The Role and Impact of the Right to Health: Evidence from Brazil’s Family Health Program

Paul Hunt, Sonia Bhalotra, Carmel Williams

Human Rights Quarterly, Volume 44, Number 1, February 2022, pp. 111-141 (Article)

Published by Johns Hopkins University Press

DOI: https://doi.org/10.1353/hrq.2022.0004

For additional information about this article
https://muse.jhu.edu/article/847247

For content related to this article
https://muse.jhu.edu/related_content?type=article&id=847247
The Role and Impact of the Right to Health: Evidence from Brazil’s Family Health Program

Paul Hunt, Sonia Bhalotra & Carmel Williams

ABSTRACT

In this article we undertake a legal and policy analysis of Brazil’s Family Health Program which confirms that the right to health extended beyond...
Brazil’s constitution, and into the laws, policies, and documents associated with that program in 1996–2004. We then use Big Data to show that the right to health contributed to the large and sustained health gains, including in maternal and infant mortality, especially among less educated women. For example, the data shows progressive realization, enhanced access in poor and underserved areas, and reduced health inequalities, all of which are features of the right to health.

I. INTRODUCTION

In 1988, Brazil constitutionalized the right to health and shortly afterwards launched a series of major health initiatives, the largest and most important being the Unified Health System (SUS), a major component of which was the Family Health Program (PSF). In this article, we focus on two related issues. First, we use a legal and policy analysis to answer the question, has the right to health been confined to Brazil’s constitution or explicitly integrated into the laws, policies, and other official documentation associated with PSF? Second, we use Big Data to answer the question, has PSF been implemented in a way that is consistent with the right to health and contributed to health, and right to health, gains?

Although our main focus is PSF, we look at the context within which it is located, such as the SUS, as well as some sexual, reproductive and maternal health initiatives associated with the PSF. Following Sonia Bhalotra, Rudi Rocha, and Rodigo Soares (Bhalotra et al., hereafter referred to as the Maternal and Child Health Analysis in Brazil), we give particular (but not exclusive) attention to the PSF between 1996 and 2004. We focus on the right to health but also look at other constitutional health rights, such as the right to family planning.

A major and recurring theme in this article is the use of explicit human rights language. Why does it matter if human rights language is implicit or explicit? According to the International Bill of Human Rights, human rights “derive from the inherent dignity of the human person.” They give rise to legal and ethical obligations, duties and responsibilities. The legal commitments form part of international, constitutional, and “ordinary” national law. Critically, rights and obligations demand accountability which comes in

1. Both acronyms follow the Portuguese. Some commentators refer to the PSF as the ESF.
different forms. Thus, there is a difference between an empowered rights-holder and a client, customer, or supplicant. There is another consideration. Sometimes those in authority suggest that they are implicitly including the right to health in policy making or a rights-based approach to health. However, in such a situation, only they know when and whether the right to health is present and, if it is, how it is interpreted and applied. Such arbitrariness is inconsistent with the raison d’être of human rights. Masking human rights and obligations drains power away from the rights-holder in favor of the duty-bearer. For these reasons, we give attention to the explicit use of human rights language in the SUS, PSF, and associated interventions.

After this introduction, we explain the right to health lens applied in this article (Section II). By way of context, in Section III, we apply the right to health lens to the assessment of the SUS provided by Michele Gragnolati, Mangus Lindelow, and Bernard Couttolenc. We choose this study because it sets out the context within which the PSF is located, provides one of the most comprehensive, substantive and up to date English-language reviews of the SUS and its impact, and considers Brazil’s constitutional right to health. Then in Section IV we focus on PSF, as well as associated sexual, reproductive, and maternal health initiatives, and ask if the relevant official documentation uses explicit right to health language. Section V applies the right to health lens to the unique data analysis of the PSF provided by the Maternal and Child Health Analysis in Brazil. Using Big Data, understood as interlinked administrative data for the entire population, the Maternal and Child Health Analysis in Brazil demonstrates the health gains arising from rollout of the PSF across municipalities between 1996 and 2004. No previous study of the PSF has provided either such a fine-grained analysis of both maternal and child health outcomes, alongside measures of access to care, or applied the right to health lens to this form of analysis of PSF. The conclusion returns to, and answers, the questions posed in this introduction and makes some final observations.

II. THE RIGHT TO HEALTH LENS

Human rights are not static, their contours and content evolve and shift over time, and the right to health is no exception. In this article, it is not necessary to provide a detailed account of the right to health’s developing

4. See infra Section 2.
7. Bhalotra et al., supra note 2.
normative character. Instead, we highlight some of the key features of the right to health which are especially salient to our discussion. In particular, we draw from the analysis provided by the UN Committee on Economic, Social and Cultural Rights (CESCR) in General Comment 14.

A. Available, Accessible, Acceptable and of Good Quality (AAAQ)

The right to health requires that all health facilities and services are available, accessible, acceptable, and of good quality (AAAQ). For example, the right to health includes primary health care. Thus, primary health care facilities and services are required to be available in sufficient quantities within a State. Additionally, the facilities and services must be accessible to all, for example, accessible without discrimination, physically accessible, and economically accessible (i.e. affordable). Accessibility also includes equality and equity, for example, the introduction of special measures for underserved communities so that health inequalities are reduced. Not only must the facilities and services be available and accessible, but they must also be acceptable e.g., respectful of cultural diversity and provided in a culturally appropriate way. Lastly, all primary health care facilities and services should be of good quality, for example, staffed by suitably qualified health professionals who treat patients with respect. Here we have illustratively applied AAAQ to primary care, but it applies to all components of the right to health, including sexual, reproductive, and maternal health.

