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Article

Municipal health law and the public policy of primary care for prenatal assistance: a study of the Nascer Urumajó Program of the municipality of Augusto Corrêa from 2022 to 2024

Direito sanitário municipal e a política pública de atenção básica para assistência pré-natal: um estudo sobre o Programa Nascer Urumajó do município de Augusto Corrêa no período de 2022 a 2024

Derecho sanitario municipal y la política pública de atención primaria para la asistencia prenatal: un estudio sobre el Programa Nascer Urumajó del municipio de Augusto Corrêa en el período de 2022 a 2024

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Abstract

Objective: to analyze the Nascer Urumajó Municipal Program as a public policy for primary maternal and child health care implemented in the Northern Region, based on the evolution of indicators from the Previne Brasil Program in the period from 2022 to 2024, in order to verify its impacts on the qualification of prenatal care and its potential for replicability in other Amazonian municipalities. **Methodology:** the inductive method is adopted, using the case study technique, in addition to bibliographic research. The quantitative-qualitative research was carried out on the public virtual portal Health Information System for Primary Care in the period 2022-2024 to investigate the evolution of the indicators of the family health public policy of the municipality of Augusto Corrêa.

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Results: between 2022 and 2024 there was significant progress in the indicators of the Previne Brasil program: prenatal consultations (minimum of six, from the 1st to the 12th week) increased from 26% to 72%; syphilis and human immunodeficiency vírus tests increased from 56% to 96%; and dental care increased from 50% to 93%, this improvement was directly reflected in the reduction of the infant mortality rate, which went from 9 deaths in 2019 to 3 in 2024, and in the maternal mortality rate, which had registered 3 deaths in 2019, falling to 1 in 2024, with no maternal deaths recorded in 2023. The data indicate the advancement and strengthening of evidence-based management, impacting resource allocation, team planning, and the response of the local system. It was noted that the program has the potential for replication in other municipalities, provided that local specificities are considered, with the following variables being replicable: planning by indicators, integration between management and teams, strategic use of federal incentives, and prioritization of maternal and child health as the axis of Primary Care. **Conclusion:** the Nascer Urumajó Program, in the municipality of Augusto Corrêa, Pará, stands out as an Amazonian public policy, structured according to its reality and needs, of primary care for prenatal assistance and maternal and child health implemented through the construction of institutional arrangements capable of coordinating actors, instruments, and resources around measurable health objectives.
Keywords: Health Law; Public Health Policies; Primary Health Care; Prenatal Care.

Resumo

Objetivo: analisar o Programa Municipal Nascer Urumajó como política pública de atenção básica em saúde materno-infantil implementada na Região Norte, a partir da evolução dos indicadores do Programa Previne Brasil no período de 2022 a 2024, com vistas a verificar seus impactos na qualificação da assistência pré-natal e seu potencial de replicabilidade em outros municípios amazônicos. **Metodologia:** adota-se o método indutivo, com utilização da técnica de estudo de caso, além de pesquisa bibliográfica. A pesquisa quanti-qualitativa foi realizada no portal público virtual Sistema de Informação em Saúde para a Atenção Básica, no período de 2022-2024, para investigar a evolução dos indicadores da política pública de saúde da família do município de Augusto Corrêa. **Resultados:** entre 2022 e 2024 houve avanço expressivo nos indicadores do Previne Brasil: consultas de pré-natal (mínimo de seis, com a 1ª até a 12ª semana) de 26% para 72%; exames de sífilis e vírus da imunodeficiência humana de 56% para 96%; e atendimento odontológico de 50% para 93%, a melhora refletiu diretamente na redução da taxa de mortalidade infantil, que saiu de 9 óbitos em 2019 para 3 em 2024, e na materna que havia registrado 3 óbitos em 2019, com queda para 1 em 2024, sendo que no ano de 2023 não houve registro de morte materna. Os dados indicam o avanço e o fortalecimento de uma gestão baseada em evidências, com impacto na alocação de recursos, programação das equipes e resposta do sistema local. Notou-se que o programa tem potencial de replicação em outros municípios, desde que consideradas as especificidades locais, sendo replicáveis as variáveis de: planejamento por indicadores, integração entre gestão e equipes, uso estratégico de incentivos federais e priorização da saúde materno-infantil como eixo da Atenção Básica. **Conclusão:** o Programa Nascer Urumajó, no município de Augusto Corrêa, Pará, destaca-se com uma política pública amazônida, estruturada conforme sua realidade e necessidade, de atenção básica para assistência pré-natal e à saúde materno-infantil implementada mediante a construção de arranjos institucionais capazes de coordenar atores, instrumentos e recursos em torno de objetivos sanitários mensuráveis.
Palavras-chave: Direito Sanitário; Políticas Públicas em Saúde; Atenção Básica à Saúde; Assistência Pré-Natal.

