The Implementation Process of Social Assistance Reference Centers (CRAS) in Brazilian Municipalities: An Analysis from the SUAS Census from 2007 to 2022

Flavio Riva[1]

[1] Institute for Mobility and Social Development (IMDS).

Summary. This technical note aims to contribute to the characterization of the expansion of the offer of basic social protection in Brazil, through the study of the implementation of one of its main facilities: the Reference Center for Social Assistance (CRAS). The analysis reveals that, 10 years after the creation of the Unified Social Assistance System (SUAS), the CRAS had achieved great capillarity in the Brazilian territory, having arrived in the vast majority of municipalities. This rapid expansion first reached the municipalities where there was a larger share and a relatively large contingent of people vulnerable to poverty. In addition, CRAS arrived first in municipalities with labor markets marked by less economic activity and less formalization, as well as municipalities with worse health indicators. Thus, perhaps surprisingly, an essentially decentralized process of expansion in time and space seems to have had desirable focusing characteristics. The note closes with a discussion on priorities for monitoring and evaluating the impact of Social Assistance facilities and programs in Brazil.

Introduction

During the 1990s, Brazil experienced a rich process of regulating the provisions of the 1988 Constitution in a national policy aimed at protecting the most vulnerable part of the population. One of the fundamental steps in this process was the creation of the Unified Social Assistance System (SUAS) by the National Social Assistance Policy (Pnas, Brazil, 2004). The SUAS fulfills essential roles, granted by the legal frameworks: on the one hand, to mitigate the negative effects of unevenly distributed risks – such as poverty and the violation of rights – and, on the other hand, to stimulate productive inclusion. The challenge of fulfilling both roles is immense and involves finding a non-trivial balance between protection and promotion.

The model that was intended to face these challenges defined two levels of social protection, the basic and the special, linked to specific public facilities. The basic protection, the focus of this note, is aimed at the population in a situation of social vulnerability and weakening of social and community ties, and the Reference Center for Social Assistance (CRAS) is the agency responsible for the care at this level. The special protection offered at the Special Reference Centre for Social Assistance (CREAS) it is aimed at families in which individuals have had their rights violated.

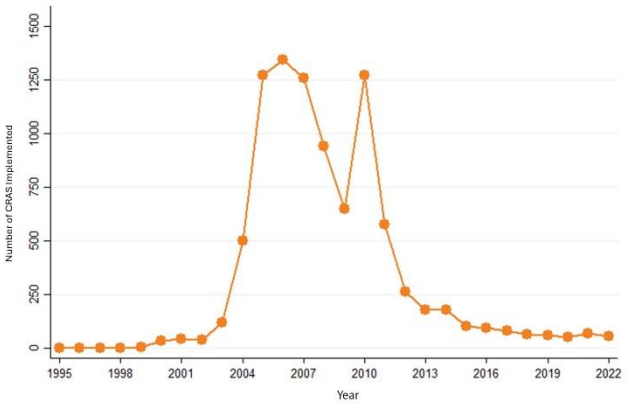
The document with technical guidelines for the CRAS (Brazil, 2009) postulates that CRAS" is characterized as *the main gateway to* SUAS" (p. 9, our emphasis). In addition, this document determines its functions. Firstly, CRAS manages Basic Social Protection at the local level. In addition, it promotes intersectoral articulation and active search in its territories of coverage. Finally, the CRAS is the unit that offers the Comprehensive Family Care Program (Paif) in a mandatory and exclusive way. The objective of this technical note is to contribute to the characterization of basic social protection in Brazil in recent decades, focusing on this central facility. Data from the SUAS Census from 2007 to 2022 and the 2000 Demographic Census were used to describe the process of implementation of the CRAS in time and space and to identify characteristics of the municipalities that adopted the facilities more or less quickly. The main results are that:

- after a period of rapid expansion between 2004 and 2009, in which approximately 1,000 CRAS were founded per year, the vast majority of the country's municipalities had one such facility in their territory;
- the municipalities that adopted the CRAS more quickly had a higher share of people vulnerable to poverty in their population, suggesting that the expansion succeeded in prioritizing the demand—at least, the potential demand—of the population that would need it the most;
- the municipalities that adopted the first CRAS more quickly were also more unequal, had labor markets marked by less economic activity and less formalization and worse health indicators.