B. Active and Informed Participation

The right to health requires that there is an opportunity for individuals and groups to participate actively and in an informed manner in health-related planning, policymaking, implementation, and accountability processes that affect them.
C. Resource Constraints and Progressive Realization

International human rights law recognizes that the realization of the right to health is subject to resource availability. However, a State is obliged—whatever its resource constraints and level of economic development—to progressively realize the right to health. In short, there is a (rebuttable) presumption that a State may not backslide. To measure progress (or the lack of it) over time, indicators and benchmarks must be identified. In other words, reliable data, one of the themes of this article, is essential for monitoring.\(^\text{12}\)

D. Accountability

The right to health introduces legal norms or standards from which obligations or responsibilities arise. These obligations must be monitored and those responsible held accountable. Accountability can be understood as monitoring, review (including independent review), and remedial action. Without accountability, human rights norms and obligations run the risk of being empty promises. Transparent, effective, and accessible accountability mechanisms are among the most important requirements of human rights, including the right to health.\(^\text{13}\)

These are the features of the right to health lens applied in this article. There are other important features which we have not included because they are less relevant for present purposes, such as the responsibility to seek and provide international assistance and cooperation. Our lens is closely aligned with the approach adopted jointly by the World Health Organization (WHO) and the Office of the High Commissioner for Human Rights, and applied in *Women’s and Children’s Health: Evidence of Impact of Human Rights* published by WHO in 2013.\(^\text{14}\)

III. THE CONSTITUTION, SUS, AND THE RIGHT TO HEALTH

The 1988 Constitution is an historic milestone on Brazil’s road to democracy and the realization of human rights.\(^\text{15}\) It recognizes civil, political, economic, social, and cultural rights, and provides that all these human rights are enforceable in the courts.\(^\text{16}\) Article 6 confirms that social rights include the right to health.\(^\text{17}\) For present purposes, a key provision is Article 196:

\[^{12}\text{Id. ¶¶ 30–32.}\]
\[^{14}\text{Flavia Bustreo, Paul Hunt et al., *World Health Org., Women’s and Children’s Health: Evidence of Impact of Human Rights* published by WHO in 2013.}\]
\[^{15}\text{Id. at 35.}\]
\[^{16}\text{Id.}\]
\[^{17}\text{Id.}\]
Health is a right of all and a duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards, and at the universal and equal access to actions and services for its promotion, protection and recovery.\textsuperscript{18}

This is amplified in Article 226(7) in relation to family planning:

Based on the principles of human dignity and responsible parenthood, family planning is a free choice of the couple, it being within the competence of the State to provide educational and scientific resources for the exercise of this right, any coercion by official or private agencies being forbidden.\textsuperscript{19}

The Constitution’s health-related provisions have generated many court cases, and this is a marker of people’s perception of health as a human right for which they can hold the state accountable. We discuss this further later in this section.

The constitutional right to health, as well as the country’s public health system, emerged from the broad-based political movement that led to the country’s democratization in the 1980s.\textsuperscript{20} National Health Conferences, especially the one held in 1986, strengthened the call for a constitutional right to health.\textsuperscript{21} As Gragnolati et al. put it, the emergence of a constitutional right to health in 1988 was “a political and social achievement rather than a technical decision.”\textsuperscript{22} Thereafter, the immense challenge was to formulate policies and programs, and establish systems and processes, to put constitutionally created health rights into practice. In the 1980s, international guidance on how to operationalize health rights was in its infancy and so Brazil could obtain little assistance from the United Nations or the Organization of American States at that time.\textsuperscript{23}

From 1990, Brazil’s public health system—the SUS—became the primary vehicle for delivery of the constitutional right to health and other health rights. SUS is explicitly grounded in the right to health. The 1990 law establishing SUS states that “[h]ealth is a fundamental right of the human person, and the State must provide for the essential conditions for its full exercise.”\textsuperscript{24} Since 1990, successive governments have introduced multiple major initiatives to develop, deliver, and reform the SUS. One of the most important is the PSF, launched in 1994. Gragnolati et al. describe PSF as “an integral part of the SUS.”\textsuperscript{25}

\begin{itemize}
  \item \textsuperscript{18} \textit{Id.}
  \item \textsuperscript{19} \textit{Id.}
  \item \textsuperscript{20} Gragnolati et al., \textit{supra} note 6, at 47.
  \item \textsuperscript{21} \textit{Id.}
  \item \textsuperscript{22} \textit{Id.}
  \item \textsuperscript{23} Hunt, \textit{supra} note 5.
  \item \textsuperscript{24} Law No. 8.080, 1990, art. 2.
  \item \textsuperscript{25} Gragnolati et al., \textit{supra} note 6, at 26.
\end{itemize}
By way of contextualization, we begin with an examination of the SUS and the right to health. We look at Gragnolati et al.’s assessment of the SUS. Focusing on the first twenty years of the SUS (i.e. 1990–2010), this substantive World Bank study recognizes the role of the right to health, but it does not aim to provide a human rights assessment of Brazil’s public health system. We apply the right to health lens (outlined in section 2) to the World Bank assessment. We ask if the SUS, as assessed by Gragnolati et al., has some of the key values and features associated with the right to health. We adopt their division of the assessment into three overlapping categories: 1) overarching principles; 2) the transformation of the Brazilian health system; 3) and outcomes. We then briefly look at one of the issues raised by Gragnolati et al.: Brazil’s health rights litigation.

A. Overarching Principles

According to Gragnolati et al., the SUS was based on three overarching principles:

(a) “universal access to health services, with health defined as a citizen’s right and an obligation of the state;
(b) equality of access to health care; and
(c) integrality (comprehensiveness) and continuity of care.”

Gragnolati et al. adds that other “guiding ideas included decentralization, increased participation, and evidence-based prioritization.” Later they emphasize: “Universality was a key founding principle of the SUS.”

Applying a right to health lens. First, the principles of universality, equality, continuity of comprehensive care, and participation resonate strongly with key values and features associated with the right to health. So does decentralization, understood as a way of promoting participation and accountability.

Second, in the human rights context, there is a contradiction between universality and health defined as “a citizen’s right.” Human rights are usually understood to apply to everyone in a jurisdiction regardless of citizenship, which means when health services are limited to only people who are citizens, they are not universally available for everyone living in a jurisdiction. We return to this issue in our discussion of the PSF.

Third, from the perspective of the right to health, there are some notable omissions from the list of principles, such as quality and accountability.

---

26. *Id.* at 1.
27. *Id.* at 57.
28. Another striking omission is respect for cultural diversity i.e. the acceptability dimension of AAAQ, *supra* section 2.
Quality is not absent from the World Bank assessment, for example, it highlights research that demonstrates substandard care within the SUS and regrets the “SUS reform did not focus explicitly on quality.” The assessment also gives significant attention to governance and accountability and finds that “[a]lthough the SUS reforms did not articulate explicit goals or principles for governance and accountability, these concepts were implicit in many of the changes to the health system that the reforms envisaged.” Our assessment confirms that the SUS reforms failed to explicitly identify the key health rights features of quality and accountability as guiding principles.