Resumen

Objetivo: analizar el Programa Municipal Nascer Urumajó como política pública de atención primaria de salud maternoinfantil implementada en la Región Norte, con base en la evolución de los

indicadores del Programa Previne Brasil entre 2022 y 2024, para verificar sus impactos en la calidad de la atención prenatal y su potencial de replicabilidad en otros municipios amazónicos. **Metodología:** se adoptó el método inductivo, utilizando la técnica de estudio de caso, además de la investigación bibliográfica. La investigación cuantitativa-cualitativa se llevó a cabo en el portal virtual público Sistema de Información en Salud para Atención Primaria durante el período 2022-2024 para investigar la evolución de los indicadores de la política pública de salud familiar del municipio de Augusto Corrêa. **Resultados:** entre 2022 y 2024 se observó un progreso significativo en los indicadores del programa Previne Brasil: las consultas prenatales (mínimo de seis, desde la primera hasta la duodécima semana) aumentaron del 26% al 72%. Las pruebas de sífilis y virus de la inmunodeficiencia humana aumentaron del 56% al 96%, y la atención dental del 50% al 93%, la mejora se reflejó directamente en la reducción de la tasa de mortalidad infantil, que pasó de 9 muertes en 2019 a 3 en 2024, y en la tasa de mortalidad materna, que había registrado 3 muertes en 2019, descendiendo a 1 en 2024, sin que se registrara ninguna muerte materna en 2023. Los datos indican un progreso y un fortalecimiento de la gestión basada en la evidencia, lo que repercute en la asignación de recursos, la planificación de equipos y la respuesta del sistema local. Se observó que el programa tiene potencial para replicarse en otros municipios, siempre que se consideren las especificidades locales, siendo replicables las siguientes variables: planificación por indicadores, integración entre la gestión y los equipos, uso estratégico de los incentivos federales y priorización de la salud materno-infantil como eje de la Atención Primaria. **Conclusión:** el Programa Nascer Urumajó, en el municipio de Augusto Corrêa, Pará, se destaca como una política pública amazónica, estructurada según su realidad y necesidades, para la atención prenatal básica y la salud materno-infantil, implementada mediante la construcción de arreglos institucionales capaces de coordinar actores, instrumentos y recursos en torno a objetivos de salud medibles.
Palabras clave: Derecho sanitario; Políticas de salud pública; Atención primaria de salud; Atención prenatal.

Introduction

In Brazil, despite the gradual reduction in infant and maternal mortality rates since the 2000s, the issue remains central to the national health agenda, primarily due to territorial inequalities, structural inadequacies in certain local health systems, and social vulnerabilities affecting historically disadvantaged regions, such as the Amazon.

Maternal and infant mortality is defined as deaths related to pregnancy, childbirth, and the postpartum period, with the main causes including hemorrhage, hypertensive disorders of pregnancy, and sepsis, while indirect causes involve conditions such as anemia and human immunodeficiency virus (HIV). The concept also includes deaths of fetuses and newborns (neonatal and perinatal)[1], such as the death of infants during the first month of life and the occurrence of stillbirths (fetal) and perinatal deaths (which include fetal and early neonatal deaths; the main causes of death among newborns are prematurity, complications during delivery, sepsis, and congenital anomalies)[2].