Databases

The SUAS Census. The SUAS Census is conducted annually through an integrated action between the National Secretariat of Social Assistance (SNAS) and the Secretariat of Evaluation and Information Management (SAGI) and represents the main monitoring effort of equipment and governance

Graph 1. Number of CRAS Implemented per Year in Brazil (1995-2022)



of Social Assistance in Brazil. The data are collected through an electronic form completed by the Secretariats and Councils of Social Assistance of the States and Municipalities. Its collection began in 2007 as an instrument for monitoring the expansion of CRAS.[1] The SUAS Census allows us to observe the year of implementation of each of the 9,251 CRAS that were in operation at some point until the year 2022.[2] Graph 1 shows the number of CRAS implemented per year in the country. The graph makes it clear that the expansion process took place mainly between 2004 and 2010, a period in which approximately 5,000 CRAS, or nearly 1000 per year, were implemented.

Additional Sources. Data from the 2000 Demographic Census were used in the compilation of indicators made by the Atlas of Human Development. These indicators were grouped into: (*i*) poverty and inequality; (*ii*) labor market and productive inclusion; (*iii*) health. In addition, in an effort to characterize the relationship between social assistance services and primary health care services, data on municipal coverage of the Family Health Program in 2000 were used.

Results

A. Implementation Planning. According to Pnas, CRAS "is a state public unit of territorial basis, located in areas of social vulnerability [... that] execute basic social protection services, organizes and coordinates the network of local social assistance services of the social assistance policy" (Brazil, 2004, p. 33). The 2007 SUAS Census allows us to understand the planning process that preceded the implementation of the first CRAS in Brazil, and, in particular, the efforts to diagnose vulnerability that guided their allocation in space. In that year, one of the questions requested information on whether and how the survey of the vulnerability situation of the territory had been carried out.[3] Only 6% of the 4,182 CRAS in the database stated that there had been no survey of any kind. Of the 3,930 CRAS that indicated that there had been a survey, 70.5% of them stated that it was based on a study carried out directly by the municipality with the objective of mapping vulnerabilities; 62.9% indicated that they had used data from the Single Registry for this purpose and 32.5% indicated that they had used data on the beneficiaries of the Continuous Benefit Program. Finally, it is interesting that 42.4% of the CRAS believe that they used information obtained by the health area to survey the situation of vulnerability.[4]

B. Geography of Expansion. Graph 2 presents a map of Brazilian municipalities in which lighter colors indicate municipalities that have implemented their first CRAS more recently, and darker colors denote those that have done so less recently. The first pattern that stands out is the massive presence of CRAS in the Brazilian territory. Only 15 municipalities in the country had not yet adopted at least one CRAS in 2022 (or 0.3% of the total). In 2012, which is the map's cut-off point for the lightest color, the vast majority of Brazilian municipalities already had a CRAS. Secondly, it is interesting to note that there seems to be a pattern specific to the units of the federation in the speed of adoption. In this sense, the pioneering spirit of some states, such as Mato Grosso do Sul, and, especially, of Rio de Janeiro, stands out. There also seems to be a faster pattern of adoption of CRAS in municipalities in the Northeast — in particular, Ceará, Rio Grande do Norte and Sergipe. On the other hand, in the Northeast, Bahia and, in the rest of Brazil, Santa Catarina have a less rapid pattern. Within the states, the heterogeneity of speed in adoption by municipalities seems to be particularly high in the Southeast, South, and Midwest states. In these cases, it is possible to find border municipalities with intervals of 5 or more years between their implementations.

C. Expansion Correlates. Graphs 4 and 7 allow us to understand in a more in-depth way how the characteristics of Brazilian municipalities relate to the timing of the implementation of the first CRAS in their territories.