B. Transformation of the Brazilian Health System

Gragnolati et al. report that the SUS significantly expanded the capacity of the system, with an emphasis on primary care. These efforts were “targeted to addressing regional disparities in access to health services.” Furthermore, “disparities in government spending across states and municipalities have fallen significantly.” There were also “targeted investments in expanding the health system in underserved parts of the country.” As we will see, these features of SUS are closely identified with PSF.

The World Bank assessment also explains that to “operationalize the [right to health], the government expanded the health facility network and maintained the legal provision that anyone can be treated for free under the SUS based on an open-ended benefits package.” The SUS was also concerned with “social participation and voice.” “Democratization in the health system was a major objective of the SUS reform and this goal was reflected in the establishment of health councils at each level of government. These councils provide formal mechanisms for society participation, but vary greatly in effectiveness.” Finally, “policy clearly favored expansion of the public sector over contracting with private providers.”

Applying a right to health lens. The expansion of the capacity of the system, and the health facility network, is aligned with the “availability” dimension of the right to health. Targeting regional disparities and under-
served parts of the country reflects the “accessibility” dimension of the right to health. The emphasis on primary care is consistent with the finding of the UN Committee on Economic, Social and Cultural Rights that “essential primary care” is a “core obligation” arising from the right to health.\(^{39}\)

The reference to “legal provision” highlights that the SUS is not based on charity but legal entitlement which gives rise to accountability; legal entitlement and accountability are among the most important hallmarks of a human rights approach. Like the SUS, the right to health has a preoccupation with “participation and voice.” While the international right to health does not take an explicit position for or against the public or private provision of health-related services, there is now a lot of evidence that private provision tends to deepen disparities between different income groups, and this practical consequence of private provision is inconsistent with the right to health.\(^{40}\) Thus, SUS favoring of the public sector is consistent with evidence-based policymaking for the right to health.

C. Outcomes

Under this heading, Gragnolati et. al. includes “intermediate health system goals,” such as utilization (that is, the usage of health care services per unit of population), and “the ultimate goals of the health system,” such as improving health outcomes.

In relation to intermediate goals, they find that although “geographic disparities in utilization declined some, a significant income gradient remains in average utilization rates across states.”\(^{41}\) They report “a reduction in unmet need, as well as in the share of households reporting lack of money as a reason for not using services.”\(^{42}\)

In relation to ultimate goals,

Brazil achieved significant improvements in life expectancy, child and infant mortality, and, to a lesser extent, maternal mortality over the last 20 years. Geographic inequalities in health outcomes were significantly reduced, with north eastern states benefiting the most, and disparities across socioeconomic groups also declined. However, significant inequalities in health status remain.”\(^{43}\)

They conclude, “the SUS reforms have achieved at least partially the goals of universal and equitable access to health care.”\(^{44}\)

39. CESC\textsuperscript{R} General Comment No. 14, supra note 9, ¶ 43.
41. Gragnolati et al., supra note 6, at 6.
42. Id. at 6–7 (italics removed).
43. Id. at 8.
44. Id. at 10.
Applying a right to health lens. Progressive improvements in utilization, unmet need, life expectancy, and child and maternal mortality align with the state’s obligation to progressively realize the right to health. These intermediate and other outcomes are necessary, but not sufficient right-to-health indicators of achievement and impact. A right to health assessment calls for these indicators, suitably disaggregated to explore equality and equity, as well as methods for capturing additional features of the right to health, such as participation and accountability. A range of qualitative and ethnographic methods are likely needed to measure these other right-to-health features.

D. Health Rights Litigation

We have already highlighted that legal entitlement and accountability are among the most important characteristics of human rights. Accountability comes in many forms, one of which is accountability before the courts. Gragnolati et al. draw attention to the enforceability of constitutional health rights in the Brazilian courts. Before looking at the PSF, it is necessary to comment briefly on this important issue.

Brazil’s constitutional health rights have generated a large amount of litigation. Judicial decisions have required the Government to take measures, such as the provision of equal access to pharmaceutical and medical services for all, including people living with HIV.

These cases have attracted controversy in the public, legal, policy, and academic spheres. In brief, some commentators argue that the health rights litigation has tended to favor the better-off, distort the public health budget, and undermine initiatives designed to promote social justice. Others take the view that these arguments are exaggerated. In their opinion, the litigation has important symbolic value, deepened accountability, and empowered individuals, including the disadvantaged.

45. Id. at 48.
47. Bustreo, Paul hunt et al., supra note 14, at 35.
49. For example, C. Rodríguez-Garavito, Beyond the Courtroom: The Impact of Judicial Activism on Socioeconomic Rights in Latin America, 89 Texas L. Rev. 1669 (2011); Biehl, Socal, & Amon, supra note 46.
For present purposes, it is unnecessary to engage in this debate in detail. We confine ourselves to three points. First, in comparison to civil and political rights, the judicial consideration of social rights is a relatively new phenomenon and courts are still developing the requisite skills and techniques, such as asking for health technology assessments to assist them in their deliberations. Second, whatever one’s view of the Brazilian litigation, it has raised the profile of the right to health and helped to place it in the consciousness of politicians, policymakers, practitioners, and the public. By acknowledging health rights, the litigation has contributed to the context within which the PSF is situated and implemented. Third, the growth in health rights litigation suggests that the Constitution, SUS, PSF, and associated interventions have reframed equitable good quality health services as an entitlement.

In this section, we have presented Gragnolati et al’s evidence of improvements in relation to the health system, intermediate goals, and other health outcomes which appear to be consistent with Brazil’s legally binding obligation to progressively realize the international right to health. They also identify some notable shortcomings. Notwithstanding these failings, our brief right to health assessment of the World Bank study suggests that the SUS is animated by some of the key values and features associated with the right to health and contributes to health gains consistent with this human right. In short, the health system’s explicit grounding in the right to health appears to be neither cosmetic nor rhetorical. Against this background, we now look more closely at PSF, one of the most important initiatives for delivery of the SUS.

IV. THE FAMILY HEALTH PROGRAM (PSF)

Transformation of the SUS overarching principles into reality has been an on-going project since 1990.50 The World Bank study identifies four waves of implementation which may be summarized in the following way.51 From 1988–1990: passing the basic laws, transferring responsibilities to the Ministry of Health, decentralization, and establishing social participation. From 1991–1995: more detailed rules and implementation of mechanisms for allocating federal funds. From 1995-mid-2000s: the organization and provision of primary care through the rollout of PSF. From mid-2000s-2010: a greater focus on efficiency, quality, governance, payment mechanisms, and establishing regional health care networks.