Maternal and perinatal deaths share the same root causes: they are closely linked to living conditions and to a lack of access to, or poor quality of, prenatal and childbirth care[2]. Therefore, this indicator reflects socioeconomic conditions and the quality of the health care system.

The reduction in maternal and infant mortality in Brazil reflects remarkable progress in public health and the country's socioeconomic conditions. Between 1996 and 2022, the infant mortality rate (IMR), defined as the number of deaths among children under one year of age per 1,000 live births (LB), fell from 25.47 to 12.59 deaths/1,000/LB, with the greatest reduction occurring between 2010 and 2016[3].

The aggregated data (1996–2022) confirmed that infant mortality was higher among boys during the early neonatal period (up to seven days of life), particularly in the North and Northeast regions. The Northeast region had the highest rate, at 18.88 deaths per 1,000 live births, while the South region had the lowest rate, at 13.28 deaths per 1,000 live births. The North region had an IMR similar to that of the Northeast, at 18.41 deaths per 1,000 live births; the Central-West region had a rate of 15.09 deaths per 1,000 live births; and the Southeast region had a rate of 14.91 deaths per 1,000 live births[3].

On the other hand, the maternal mortality ratio (MMR) in Brazil reveals a substantially more complex picture fraught with structural challenges. Although the indicator showed a reduction of approximately 49% between 1990 and 2019, falling from 111.4 to 62.1 deaths per 100,000 live births[4], these historic gains suffered a severe setback with the Coronavirus Disease 2019 (COVID-19) pandemic. In 2020, the rate jumped to 74.7 deaths per 100,000 population and reached a critical peak of 100.9 deaths per 100,000 population in 2021[5].

Although the country began a recovery in healthcare outcomes in 2022[5], with the rate falling to 57.7 deaths per 100,000 population[5], the progress made is still insufficient to fully meet the ideal targets agreed upon with international health organizations; Target 3.1 of the United Nations' Sustainable Development Goal (SDG) 3, set for Brazil, was up to 30 deaths per 100,000 population by 2030[5].

A temporal analysis of the MMR (1990–2022)[4,5] showed that the indicator did not decrease uniformly across Brazilian regions, with the North and Northeast regions exhibiting the lowest rates of reduction[5]. The increase in the MMR was marked by a shift in causes of death, with indirect obstetric complications (chronic diseases exacerbated by pregnancy) and hypertensive disorders of pregnancy emerging as the primary causes of mortality, underscoring the urgent need to equitably improve prenataland postpartum care[4,5].

Initiatives aimed at improving the quality of obstetric and neonatal care have gained greater institutional relevance, notably the "Nascer no Brasil" project, developed by the Oswaldo Cruz Foundation (Fiocruz), which consolidated the scientific basis for women's and newborn health care in the country[6]. The initiative contributed to the generation of evidence on access, quality of care, and regional inequalities, thereby strengthening the formulation of public policies focused on maternal and child health.

At the international level, agencies affiliated with the United Nations (UN), particularly the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and the United Nations Inter-Agency Group for the Estimation of Infant Mortality (UN IGME)[7], have highlighted significant progress in recent decades, although profound regional and socioeconomic inequalities persist. In 2022, mortality among children under five reached its lowest global rate on record, estimated at approximately 4.9 million deaths, a result linked to expanded access to health services, particularly prenatal care, obstetric and neonatal care, and immunization and primary health care policies[8].

The protection of maternal and child health finds its legal basis in Article 196 of the Federal Constitution[9], which establishes health as a right of all and a duty of the State. Primary Health Care (PHC) plays a strategic role in disease prevention, prenatal and postpartum care, child care, and the promotion of comprehensive care for pregnant women and newborns. However, although the Unified Health System (SUS) is one of the largest universal public health systems in the world, regional

disparities persist regarding municip y and administrative capacity, the availability of specialized services, and the implementation of localized health policies, especially in Amazonian municipalities[10].