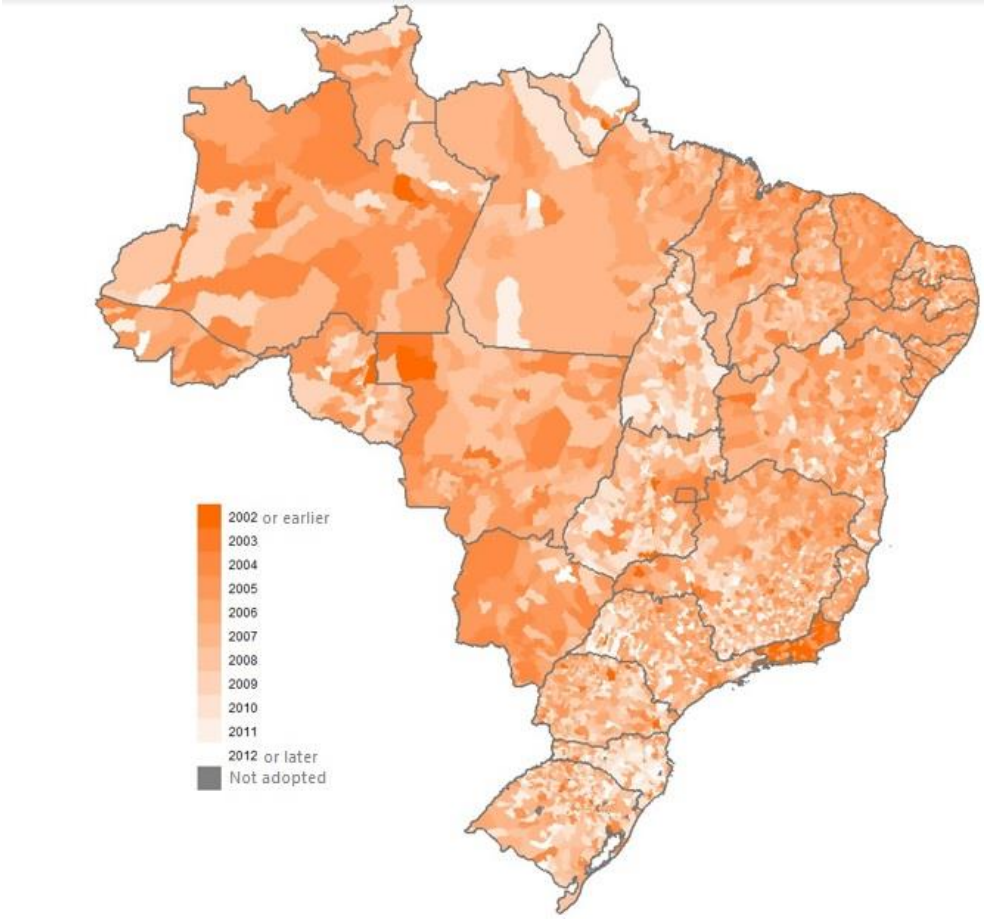
[1] From 2010 onwards, information began to be collected not only on the main facilites of Social Assistance – CRAS and CREAS – but also on other dimensions of the social assistance network, this instrument being regulated by Decree No. 7,334 of October 19, 2010.

[2] Each CRAS is identified at the base by an 11-digit number. The The first 6 numbers replicate the official code of the municipality in which CRAS is situated. In no case did the annual SUAS Census databases contain two or more entries of information that referenced the same code. Thus, no decision regarding the recording of duplicate information had to be made.

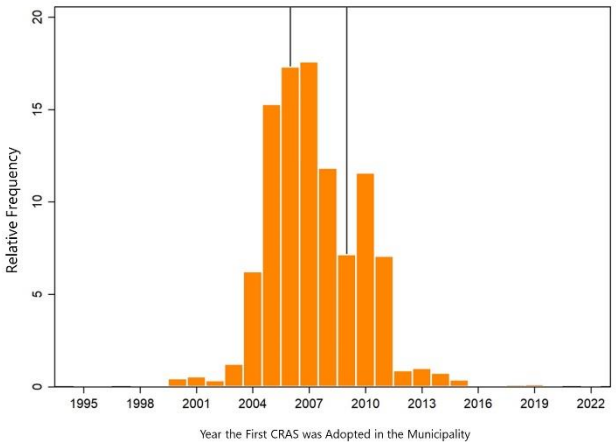
[3] Unfortunately, the SUAS Censuses of later years did not collect this information.