50. Gragnolati et al., supra note 6, at 17.
51. Id. at 17–18.
Although PSF’s origins go back to the 1980s, the third wave of SUS (1995-mid-2000s) was a highly formative period for the program. These years coincide with a global turning point in relation to understanding what a human rights-based approach to health means, as well as the contours and content of the international right to health. Elsewhere, Hunt has charted the evolution of these concepts and we will not repeat that analysis here.\(^{52}\) Suffice to say that, in 1998, The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Office of High Commissioner for Human Rights (OHCHR) published their *International Guidelines on HIV/AIDS and Human Rights*, which was one of the earliest international attempts to identify a human rights-based approach to health.\(^{53}\) In 2000, the UN Committee on Economic, Social and Cultural Rights adopted its ground-breaking interpretation of the international right to health.\(^{54}\) In 2002, the UN Commission on Human Rights established a “special procedure” on the international right to health which led (and continues to lead) to in-depth discussions of this human right.\(^{55}\) Interestingly, the UN Commission decided to establish this right to health special procedure on the initiative of the government of Brazil.\(^{56}\)

In short, the third wave of SUS implementation, which prioritized roll-out of the PSF, coincided with unprecedented international attention on both the human rights-based approach to health and the international right to health. Further research is needed to clarify the degree to which Brazil’s approach to health was shaping, and being shaped by, these international developments. However, it seems likely that the PSF’s formative years were not immune to pioneering international progress on the meaning of health rights and how to implement them.

Piloted in the 1980s and adopted nationally in 1993–1994, PSF was preceded by, and builds upon, the Community Health Agents Program (PACS). PSF and PACS are siblings and consequently when considering PSF it is also appropriate to consider PACS.\(^{57}\) The following box provides an outline of PSF.

---

52. Hunt, *supra* note 5.


The Family Health Strategy was designed to provide first contact, comprehensive, and whole person care coordinated with other health services, emphasizing care that takes place within the context of families and communities. In the PSF, multi-professional health teams (i.e., a physician, nurse, nurse assistant, and four to six community health workers) are organized by geographic regions, with each providing primary care to approximately 1,000 families. In 2004, oral health teams were added to the program. The PSF teams are based in basic care units and backed by other professionals. Their activity is heavily focused on prevention and promotion outreach activities, with monthly visits to enrolled families. The PSF was meant to correct the limitations of the facility-centered, passive, and curative approach to care. It includes typical primary health care activities, mostly targeting children and women, and activities focusing on the control of communicable and chronic diseases, including tuberculosis, hypertension and diabetes.

A. Does the PSF use Explicit Human Rights Language?

With a focus on the years between 1996 and 2004, this section asks if the PSF uses explicit human rights language. To address this question, first, we catalogued the relevant documentation (that is, laws, policies, guidance, and other governmental documentation) on the websites of the Ministry of Health and its Basic Healthcare Department. Second, we electronically searched these documents using the Portuguese terms for “human rights,” “right(s) to health,” “right(s)” and “health.” Third, we reviewed documents with one or more of these terms and, fourth, we translated key passages into English. As already suggested, the SUS and PSF are co-dependent, and it is sometimes difficult to disentangle them. Accordingly, in the following discussion we focus on PSF, but sometimes refer to SUS documentation.

An Ordinance from 1997 sets out “norms and guidelines” for both PACS (Annex 1) and PSF (Annex 2). Annex 1 includes explicit reference to human rights. In the same year, another Ordinance, which redefines SUS, highlights the role of the right to health. For example, it refers to the

58. This box is based on GRAGNOLATI ET AL., supra note 6, at 27.
60. We are most grateful to Mayra Gurgel, a lawyer with the Popular Centre for Youth Empowerment, Brasilia, for her indispensable research from which this section draws.
62. It is unclear why Annex 2 does not explicitly refer to human rights.
Constitution and the right to health and says that “each and every Brazilian” shall benefit from public policies that reduce health risks and problems. The Ordinance also emphasizes that, in addition to health promotion and protection, “the right to health . . . means universal . . . and equal . . . access to services.” It highlights that the SUS aims to contribute to “implementing the constitutional principles” and the “right to health.”

From time to time, the Ministry of Health publishes guidance on aspects of the SUS. For example, it published a commentary on PSF in 1997. In its introduction, this guidance regrets the “gap between constitutionally guaranteed social rights” and the capacity of public services to deliver them. Twenty years later, demonstrations about the poor quality of health and other public services highlighted that there was still an unacceptable gap between law and practice. The guidance of 1997 emphasizes that a specific goal is to promote health to “a right to citizenship.” Because of the principle of universality, human rights are usually understood to apply to everyone in a jurisdiction; they are not usually regarded as an attribute of “citizenship.” This issue recurs later in the guidance, under the heading “Operational guidelines,” when doctors and nurses are advised to discuss with patients and communities the right to health, including its legal basis, in the context of “citizenship.”

In 2000, the Ministry of Health published further guidance on the PSF and reiterated that “the family health team” should discuss with “the community . . . the concept of citizenship, emphasizing the right of health and its legal basis.” In 2001, the Ministry published a “Practical Guide” to the PSF, the second part of which is on oral health, and includes references to the right to health along the same lines as the earlier guidance. For example, health professionals are to “promote popular participation” and “discuss with the community concepts of citizenship and the right to health and its legal basis.” It then sets out the foundation for the work of the family and oral health teams and emphasizes that the “achievement of health as a legitimate right of citizenship is a pillar of the family health strategy.”

64. Id.
66. For some of the shortcomings, see Graignolati et al., supra note 6, at 72.
68. Id. at 16, 17.
69. Basic Attention Notebook 1—Family Health Programme, Brazil Ministry of Health 16 (2000).
71. Id. at 86.
72. Id. at 75.
the community” and “promote significant changes if they pay attention to people . . . and SUS concepts.” Further, the “fundamental attributions of the family health units” include: “[h]ealth, promotion and surveillance; [i]nterdisciplinary teamwork; and a [h]olistic approach to the family.” These short passages reflect the essence of the PSF.