Starting in 2019, the Previne Brasil Program, established by Ministry of Health Ordinance No. 2,979[11], dated November 12, 2019, began restructuring the federal funding model for Primary Health Care, establishing criteria based on weighted per-capita funding, performance-based payments, and incentives for strategic actions. Among the performance indicators established by the program, those related to maternal and child health stand out, particularly prenatal care, the performance of essential tests during pregnancy, and coverage of care for women and children[12]. Previne Brasil began to function not only as a financing mechanism but also as a tool to drive municipal public policies aimed at improving the quality of primary care and strengthening health indicators[12].

The Previne Brasil Program was discontinued by Ministry of Health Ordinance No. 3,493[13], dated April 10, 2024, which established the Saúde Brasil Program and altered the funding methodology for Brazilian public health; however, the funding rules for public policies focused on prenatal care were not regulated until April 29, 2025, by Ordinance GM/MS No. 6,907[14]. The Saúde Brasil program will not be addressed in this study, since the data from the Nascer Urumajó Program analyzed (2023–2024) used indicators from the Previne Brasil Program.

The municipality of Augusto Corrêa, located in the Caeté integration region in the state of Pará, fits into this context. According to data from the Brazilian Institute of Geography and Statistics (IBGE), the municipality had an estimated population of 47,912 inhabitants in 2025[15], with a Human Development Index (HDI) of 0.520[15] and a FIRJAN Municipal Development Index (IFDM) of 0.3515[16], classified as "critical development" according to the methodology of the Federation of Industries of the State of Rio de Janeiro (FIRJAN).

Local social and economic indicators directly influence the design of public health policies. Data from the Infant and Fetal Mortality Monitoring Panel of the Department of Epidemiological Analysis and Surveillance of Noncommunicable Diseases (DAENT/SVSA)[17] indicated that the municipality of Augusto Corrêa recorded a total of 40 deaths[18], per household, among children, due to preventable causes between 2019 and 2024[17]. The annual distribution of cases reveals a downward trend over the period, with 9 deaths recorded in 2019[17], 9 in 2020[17], 7 in 2021[17], 8 in 2022[17], 4 in 2023[17] and 3 in 2024[17]. This time series was compiled from the category of reported infant and fetal deaths, using the "All" parameter for the variables of place of occurrence and cause of death by race/color and sex[17]. The highest risks of pregnancy loss or neonatal death are associated with: racial inequality (children of Black, Brown, and Indigenous pregnant women are at higher risk), vulnerability and urban segregation (areas with lower investment in health and infrastructure), and low educational attainment and poverty[2].

Data from the Maternal Mortality Monitoring Panel, also from DAENT/VISA[18], showed that there were 6 maternal deaths in the municipality between 2019 and 2024[18]. The chronological trend for the period shows 3 deaths in 2019[18], none in 2020[18], 1 in 2021[18], 1 in 2022[18], none in 2023[18] and 1 death in 2024[18]; the number of deaths was filtered by the "reported maternal" indicator within the category of reported deaths of women aged 10 to 49, with the "All" parameter selected for the variables of place of occurrence, cause of death, and race/color[18].

This scenario highlights the difficulties faced by municipal authorities in consolidating structured health policies focused on maternal and child health, especially in areas marked by social vulnerabilities, institutional limitations, and low operational capacity of the public health system. In this context, the Municipal Health Secretariat of Augusto Corrêa developed, in 2022, the Nascer Urumajó Municipal Program, which was subsequently institutionalized by Municipal Law No. 1,994/2023[19]. The program was designed as a permanent public policy aimed at improving the quality of prenatal care and strengthening maternal and child health within the framework of Primary Health Care, taking into account the territorial and social specificities of the Amazon region. The initiative sought to expand access to basic services, improve the quality of prenatal care, and contribute to the improvement of health indicators related to women's and children's health.