[4] Note that answers were not mutually exclusive, i.e., each CRAS could inform multiple ways in which the survey of the situation of vulnerability in its territory was conducted.

Graph 2. Year of Implementation of CRAS in Brazilian Municipalities

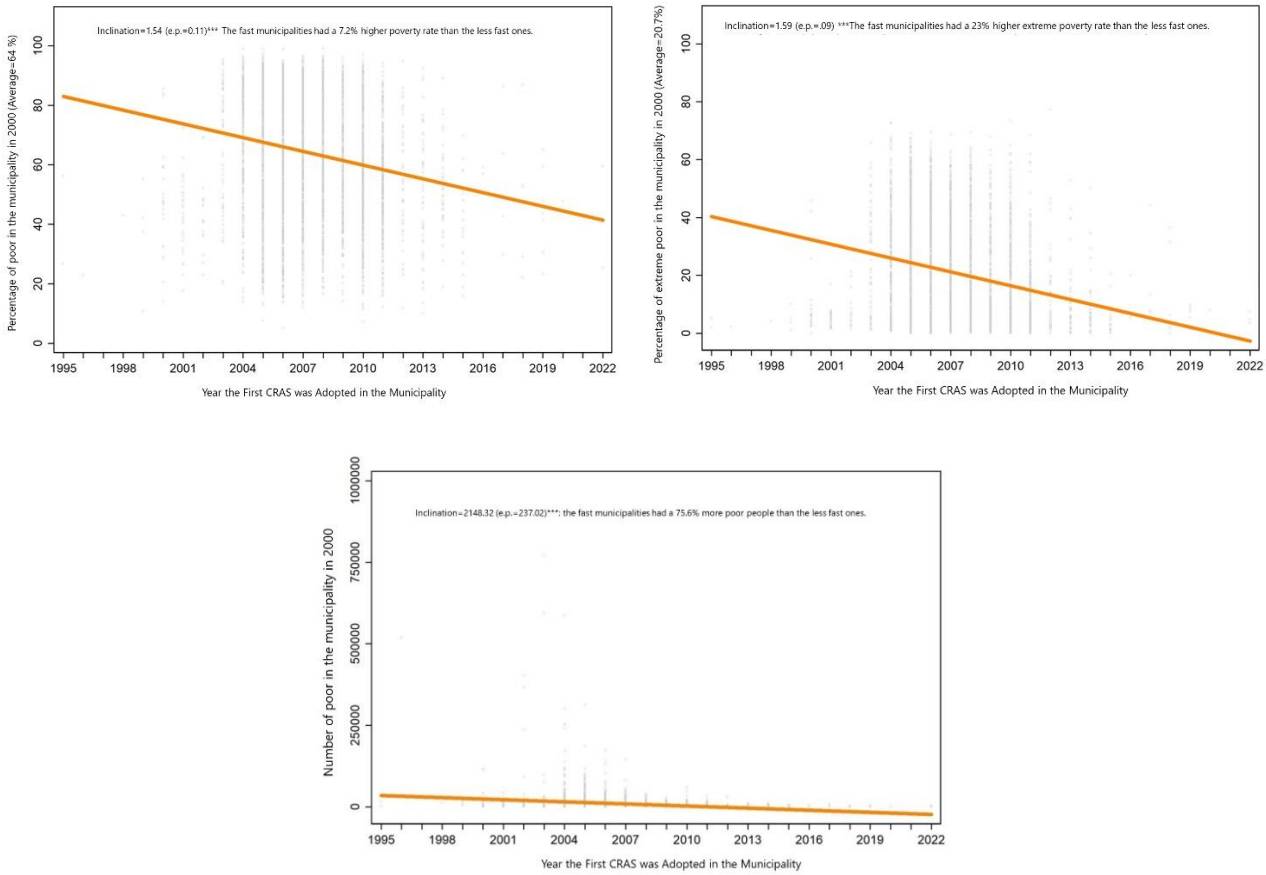


Graph 3. Expansion of CRAS in Brazilian Municipalities



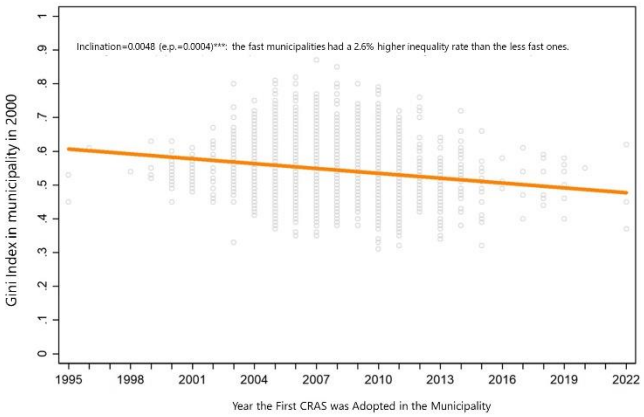
In these graphs, the axis of the abscissas always represents the year of adoption of the first CRAS, constructed using the SUAS Census data described in the section above. Figure 3 shows the distribution of this variable. The 25th percentile is given by the year 2006, which indicates that 1 in 4 Brazilian municipalities had implemented its first CRAS by that year. We will call, in what follows, the municipalities that adopt their first CRAS by 2006 "fast". On the other hand, we will call the municipalities that adopt their first CRAS after the year corresponding to percentage 75 (2009) of this variable "less fast". The axis of the ordinates, in turn, represents the level of a variable of interest. Note that since the implementation process gains scale from 2002 onwards and these variables were measured in 2000, they cannot have been affected by the expansion itself. In this sense, these figures bring descriptive information, and not the causal impact of CRAS. The line superimposed on the point cloud represents the best linear approximation to the data. To aid interpretation, the simple regression coefficient associated with the variable that captures the year of implementation and its standard error are also presented. Also, next to the estimates,

Graph 4. Correlates the Timing of Implementation of CRAS in Brazilian Municipalities: Poverty



the comparison between the "faster" and the "less fast" municipalities is presented, based on this linear approximation.

Graph 5. Correlates of the Timing of Implementation of CRAS in Brazilian Municipalities: Inequality



C.1. **Income Distribution**. Graphs 4 and 5 analyze how the income distribution of the municipalities in 2000 is related to the year of adoption of the CRAS in the municipalities, using indicators of vulnerability to poverty and inequality. The first figure in Graph 4 considers the percentage of individuals with *per capita* household income even if it occurred in a decentralized