This was followed by a Ministry of Health publication which considers health progress in Brazil between 1994 and 2001 and refers to health rights. For example, it highlights that health, described as a “progressive” social right recognized in Article 6 of the Constitution, “depends on positive action from the State and society for its full realisation.” It also recognizes the role of human rights in relation to sexual and domestic violence against women. Finally, the Ministry of Health’s book of 2003 on the SUS includes a passage headed “Guidelines for Operationalisation of the Programme” (PSF) and this appears to advocate a human rights approach—its precise words are “an approach towards human rights.” Like its predecessors, the publication refers to the constitutional right to health.

We recognize that the references to health rights are sometimes limited by nationality or citizenship whereas human rights are usually understood to have universal application, applicable to everyone regardless of nationality or citizenship. We do not think, however, that this detracts from the profile of health rights in SUS, PSF and PACS. Rather, it signals that there is an issue in Brazil about who are the rights-holders in relation to health rights. Other countries also wrestle with this question.

B. Do Sexual, Reproductive and Maternal Health Initiatives use Explicit Human Rights Language?

SUS, PSF, and PACS are large-scale initiatives—part of the architecture of Brazil’s public health system. They are the vehicles for the delivery of many

73. Id. at 73.
74. Id.
76. Id. at 84.
77. Id. at 52.
78. SUS Legislation, Brazil Ministry of Health 96, 99 (2003).
79. Id. at 60.
80. While on mission to Sweden as UN Special Rapporteur on the right to the highest attainable standard of health, for example, it was suggested to Hunt that asylum-seekers and undocumented foreign nationals did not have the same right to health entitlements as Swedish citizens and residents, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical And Mental Health, Paul Hunt, on Sweden, U.N. Doc. A/HRC/4/28/Add.2, ¶¶ 37, 67–75 (28 Feb. 2007).
81. This section draws from Bustreo, Hunt et al., supra note 14, at 34–41, Annex 3.
health initiatives which are more specific and targeted, for example, those on sexual, reproductive, and maternal health. In this section, we highlight some of the explicit human rights content of Brazil’s laws, policies, and programs on sexual, reproductive, and maternal health which, to one degree or another, depend upon the PSF. In this way, we aim to demonstrate that human rights are not only an explicit part of the architecture of Brazil’s public health system, but also its more detailed targeted programs and policies.

Launched in 1984, the Programme for Comprehensive Assistance to Women’s Health (PAISM) was ahead of its time. For example, it anticipated the Constitution (1988) and SUS (1990). At the international level, it foreshadowed the Programme of Action of the International Conference on Population and Development (Cairo, 1994) and the Platform of Action of the Fourth World Conference on Women (Beijing, 1995). Driven by Brazil’s women’s movement, the Programme affirmed sexual and reproductive rights. It emphasized that “control of one’s fertility [is] a fundamental right of the person,” recognized that all individuals should have access to contraceptive information and services, aimed to increase coverage of antenatal care, and sought to improve institutional and home deliveries.

The Programme was implemented through numerous initiatives, for example, in 1996 a new family planning law confirmed that “family planning is a right of every citizen” and defined family planning as “a set of actions aimed at controlling fertility that ensures equal rights for women, men or couples with regard to starting, limiting or expanding their families.” In 1999, technical guidelines on the prevention and treatment of injuries resulting from sexual violence emphasized that “the Brazilian State, through the Ministry of Health, has made a commitment to the human rights of women and to guarantee the full exercise of their physical and mental health, by devising public health policies that respond to their needs.”

When reforming the National Maternal Mortality Commission in 2003, the Ministry of Health emphasized that “the rates of maternal mortality in Brazil constitute a violation of the human rights of women and a grave public health issue” and urged “the adoption of concrete measures to reduce such rates.”

83. Bustreo, Paul Hunt et al., supra note 14, at 37.
87. Id.
Adopted in 2000, the Programme on Humanized Assistance to Pregnancy and Childbirth (PHPN) aimed to strengthen the continuum for antenatal, delivery, and postnatal care. It recognized the “right to dignified and quality care during pregnancy, birth and the postnatal period; the right to adequate antenatal care . . . ; the woman’s right to know the hospital where she will be assisted in her delivery; and the right to have ‘humanized’ and safe maternal health care.”

In 2004, the National Policy for Comprehensive Assistance to Women’s Health (PNAISM) extended the PAISM of 1984. The Policy confirmed that “the commitments here reflect the guarantee of women’s human rights and the goal to reduce maternal mortality” and aimed “to make sexual and reproductive rights concrete.” It emphasized “the character of health care as being a right” and promoted the “advancement of women’s health by guaranteeing their access to rights that are legal obligations of the State.” The policy also emphasized the importance of specific measures for the disadvantaged, such as rural, black, and indigenous women.

In the same year, the National Pact to Reduce Maternal Mortality, which is closely associated with PNAISM, emphasized that “the high rates of maternal and neonatal mortality in Brazil are a violation of the human rights of women and children.” The Pact’s guiding principles include “respect for human rights of women and children,” “the inclusion of gender, race and ethnicity considerations in all strategies and measures,” and “the consideration of social inequalities in decision-making processes.” Notably, the Pact aimed to expand the PSF for family planning and maternity-related care in community health units, and to train medical professionals to assist in home deliveries. In other words, this is an especially clear illustration of the relationship between the public health architecture (PSF) and a more specific health initiative (the National Pact to Reduce Maternal Mortality).

Although falling just outside our main focus (1996–2004), it is worth noting that in 2005, the National Sexual and Reproductive Rights Policy (PNDSR) included (as befits its title) reaffirmations of human rights, such as “the Brazilian government abides by the respect and guarantee of human rights, among which are sexual and reproductive rights, for the formulation and implementation of policies in relation to family planning and to any other matter related to population and development.” Its aims included

88. Id. at 38.
89. National Policy for Comprehensive Assistance to Women’s Health, Brazil Ministry of Health (2004); Bustreo, Paul Hunt et al., supra note 14, at 38.
90. Id.
91. Id.
92. Id.
94. Id.
95. Id.
expanding the supply of reversible contraceptive methods and it emphasized the importance of including the prevention of HIV/AIDS and other sexually transmitted diseases as an essential component of all family planning strategies.\(^{97}\)

PAISM, PHPN, PNAISM, and PNDSR were considered in a recent WHO study and analyzed through a right to health lens like the one adopted in this article. We will not repeat the WHO analysis, however, it suggests the implementation of the four initiatives was aligned, at least in part, with several right to health requirements, including availability, accessibility, quality, participation, and accountability.\(^{98}\)

In this section we have analyzed the relevant official documents to demonstrate that the right to health is not only explicit in the constitution, but also PSF, SUS, and PACS. Moreover, sexual, reproductive, and maternal health initiatives associated with PSF also use explicit human rights language. In short, official documents not only affirm health as a constitutional human right underpinned by law, they also explicitly promote the operationalization of the right to health via laws, policies, and practices.