This article aims to analyze the Nascer Urumajó Municipal Program as a public policy for primary maternal and child health care implemented in the Northern region, based on the evolution of indicators from the Previne Brasil Program from 2022 to 2024, with a view to assessing its impacts on improving prenatal care and its potential for replication in other Amazonian municipalities.

Methodology

This is an applied research study that adopts an inductive method with a quantitative-qualitative approach using a case study strategy. The inductive method is adopted insofar as the research begins with the empirical analysis of a specific case the Nascer Urumajó Program and the evolution of health performance indicators in the Primary Care Health Information System (SISAB), in order to use these findings to formulate a hypothesis regarding the replicability of the public policy in similar contexts[20,21].

The literature review was structured based on a systematic search of widely recognized scientific and legal databases, including the Scientific Electronic Library Online (SciELO), Google Scholar, and the Virtual Health Library (BVS). The search strategy was guided by predefined keywords, in Portuguese and English, related to the central themes of the research, such as "health law", "public health policies", "primary care", "maternal and child health", "state capacity" and "legal-institutional arrangements".

During the identification phase, four records were found in SciELO and 30 records in Google Scholar; no results were identified in the BVS. In the screening phase, titles and abstracts were analyzed, followed, when necessary, by an exploratory reading of the full-text articles. The following exclusion criteria were adopted: (i) lack of thematic alignment with the research objective; (ii) a partial approach to the analytical axes without integration between health law, public policies, and maternal and child health; and (iii) duplicate records.

At the end of this stage, the identified records were excluded, highlighting the low incidence, in general-purpose databases, of studies that integrate the proposed theoretical frameworks in a comprehensive manner, which indicates an innovative study.

In the eligibility stage, we opted for a targeted selection of scientific journals with recognized standing in the fields of law, public health, and public policy, considering criteria such as: (i) classification in the Qualis/CAPES "A" and "B" journal tiers for the 2021 - 2024 four-year period, in addition to the impact factor; (ii) indexing in established databases; (iii) the existence of an editorial board and peer review; and (iv) thematic alignment with the research axes.

At the conclusion of this process, the results indicated the need to refine the methodological strategy, redirecting the search toward specialized and theoretically sound sources. Based on these paramerts, the following journals were selected: Cadernos de Saúde Pública (A1), Revista de Saúde Pública (A1), Revista de Direito da Cidade (A2), Revista de Informação Legislativa (A2), *Revista Estudos Institucionais* (A2), *Saúde e Sociedade* (A2), *Revista Estado y Políticas Públicas* (A3), *Revista de Direito Público* (A4), *Caderno Ibero-americano de Direito Sanitário* (B1), *Revista Enfermagem Contemporânea* (B1), and *Revista Campo de Pública: conexões e experiências* (B4).

Based on the results of the journal search, we selected the articles whose authors provided the theoretical foundation for the main themes of this study. For the study of municipal health law and the general theory of health law, the theoretical framework drew on the work of Lenir Santos[22] and Fernando Mussa Aith[23]. Regarding the fundamental right to health, the contributions of Sueli Dallari[24] and Krishina Day Ribeiro[25] were drawn upon. As for maternal and child health, with a focus on parenting and emotional bonds, the studies by Brazelton[26] and Bowlby[27] were adopted. Finally, the section on legal and institutional arrangements was based on the work of Márcio Iorio Aranha[28], Isabela Ruiz, and Maria Paula Dallari Bucci[29].

The unit of empirical analysis**,** as a case study, was defined by the primary health care public health policy known as the Nascer Urumajó Program, in the municipality of Augusto Corrêa, state of Pará, during the period from 2022 to 2024. Empirical data were collected from the Health Information System for Primary Care, the official database of the Ministry of Health (https://sisab.saude.gov.br/), which provides public and secondary data regarding the performance of primary care teams.