way, the expansion process seems to have contained the desired characteristics of equal to or less than R$ 255.00 per month, in Brazilian Reais of August 2010. This value was equivalent to 1/2 the minimum wage on that date and was used as an indicator of vulnerability to poverty. The simple regression coefficient that describes the relationship between both variables is -1.54 percentage points and is statistically significant. This linear approximation indicates that municipalities that were faster in adopting their CRAS had, on average, a rate of vulnerability to poverty that was 4.6 percentage points higher than the less rapid populations. Using the mean municipal ratio in 2000 (64%) to guide the magnitude of the correlation, it is found that this difference would correspond to 7.2% of this value. Qualitatively similar conclusions appear when we consider the percentage of people who were extremely poor, that is, individuals with a per capita household income equal to or less than R$ 70.00 per month. In 2000, the average municipal rate of extreme poverty was 20.7%. The difference between more and less rapid municipalities predicted by the best linear approximation to the data is 4.8 percentage points and is equivalent to 23% of the average municipal rate in 2000. Thus, the municipalities that adopted CRAS in the early years of the expansion tended to be poorer. This indicates that the SUAS was focusing on the most vulnerable.

Note, however, that the fact that CRAS arrived first in municipalities that had a higher percentage of those vulnerable to poverty does not mean that these devices also arrived first in municipalities that had a relatively large contingent of poor people. It would be possible, in fact, that the expansion process had begun in smaller municipalities. To evaluate this hypothesis, the last graph in Figure 4 repeats the exercise using the size of the population of the municipalities as the variable explained. It is noted that a similar pattern is maintained, that is, that municipalities faster in the adoption of their CRAS had, on average, more poor people, also in absolute numbers, than the less rapid municipalities. However, as the Brazilian municipalities have very different populational sizes, it is possible that a linear model is less suitable in this case than the one used in the last two graphs.