V. USING DATA TO MEASURE THE EVIDENCE OF IMPACT OF THE PSF

Official documents affirm the right to health, and explicitly promote its operationalization, but is there evidence that the PSF was implemented in practice in a way that is consistent with the right to health and contributed to health gains?

Gragnolati et al. note the significant expansion of outpatient facilities and growing emphasis on primary care “with the Family Health Strategy . . . being a key driver of this change.”\(^{99}\) Moreover, the “reallocation of resources in favour of primary care has helped to reduce the hospital-centric nature of the health system.”\(^{100}\)

Importantly, they also confirm that the “expansion of the ESF started in poor and underserved areas of north-eastern states.” They also cite Rocha and Soares who found that adoption of PSF “has tended to be greater in areas with poorer initial health and fewer resources (for example, water and sanitation) and limited or no prior access to health services.”\(^{101}\) They report that this pattern is also reflected in household survey data which show that “people listed as enrolled in the ESF are most likely to be found in the lowest-income quintiles and that the proportion of families enrolled in the ESF declines as family income increases.” Gragnolati et al. observe that PSF

\(^{97}\) Id.
\(^{98}\) Id. at Annex 3.
\(^{99}\) Gragnolati et al., supra note 6, at 2.
\(^{100}\) Id. at 3.
\(^{101}\) Romero Rocha & Rodrigo Soares, Evaluating the Impact of Community-Based Health Interventions: Evidence from Brazil’s Family Health Program, 19 Health Econ. 126 (2010).
coverage tends “to be higher in the states with low household income per capita.”\textsuperscript{102} Although acknowledging “the picture is not entirely clear,” they conclude that the “gradual equalization of the availability of services across states, achieved by restructuring the hospital system and focusing the ESF rollout on the poorer states, has helped to reduce geographic disparities in utilization.”\textsuperscript{103} They add that “studies provide a strong indication that the rollout of the ESF has contributed to a reduction in mortality, in particular among children and in the North and Northeast” which are among the poorest regions of Brazil.\textsuperscript{104}

Applying the right to health lens: Gragnolati et al.’s remarks on the PSF are notable for at least three reasons. First, consistent with the availability requirement of the right to health, the PSF has substantially increased the quantity of primary care services in Brazil. Second, consistent with the accessibility requirement, the PSF rollout began in poorer and underserved areas and has reduced regional disparities in utilization. Third, consistent with progressive realization of the right to health, as well as accessibility, there is evidence that the PSF has contributed to mortality reduction, especially among children and Brazil’s poorer regions.

A. Did the PSF Contribute to the Realization of the Right to Health?

While Gragnolati et al. provide descriptive evidence of PSF impacts which are consistent with a commitment to the right to health, the recent research in the Maternal and Child Health Analysis in Brazil\textsuperscript{105} uses an event study approach to generate evidence that the changes in maternal and child health outcomes are causal impacts of the introduction of PSF, rather than more generalized trends that may reflect improvements in economic or other conditions.

Their study uses administrative data on municipalities over time for a range of detailed measures of PSF impact, including measures of public health provision and measures of health outcomes, which may be thought to summarize the success of implementation of the right to health principle. The PSF increased the density of primary care facilities staffed by general physicians, re-directing resources away from secondary care and hence away from hospitals and specialists. They have measures of the number of prenatal care visits and of hospitalization by cause, which reflect both provision and demand. Finally, they have measures of outcomes including maternal and child mortality by cause, measures of birth quality including birth weight and

\begin{itemize}
\item \textsuperscript{102} Id. at 30.
\item \textsuperscript{103} Id. at 62.
\item \textsuperscript{104} Id. at 88.
\item \textsuperscript{105} Bhalotra et al., supra note 2.
\end{itemize}
the APGAR score,\textsuperscript{106} and fertility by age group, so that teenage pregnancies can be assessed. Following Alfradique et al.,\textsuperscript{107} the Maternal and Child Health Analysis in Brazil classifies health conditions into those responsive to primary care (ICSAP) and those not responsive to primary care (non-ICSAP).\textsuperscript{108} The data allows the study to identify, as markers of disadvantage, the education of the mother and the zip code of the municipality.

Crucially, no previous study has attempted to assimilate this range of data, to identify causal impacts of program implementation on this range of outcomes, or to dig into the restructuring of provision that made these enormous investments feasible. By virtue of linking population-level data from different administrative sources, they create what we refer to as “Big Data.” They track the PSF through 1996–2004, its period of expansion described by Gragnolati et al. as the third wave of SUS implementation. We use data for the entire country that track public health infrastructure and health outcomes at the municipality level, over time.

Their strategy for causal identification relies on administrative data that provides the exact date of implementation of the PSF by municipality, leveraging the fact that the staggered timing of the program across municipalities was not based upon trends in maternal and child health. This boils down to looking, for each municipality, at the evolution of outcomes before versus after PSF was introduced. Their primary aim is to investigate impacts of PSF on service provision and outcomes, with a focus on maternal and child health. They found that re-structuring and, in particular, the massive expansion of primary health care after 1995 resulted in large and sustained declines in maternal, fetal, and infant mortality which were most marked among less educated women, with higher baseline mortality rates. They also found significant program-led declines in fertility.\textsuperscript{109} In this section of our article, we add to their analysis by applying the right to health lens to it for the first time. We ask: to what degree did the documented impacts contribute to the realization of the right to health?

