHA access to public service positions, whose stability could compromise this attribute. The repercussions of these prohibitions marked the conditions under which CHAs have built their professional histories.

Established as an occupation within SUS in 1991, the work of CHAs was only recognized as a profession in 2002 by Law 10,507[21]. It is important to remember that the CHA profession was based on very basic requirements: knowing how to read and write, residing in the community where they will work, and being available for 40 hours. With the creation of the profession, education was defined as having completed elementary school, and preparation for the job required a qualification course, which at the time was considered basic.

Law 11,350[22], published in 2006, addresses a demand regarding the employment relationship of these workers by defining "the direct link between the aforementioned Agents and a body or entity of the direct, autonomous, or foundational administration". This decision is a victory of the organized action of the category, which strengthened the movement for the decrease of precarious employment modalities that affected most CHAs.

Regarding employment relationships, national survey data indicate that the situation has changed, with a greater share of more stable contracts with associated labor rights as a means of retaining agents. Another achievement for the category was the approval of the national minimum wage of R$ 1,014.00 (one thousand and fourteen reais), 28% above the minimum wage at the time. This amount was modified by Constitutional Amendment No. 120/2022[23], which established two minimum salaries as the minimum wage and instituted hazardous work pay and special retirement.

Regarding training, two key milestones stand out. The first was the publication, in 2004, of the Curricular Reference 24 for the Technical Course for CHAs[24], which provided for three training stages with progressive educational requirements to cover all workers. This training was not agreed upon by the Tripartite Intermanagerial Commission, and initial qualifications remained in place through the offer of the first stage of the Technical Course. In 2020, the document, Technical Course in Community Health Agents – CHA: guidelines and orientations[25], was published, which now guides technical training aimed at these workers.

The second phase involves nationwide technical training for the entire category through the Health with Agents Program (*Programa Saúde com Agente*)[26-28], the first call for applications for which was launched in 2022 and re-

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named More Health with Agents[29], with the second call for applications in 2024. The program is promoted by the Ministry of Health in partnership with the Federal University of Rio Grande do Sul (UFRGS) and the National Council of Municipal Health Departments (Conasems). This consists of offering two technical courses – the Community Health Agent Technical Course and the Health Surveillance Technical Course with an Emphasis on Endemic Disease Control – in a distance learning format, using a Virtual Learning Environment (VLE) and with the participation of tutors and preceptors. Practical, in-person activities are planned, developed at the workplaces of the CHAs and endemic disease control agents.

It must be acknowledged that the technical training offered meets the needs of the profession and the need for qualifications for new clinical-level roles. However, it is important to note that the SUS technical schools (*Escolas Técnicas do SUS* - ETSUS), historically involved in the training of mid-level workers, especially CHAs[30], did not directly participate in the first training course. The predominance of distance learning is the subject of debate and criticism, considering positions in the education and health fields that argue that vocational training, whether technical or higher, must be in-person. There is also concern about the risk of the uniformity of training and the omission of the specificities of different regions and locations, given the degree of standardization of the process and its instruments.

It is important to note that, for the second training course offered, important changes were made. Concepts of equity in sexuality and gender, race and ethnicity, mental and oral health in PHC were included in the curriculum, in addition to elective courses on topics including agroecology, health and the environment, and Integrative and Complementary Practices. Also important was the initiative to offer specialization courses for tutors and preceptors and the partnership with ETSUS.

The concerns expressed here aim to highlight that improving the technical training of CHAs needs to be a permanent public policy commitment. This recognizes a right of female workers and a need for the SUS, which seeks to redress a historical debt the state owes to a category that it itself established.

Working under stressful conditions and its repercussions for CHAs

The benefits of CHA work for the population's health are evident in most areas of PHC, such as monitoring people with chronic diseases and pregnant women, disease prevention, and health promotion. However, several obstacles overlap, hindering these workers from realizing their full potential.

For several decades, violence has been a growing concern in the territories. This multifaceted phenomenon is fueled by a series of issues, such as the absence of the State's presence, or the way it shows its presence, poverty, social inequities, organized crime, unemployment, income instability, and educational deficits, which repeatedly affect not only Brazil but also Latin American countries[31]. This phenomenon is neither static nor uniform, placing a greater emphasis on the most vulnerable communities, where CHA work is concentrated. Studies conducted in recent years have described the high prevalence of urban violence faced by CHAs and its effects on their physical and mental health, as well as its impact on their work processes[32,33]. This reality results in activities primarily carried out by CHAs, such as home visits, active search, and community health promotion activities, not being fully implemented[34], with potential repercussions on the population's health.

Urban violence, considered a chronic stressor on the health system, is compounded by other frequent circumstances, such as the occurrence of dengue and Zika, and, more recently, the COVID-19 pandemic, impacting PHC. During the COVID-19 pandemic, it became clear that violence limits the ability of CHAs to provide care in PHC, hindering or preventing their work in more vulnerable regions with poorer socioeconomic and health indicators[33,34].

With the rise of organized crime in all regions of the country and the weakening of solidarity and support networks, living and working in the same community, considered an advantage for CHAs in carrying out their work, can place them at risk and cause suffering, especially among women, with repercussions for their health and work[32].

The worsening socio-environmental crisis, with the more frequent occurrence of extreme weather events, poses new challenges for PHC and CHAs living in the territories most affected by climate change. As both residents and workers, they have knowledge and a more accurate understanding of the conditions and problems

faced by the victims of these events, while also directly suffering their consequences.

Culturally, the persistence and dissemination of disinformation systems, which foster discredit in science and feed on the production and consumption of false and/or distorted information, presents a significant barrier to the successful development of health education work. It must be acknowledged that healthcare professionals, including CHAs, are not immune to the effects of this phenomenon. At the same time, due to the characteristics of their work, CHAs are potentially the best professionals to address this reality, not sporadically but continuously, as the COVID-19 infodemic has demonstrated to be absolutely necessary[35].

Understanding these challenges is essential for planning public policies that strengthen the qualified work of CHAs while ensuring quality of life, health, and well-being for these professionals, creating a positive cycle of care for the community and those they care for.

Final considerations

If at some point during the development of SUS, and in particular the FHS, CHAs were thought to represent a transitional strategy, their history demonstrates that they have come to occupy a permanent place in Brazilian PHC. Although this permanence is achieved at the cost of much tension, it is important to note that these tensions are expressions of the disputes surrounding the direction of PHC, revealing different conceptions of health, rights, the care model, and the management of care and work.

While, on the one hand, their permanence as SUS workers is evident, on the other, their susceptibility to changes in policy becomes clear, altering the direction and design of their work, with repercussions for what they do, how, where, and with whom they do it. This vulnerability is limited by the political strength of the category, organized at the national and local levels, which has achieved successes in the areas of labor regulation and training, being recognized as health professionals and obtaining technical training guarantees from the Ministry of Health. Together, these elements contribute to the development of their profession.

When designing a future for CHAs, one must bear in mind that this future is directly linked to the future of PHC itself within SUS. Ensuring comprehensive PHC, based on the attributes of territorialization, community orientation, multidisciplinary work, and guided by the perspective of the social determination of the health-disease process and health as a universal right, cannot preclude the complexification of the work processes of FHS teams and CHAs in particular.

Collaborations

MVGC Morosini contributed to the conception of the article, the analysis of sources and information, and the writing. AF Fonseca contributed to the conception of the article, the analysis of sources and information, and the writing. APGF Vieria-Meyer contributed to the conception of the article, the analysis of sources and information, and the writing.

Data availability statement

The data sources adopted in the research are indicated in the article's body.

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