A total of 1,843 records of pregnant women participating in the Nascer Urumajó Program were identified, and information was reviewed regarding prenatal care performance indicators defined within the framework of federal funding for primary care—notably those established by the Previne Brasil Program and subsequently incorporated into the methodology of the Saúde Brasil Program. The indicators used in public policy are: (I) the proportion of pregnant women who had at least six prenatal visits, beginning by the 12th week of gestation; (II) the proportion of pregnant women who underwent testing for syphilis and HIV; and (III) the proportion of pregnant women who received dental care during pregnancy. These indicators were examined comparatively and over time, considering the four-month periods within the analyzed timeframe.

The unit of analysis adopted covered, at the aggregate level, the municipality, and, at the disaggregated level, the 21 Family Health Strategy (ESF) units, allowing for the assessment of both the overall evolution of the indicators and the internal variations among the units responsible for implementing public policy, distributed to cover both the municipal seat and the outlying areas. The National Registry of Health Facilities establishes that in the urban area, care for the population is provided by six units, namely: ESF Sede, ESF São João, ESF Cidade Nova, ESF Pratiaçú, ESF Lírios, and ESF São Benedito[30].

In turn, the rural area has a more extensive network to address the specific needs of the territory, subdivided into units on dry land and riverine areas. Care for riverine populations, in conjunction with rural populations, is provided through four units: ESF Nova Olinda I, ESF Zé Castor, ESF Arai, and ESF Perimirim. The remaining rural localities, meanwhile, are served by the Nova Olinda II Family Health Centers (ESF), Santa Maria Family Health Centers (ESF), Itapixuna Family Health Centers (ESF), Vila Verde Family Health Centers (ESF), Aturiaí I Family Health

Centers (ESF), Patal Family Health Centers (ESF), Aturiaí II Family Health Centers (ESF) and Trevinho Family Health Centers (ESF). It is worth noting that some of these rural units have integrated support structures, such as the ESF Vila Nova, the ESF Buçu, and the ESF Travessa do Dez[30].

The study adhered to applicable ethical principles, as it used exclusively secondary data—either publicly available or provided institutionally by the municipality—without individual identification of participants in the public policy, in accordance with current transparency and data protection regulations.

Data analysis followed a descriptive quantitative approach, with an emphasis on comparative analysis. The construction of time series allowed for an examination of the trajectory of maternal and child health indicators, enabling a dynamic interpretation of the results and supporting subsequent qualitative interpretation in light of the adopted analytical categories, in line with the inductive methodological strategy.

The analytical categories were constructed based on the interaction between the theoretical framework and the empirical findings, notably: (i) municipal government capacity; (ii) legal and institutional arrangements; (iii) performance on health indicators; and (iv) replicability of public policies in contexts of territorial vulnerability.

Results and Discussion

Evolution of the indicators for the municipal public health policy "Nascer Urumajó" Program from 2023 to 2024

The Nascer Urumajó Program was designed to meet the indicators established by Previne Brasil by December 2024, which includes three health assessment indicators for prenatal care. The first indicator measures the proportion of pregnant women who have had at least six prenatal visits, with the first occurring between the 1st and 12th weeks of gestation[31]; the second indicator assesses the proportion of pregnant women who have undergone testing for syphilis and HIV[31] and the third indicator measures the proportion of pregnant women who have received dental care[31].

These three federal indicators served as the basis for the enactment of Municipal Law No. 1,994/2023[19] The creation of a structured policy provided the Family Health Strategy (ESF) with targeted guidance that established a link between the multidisciplinary teams and pregnant women, which had a direct impact on the municipality's indicators.

The progress of the municipal policy is measured through the historical evolution of the Previne Brasil indicators, which are currently transitioning to the Saúde Brasil methodology. Below is a comparative analysis between the pre-implementation/initial period in 2022 and the current scenario consolidated in 2024, demonstrating a substantial improvement in the indices, with data from the four-month periods extracted from the Primary Care Health Information System (SISAB)[31].