Figure 5 considers whether CRAS also arrived first in more unequal municipalities, using the Gini index.[5] The pattern here is not as characterized as that found for poverty rates in Figure 4, which is perhaps to be expected, given that inequality is not a specific target of Social Assistance. However, the line that characterizes the relationship between both variables is also negatively inclined, with a slope of −0.0048 Gini points and this difference is equivalent to 2.6% of the average of the index of Brazilian municipalities in 2000. Thus, the municipalities that adopted CRAS in the early years of the expansion tended to be not only poorer, but relatively more unequal.

C.2. **Labor Market**. As discussed above, one of the functions of Social Assistance is to stimulate productive inclusion – understood as a set of actions to promote a positive right to work, with lasting consequences for increasing the purchasing power of the youngest segment. Graph 6 considers whether CRAS arrived first in municipalities with more or less developed local labor markets, considering the level of economic activity and the rate of formalization of the labor force. The graph at the top considers as an indicator of development the rate of activity in the labor market, that is, the ratio between people aged 18 years or older who were economically active, that is, who were employed or unemployed in the reference week of the Census and the total number of people in this age group multiplied by 100.[6] It is noted that the CRAS arrive first in municipalities with a lower activity rate, with a difference of -1.8% in the rate of the fastest and least fast. When we consider as an indicator a percentage of occupied persons who occupied formal jobs with a formal contract, the coefficient of the simple regression that describes the relationship between the variables is approximately 0.91 percentage points and, as in the case of the activity rate, statistically significant. Using the average in 2000 (36.0%), it is found that the difference between the most and least rapid municipalities would correspond to 7.6%. One concludes, therefore, that the CRAS arrived first in municipalities characterized by less extensive and less formalized labor markets.

C.3. **Health**. Graph 7 describes how health indicators and the timing of CRAS adoption are related. The first graph considers the infant mortality rate up to 5 years of age. The simple regression coefficient that describes the relationship between the variables is approximately -1.85 children per 1,000 and statistically significant at 1 %. Thus, municipalities that adopted CRAS in the early years of the expansion tended to have relatively higher mortality rates. A similar pattern can be deduced from the analysis of life expectancy. The coefficient of the simple regression that describes the relationship between the variables is approximately -0.4 years of life and, also in this case, statistically significant. Using the average of municipal life expectancy in 2000 (68.4 years) to guide the magnitude of the correlation, it is found that this difference would correspond to 1.8% of the average municipal life expectancy. It is concluded, therefore, that the CRAS arrived first in municipalities characterized by poor health indicators.

The figure at the bottom of Graph 7 performs the same exercise using data on the coverage of the Family Health Program (FHP). To keep the comparison as consistent as possible with the above exercises, we used the average coverage in the year 2000, based on the monthly data from the Primary Care Information System. Although it is possible to conclude that the coverage of the FHP was lower in the fastest municipalities, this association is relatively small in magnitude and is not statistically at conventional levels.