There are two reasons that the Maternal and Child Health Analysis in Brazil focuses on maternal and child health. One is that these are declared priorities in global health discussions of universal health coverage, since a majority of families experience pregnancy and birth. In line with this, prenatal care and infant and maternal health were declared priorities of the PSF. The focus of the Maternal and Child Health Analysis in Brazil on births corresponds with our examination in section 4 of sexual, reproductive, and maternal health initiatives associated with the PSF. The other reason is

\begin{itemize}
  \item \textsuperscript{106} APGAR stands for Appearance, Pulse, Grimace, Activity, and Respiration, which are five tests of the health of a newborn baby.
  \item \textsuperscript{108} Bhalotra et al., supra note 2, at 17. The ISCAP acronym follows the Portuguese.
  \item \textsuperscript{109} Id. at 25.
\end{itemize}
that, in analyzing access to care for morbidity (disease-related conditions), it is difficult to disentangle access from the prevalence of morbidity. For example, a decrease in cancer-related deaths may signal improved access to cancer treatment at constant rates of cancer incidence (marking better health provision) or decreasing rates of cancer in the population with no change in access (marking possibly other improvements including in dietary habits or environmental exposures). This does not arise in the same way for pregnancy and childbirth. Rather, a decrease in maternal and child mortality rates is a fair reflection of improved access to reproductive and child health services as long as there are no significant changes in the composition of women giving birth. For example, if, over time, a greater share of births in the population is from women with higher child health risks (for example, poorer women), then changes in mortality rates will tend to under-estimate improvements in service provision.

Using the right to health lens, we now examine some of the data analysis provided by the Maternal and Child Health Analysis in Brazil. So far as the health gains identified in this analysis map onto the right to health, it helps to show that Brazil was delivering its constitutional right to health commitments in the relevant period. In this way, we will demonstrate the potential of Big Data to hold Brazil and other governments accountable for their national and international right to health obligations.

B. Availability

An important feature of PSF design was restructuring. The main objective was to increase the number of community-level primary facilities with general practitioners to widen access in more remote and rural areas. These facilities included outreach workers who provided preventative advice and information. This expansion of primary care was in part achieved by limiting resources spent on hospitals. Before the PSF was introduced, hospitals were dealing with cases that were amenable to primary care. This led to overcrowding in hospitals and to individuals from more remote locations having to travel a long way to hospitals in urban centers to access primary care. With an expansion of community-based outpatient facilities, patients had better access to care and physicians were better able to triage cases, referring only those that needed hospital care to hospitals. The Maternal and Child Health Analysis in Brazil assesses this re-design of the system and the extent to which it achieved results.

*Outpatient vs inpatient facilities:* the Maternal and Child Health Analysis in Brazil shows that PSF implementation was associated with immediate and statistically significant increases in PSF teams per capita and a decline in hospital beds per capita (see Figure 1). Further analysis shows that this restructuring of the infrastructure was mirrored in a shift in the composition of services away from specialists and towards general practitioners (see Figure 2).
Importantly, a decline in the number of obstetricians and pediatricians per capita does not necessarily mean that the government was in breach of its right to health commitments if the expansion of primary care led to prevention and early treatment of problems, thereby lowering the demand for specialist care. The data must be read with other information, including the following data on accessibility and widespread health gains.
C. Accessibility

*Population coverage:* The share of the population covered by PSF increased from 14 percent in the first year to 48 percent in the eighth year and there was a similar pattern for the share of children up to one year old covered by PSF. The per capita numbers of outpatient *procedures*, home visits, and educational (preventive) activities increased significantly (see Figure 3). Home visits (by professionals) and educational activities are markers of community outreach which was one of the hallmarks of PSF.

The data analysis of the Maternal and Child Health Analysis in Brazil goes into deeper levels of specificity. From the perspective of the right to health, this granularity is important. It sheds light on important dimensions of the right to health, such as accessibility and progressive realization, and helps to clarify the degree to which Brazil was delivering its constitutional right to health commitments in the relevant period.

*Prenatal care:* Pregnant women’s access to community-based prenatal care increased, with a significantly larger share of women accessing the recommended seven visits (see Figure 4). Further analysis shows that the increase in prenatal care was driven by less-educated women (see Figure 5).

The evidence presented so far establishes that there was a very substantial expansion of the share of the population with access to primary care, and that this had a strong preventive component. Pertinent to our emphasis on access to reproductive health, there was an increase in prenatal care and, pertinent to our emphasis on universal access, this was primarily an increase among less educated women.
Figure 4. PSF Effects on Access to Prenatal Care

Note: The figure plots coefficients with uncertainty intervals showing how the outcome named in the figure title evolves over time and responds to the introduction of the Family Health Programme in a municipality.

Figure 5. PSF Effects on Improvements in Prenatal Care Reduced Inequality: Greater Improvements for Less Educated Women

Note: The figure plots coefficients with uncertainty intervals showing how the outcome named in the figure title evolves over time and responds to the introduction of the Family Health Programme in a municipality.
We next consider whether these gains were achieved at the expense of hospital-based care. This is a potential concern given that there was a system-level change that redirected resources away from hospitals and towards primary care. In keeping with a focus on maternal and child health, the Maternal and Child Health Analysis in Brazil examined the following indicators.

**Hospital births**: Despite the tendency for the number of hospital beds to fall, the share of hospital births increased with the introduction of the PSF (see Figure 6).

**Maternal hospitalization rates (MHR)**: The intention driving the system restructuring in Brazil was that problems amenable to primary care would be addressed by the new community-level health centers, and that individuals who needed hospital care would then find easier access to less crowded hospitals. The Maternal and Child Health Analysis in Brazil therefore analyzed maternal hospitalization rates by cause, distinguishing causes amenable to primary care (ISCAP) from those that were not. It found no change in maternal hospitalization for ISCAP causes and an increase in maternal hospitalization for non-ISCAP causes. Maternal hospitalization of women for non-ISCAP causes increased by 8.1 percent in the first year, climbing to 40.6 percent in the eighth year (see Figure 7).

These results show a major increase in outpatient care under the PSF which will have reduced the caseload of hospitals, and a concomitant increase in hospital admissions for procedures that require inpatient care. Specifically, consistent with the right to health, the PSF contributed to (a) dealing with cases amenable to primary care at the community level and (b), as first point of contact, performing triage and referral to hospital for cases that needed it.
D. Quality

As discussed above, the PSF was associated with more home visits by health personnel with a college degree, an indicator of better-quality care. But the qualifications of a health professional do not address other vital dimensions of quality, such as providing patients with good clinical care and treatment in a respectful manner. While large-scale administrative data has the advantage of covering the entire population and allowing researchers to make robust inferences, it tends not to contain direct measures of quality. However, a deterioration in the quality of public health provision would be likely to show up in mortality statistics. We look at these next.