Table 1. Percentage for the first Previne Brasil indicator: proportion of pregnant women who have had at least six prenatal visits, with the first occurring between the 1st and 12th weeks of pregnancy

	FAMILY HEALTH STRATEGIES	2022			2023			2024		
		Q1 (%)	Q2 (%)	Q3 (%)	Q1 (%)	Q2 (%)	Q3 (%)	Q1 (%)	Q2 (%)	Q3 (%)
1	ESF BUÇU	**70**	**33**	**60**	**70**	**67**	**90**	**67**	**38**	**93**
2	ESF NOVA OLINDA II	**13**	**25**	**44**	**100**	**80**	**75**	**60**	**57**	**92**
3	ESF ARAI	**0**	**14**	**45**	**71**	**55**	**100**	**82**	**90**	**91**
4	ESF ZÉ CASTOR	**0**	**23**	**21**	**58**	**38**	**67**	**36**	**35**	**81**
5	ESF PATAL	**5**	**24**	**39**	**56**	**67**	**55**	**60**	**40**	**79**
6	ESF CIDADE NOVA	**71**	**65**	**67**	**82**	**50**	**62**	**86**	**71**	**78**
7	ESF PRATIAÇU	**17**	**33**	**64**	**82**	**25**	**55**	**69**	**100**	**76**
8	ESF Vila Verde	**75**	**80**	**63**	**50**	**67**	**60**	**75**	**40**	**75**
9	ESF Vila Nova	**0**	**0**	**0**	**67**	**40**	**50**	**31**	**38**	**75**
10	ESF LÍRIOS	**41**	**23**	**63**	**54**	**40**	**83**	**87**	**79**	**74**
11	São João Family Health Program	**36**	**55**	**44**	**85**	**93**	**64**	**58**	**80**	**73**
12	ESF ITAPIXUNA	**24**	**12**	**48**	**58**	**71**	**35**	**50**	**60**	**71**
13	ESF HEADQUARTERS	**43**	**62**	**64**	**65**	**62**	**70**	**67**	**75**	**69**
14	ESF SANTA MARIA	**11**	**0**	**67**	**100**	**89**	**78**	**57**	**75**	**67**
15	ESF PERIMIRIM	**25**	**33**	**33**	**75**	**71**	**80**	**50**	**25**	**67**
16	ESF ATURIAÍ II	**40**	**36**	**54**	**50**	**50**	**69**	**86**	**80**	**64**
17	ESF ATURIAÍ I	**0**	**9**	**40**	**50**	**47**	**50**	**53**	**50**	**64**
18	ESF NOVA OLINDA I	**29**	**33**	**22**	**0**	**25**	**71**	**50**	**75**	**50**
19	ESF TREVINHO	**0**	**0**	**0**	**75**	**57**	**75**	**78**	**60**	**50**
20	São Benedito Family Health Program	**73**	**75**	**50**	**69**	**82**	**87**	**50**	**75**	**45**
21	ESF TRAVESSA DO DEZ	**38**	**0**	**33**	**56**	**36**	**60**	**78**	**57**	**44**
OVERALL SCORE FOR THE MUNICIPALITY OF AUGUSTO CORRÊA (0–100)		**26**	**33**	**48**	**66**	**56**	**66**	**53**	**45**	**72**

Source: Adapted from the SISAB indicator panel[31].

The first indicator analyzes the proportion of pregnant women with at least six visits, from the 1st to the 12th week[31]; as shown in Table 1, the municipality exhibited critical rates in terms of early enrollment and continuity of care. In the first four-month period (Q1) of 2022, the municipal average was only 26%[31], with the Vila Nova, Araí, and Zé Castor Family Health Units (ESFs) scoring zero. Following the implementation of the Nascer Urumajó Program, there was an increase in compliance with the indicator; in Q3 of 2024, the municipal average reached 72%, and units that previously had zero performance, such as the Vila Nova Family Health Center (ESF), reached 75%[31], others, such as the Buçu and Nova Olinda II Family Health Centers (ESF), reached peaks above 90%[31].