Final Comments

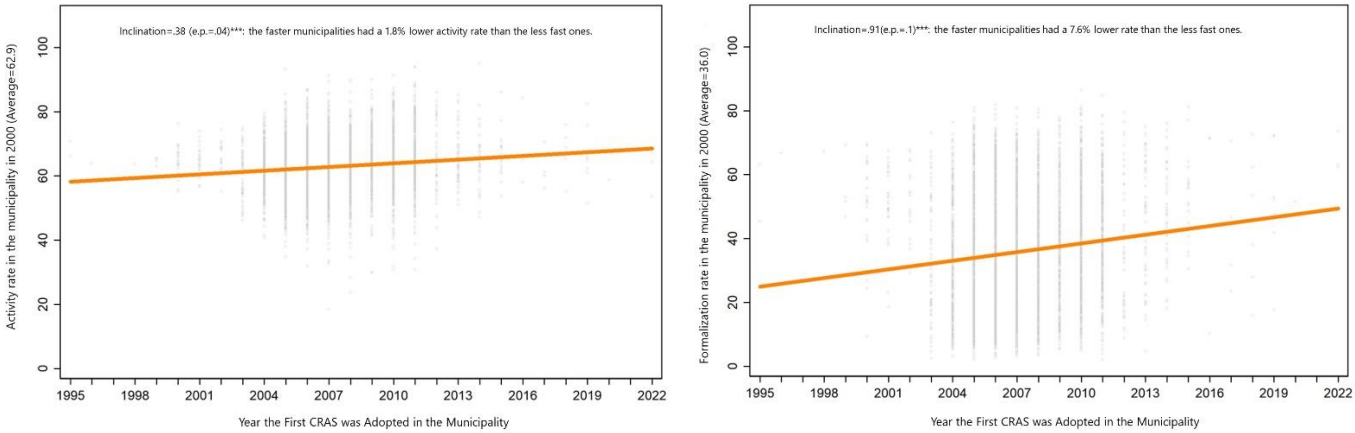
Over the last two decades, the convergence of efforts for the construction of the institutional architecture and the implementation of the facilities, services, benefits, and programs of the SUAS have resulted in a capillary presence of Social Assistance throughout the country. One of the central characters in this story — perhaps *the* central character, along with the *Bolsa Família* Program — is the Social Assistance Reference Center (CRAS). This technical note uses data from the SUAS Census to understand the dynamics of its expansion in the Brazilian territory.

The analysis reveals that the rapid process of implementation of the

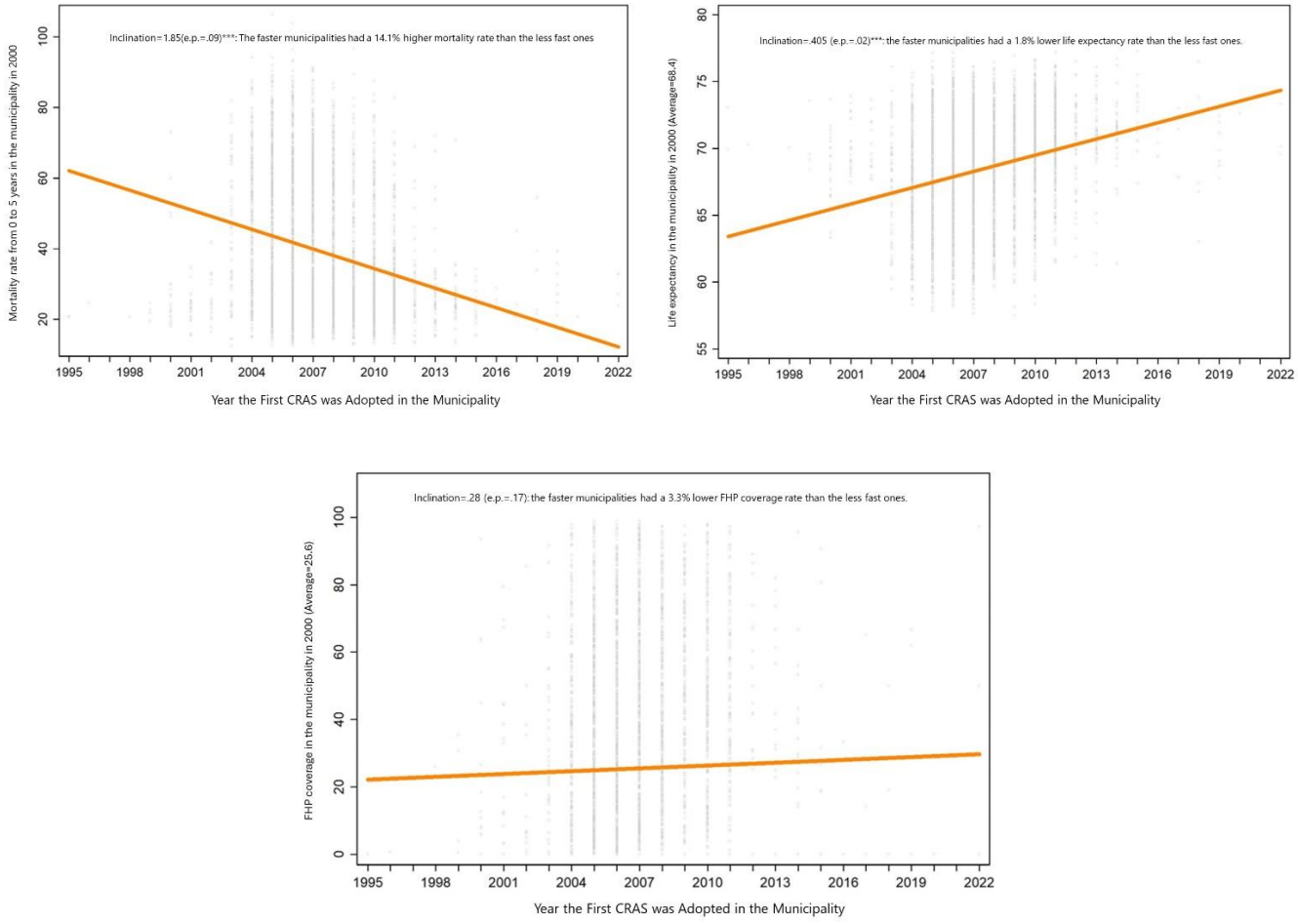
[5] The support of the Gini index ranges from 0, when there is no inequality (the *per capita* household income of all individuals in a municipality has the same value), to 1, when the inequality is maximum (only one individual holds all the income of the municipality).