E. Evidence of Progressive Realization: Health Outcomes

Context: Prior to PSF implementation in 1996, with maternal mortality at 0.5 per 1000 births (against a world mean in 1996 of 3.66), Brazil had already achieved the global Sustainable Development Goals (SDG) target of 0.70 per 1000 births by 2030. Similarly, its pre-PSF neonatal mortality rate of 10.37 in 1000 births (compared with a global mean of 33.7) was ahead of the SDG target of 12 in 1000 births. In general, there are diminishing returns for life-saving interventions because when mortality rates are high, the share of readily preventable deaths is larger. Thus, one might have expected modest impacts of PSF expansion on mortality rates in Brazil but, in
fact, the Maternal and Child Health Analysis in Brazil identifies exceptional improvements.

Maternal mortality rate (MMR): Upon introduction of PSF, the Maternal and Child Health Analysis in Brazil observes a sharp reduction in MMR. To allow for mismeasurement of MMR, it also reports results for mortality among women of reproductive age and this also declines (see Figure 8). There was a decline of 53.1 percent by the eighth year following PSF implementation, which exceeds the 44 percent decline achieved worldwide over a twenty-five-year period, 1990–2015.

Infant mortality rate (IMR), or the number of deaths in the first year of life per 1,000 live births, shows a significant improvement of 9 percent by the second year of PSF implementation, rising steadily to 34 percent in year eight (see Figure 9). The Maternal and Child Health Analysis in Brazil confirms that this decline is evident for infant mortality from causes amenable and not amenable to primary care. This suggests that both primary and hospital-based care functioned better after the PSF was implemented (see Figure 10). Broken down further by cause of death, it shows declines in infant mortality from infectious, respiratory, perinatal, and congenital causes apparent in the neonatal (first month) and post-neonatal period.

Fertility rate: or the rate of births per woman of reproductive age declines upon the introduction of PSF. This decline is apparent for teenagers and older women. For instance, teenage fertility (age 10–19) fell three percent in year one, six percent in year three, and 21.1 percent by year eight (see Figure 11). The PSF may have stimulated fertility decline directly through outreach workers providing information and through local clinics providing contraception, or indirectly by encouraging a decline in infant mortality.
Figure 9. PSF Effects on Infant and Neonatal Mortality Rates

Note: The figure plots coefficients with uncertainty intervals showing how the outcome named in the figure title evolves over time and responds to the introduction of the Family Health Programme in a municipality.

Figure 10. IMR: ICSAP and non-ICSAP

Note: The figure plots coefficients with uncertainty intervals showing how the outcome named in the figure title evolves over time and responds to the introduction of the Family Health Programme in a municipality.
In this section we have shown that the expansion of the PSF started in poor and underserved areas of the northeast, and more generally, in areas with poorer initial health and fewer resources. Thus, the PSF has been implemented, at least in this respect, in a way that is consistent with the right to health and its emphasis on advancing equality and equity.

The data analysis of the Maternal and Child Health Analysis in Brazil provides unique insights into dimensions of the right to health in Brazil, such as availability and accessibility. In relation to accessibility, for example, we learn that PSF led to a significant increase in women’s access to community-based prenatal care. We also learn that this increase comes from less-educated women. This suggests PSF’s implementation was consistent with the right to health requirement of accessibility and contributed to improved access for disadvantaged women.

Further disaggregation (e.g. by ethnicity, indigeneity, and age) might confirm (or otherwise) that other disadvantaged groups benefited from the right to health requirement of accessibility. Also, additional disaggregation might enable policy makers to design and implement more effective measures for disadvantaged individuals and communities and help to hold the government accountable, consistent with the right to health. In short, the Maternal and Child Health Analysis in Brazil data not only provides insight into dimensions of the right to health, but it also signals the potential of data in relation to impact measurement, policy design, and accountability for the right to health.

While this data turns a searchlight onto some vital dimensions of the right to health, such as “availability,” “accessibility,” and “progressive realization,”
the Maternal and Child Health Analysis in Brazil does not shed light on other crucial dimensions, such as respect for cultural diversity, participation, and accountability. Moreover, some of these other dimensions are not readily amenable to quantitative methods. For example, if we wish to measure the impact of the right to health on respect for cultural diversity within the SUS or PSF, data alone is unlikely to do the job; ethnographic and other methods will probably be required.¹¹⁰

VI. CONCLUSIONS

We answer affirmatively the first question posed in the opening paragraph of this article, that the right to health extends beyond Brazil’s constitution and is explicitly integrated into the laws, policies, and other official documentation associated with PSF and its related initiatives. This came about because the Brazilian SUS is explicitly grounded in the constitutional right to health, is animated by some of the key values and features associated with the right to health, and contributes to health gains consistent with this human right. It is clear that significant attempts were made to take the relevant constitutional provisions and apply them in law, policy, and practice.

Through the use of Big Data, we have also answered our second question in the affirmative, finding that PSF was implemented in a way that is consistent with the right to health and it contributed to health, and right to health, gains between 1996 and 2004. Our analysis of the large and sustained health gains, including in maternal and infant mortality, especially among less educated women, are right to health gains. For example, the data showed progressive realization and enhanced access in poor and underserved areas, two features of the right to health. However, we agree with Gragnolati et al. that more work is needed to explore equity issues.

Our findings are highly relevant to an assessment of Brazil’s right to health record. However, they do not prove that Brazil was in complete conformity with its constitutional right to health obligations, as more research, including qualitative research, is needed before it might be possible to arrive at this conclusion. Additional data, for example disaggregation by ethnicity, indigeneity, and age, may confirm and deepen the finding that the PSF started with and focused on poor and underserved areas and improved equality and equity.

Our research also demonstrates how Big Data can be used to help hold Brazil, and other governments, accountable in relation to their national and

international right to health obligations. Big Data can be used by national bodies (for example, national human rights institutions and courts) and international bodies (for example, UN Human Rights Council and Universal Periodic Review) for accountability purposes.

Human rights impacts are complex, nuanced, and multi-sectoral. They are unlikely to be captured only by legal and policy analysis, interlinked administrative data, or other forms of Big Data. Capturing human rights impacts across a spectrum of change will usually require a range of mixed methods, including sociological studies and ethnographic research.\footnote{Id.}

In summary, Brazil took steps to explicitly integrate the constitutional right to health into SUS, PSF, and related initiatives. The Maternal and Child Health Analysis in Brazil demonstrates these human rights-shaped legislative and policy reforms resulted in reduced health inequalities and advanced the health of poorer women and children first. In our research we have demonstrated that these health gains are prima facie right to health gains. Our position is not that the right to health caused these gains, but the right to health contributed to the design and implementation of the PSF and in this way contributed to gains which saved lives, reduced suffering, and lessened health inequities.