[6] The person is considered unoccupied who, not being occupied in the reference week, had sought work in the previous month.

Graph 6. Correlates the Timing of Implementation of CRAS in Brazilian Municipalities: Labor Market and Productive Inclusion



Graph 7. Correlates the Timing of Implementation of CRAS in Brazilian Municipalities: Health Indicators



CRAS was able to reach first the municipalities where there was a share and a relatively larger contingent of people vulnerable to poverty. Using the rate of extreme poverty as a marker of social vulnerability, we conclude, for example, that the difference between more and less rapid municipalities is equivalent to 23% of the average rate in 2000. There is a fairly strong association between the variables and suggests that even a highly decentralized process of expansion had desirable characteristics in terms of focusing.

As the SUAS Census data are of indisputable richness, it is reasonable to wonder why the scientific literature on the causal impacts of Social Assistance services in Brazil — with the exception of the Bolsa Família Program (see Gerard et al., 2021, for example, for a recent period)—has not yet reached the maturity of literatures focused on social policies aimed at Health and Education. Some challenges of conducting impact assessments are well known and are not specific to Social Assistance. It is possible that the municipalities that adopted the CRAS more quickly had, at the time of adoption, more competence to, or intended to, attack the social problems that affect the vulnerable population. In addition, as we have seen, faster adoption is associated with the municipality's poverty rate in 2000, so the association between the existence of CRAS and future poverty runs the risk of generating more information about how persistent poverty is, rather than about the impact of CRAS itself.

Other challenges are, however, specific to the area of Social Assistance. One is that there is no established indicator of coverage, which would certainly influence the intensity of the effects—if any—of social protection services. It is not simple to map how the entry of CRAS in a given municipality generates a certain coverage of the population because, in principle, the CRAS serve only those who need it. Thus, although we know when the CRAS began operating in the territories, we know little about how intense their activities were because we do not know what the demand for their services was and would have difficulties in measuring it. These difficulties will need to be addressed by researchers interested in a characterization of the impacts of SUAS that is equal to the enormous challenges granted to its facilities, services, benefits, and programs. The results of such efforts could have important consequences for the good monitoring of the SUAS.

References

Brasil (2004). Política Nacional de Assistência Social. *Brasília: Secretaria Nacional de Assistência Social*.

Brasil (2009). Orientações técnicas: Centro de referência de assistência social-cras.

Gerard, F., Naritomi, J., and Silva, J. (2021). Cash transfers and formal labor markets: Evidence from brazil.