Table 2. Percentage data for the 2nd Previne Brasil indicator: proportion of pregnant women tested for syphilis and HIV

	FAMILY HEALTH STRATEGIES	2022			2023			2024		
		Q1 (%)	Q2 (%)	Q3 (%)	Q1 (%)	Q2 (%)	Q3 (%)	Q1 (%)	Q2 (%)	Q3 (%)
1	ESF Vila Verde	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
2	ESF São Benedito	**91**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
3	ESF HEADQUARTERS	**86**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
4	ESF PERIMIRIM	**88**	**93**	**89**	**100**	**100**	**93**	**100**	**100**	**100**
5	ESF BUÇU	**80**	**89**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
6	ESF ITAPIXUNA	**82**	**82**	**100**	**100**	**100**	**94**	**100**	**100**	**100**
7	ESF PRATIAÇU	**67**	**100**	**82**	**100**	**95**	**91**	**92**	**100**	**100**
8	São João Family Health Program	**36**	**91**	**100**	**92**	**100**	**100**	**100**	**100**	**100**
9	ESF ARAI	**83**	**43**	**91**	**100**	**100**	**100**	**100**	**100**	**100**
10	ESF NOVA OLINDA I	**47**	**58**	**89**	**100**	**100**	**100**	**100**	**100**	**100**
11	ESF ATURIAÍ I	**82**	**45**	**80**	**80**	**94**	**100**	**94**	**100**	**100**
12	ESF ZÉ CASTOR	**50**	**38**	**89**	**92**	**90**	**100**	**100**	**100**	**100**
13	ESF NOVA OLINDA II	**29**	**56**	**78**	**100**	**100**	**100**	**100**	**100**	**100**
14	ESF CIDADE NOVA	**90**	**100**	**95**	**100**	**100**	**97**	**100**	**94**	**100**
15	ESF PATAL	**70**	**94**	**100**	**100**	**89**	**100**	**100**	**93**	**100**
16	ESF LÍRIOS DO VALE	**100**	**77**	**94**	**92**	**100**	**100**	**100**	**93**	**95**
17	ESF Vila Nova	**0**	**0**	**100**	**100**	**100**	**100**	**92**	**100**	**94**
18	ESF ATURIAÍ II	**80**	**79**	**85**	**100**	**100**	**100**	**100**	**100**	**86**
19	ESF TRAVESSA DO DEZ	**88**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**81**
20	ESF SANTA MARIA	**33**	**50**	**100**	**100**	**100**	**89**	**100**	**100**	**78**
21	ESF TREVINHO	**0**	**0**	**0**	**100**	**100**	**100**	**100**	**100**	**50**
OVERALL SCORE FOR THE MUNICIPALITY OF AUGUSTO CORRÊA (0–100)		**56**	**79**	**94**	**98**	**97**	**98**	**83**	**74**	**96**

Source: Adapted from the SISAB indicator panel[31].

The second indicator examines the proportion of pregnant women tested for syphilis and HIV[31], measuring the effectiveness of screening for vertically transmitted infections. In 2022, the municipal average in Q1 was 56%[31]; Family Health Units (ESFs) such as Trevinho and Vila Nova did not report data. By 2024, testing had become universal, and the municipal average in Q3 of 2024 reached 96%[31]. The vast majority of units, including those in rural areas such as the Vila Verde and Buçu Family Health Units (ESFs), maintained 100%[31] coverage during several four-month periods in 2024.

Table 3. Percentage of the 3rd Previne Brasil indicator: proportion of pregnant women who received dental care

	FAMILY HEALTH STRATEGIES	2022			2023			2024		
		Q1 (%)	Q2 (%)	Q3 (%)	Q1 (%)	Q2 (%)	Q3 (%)	Q1 (%)	Q2 (%)	Q3 (%)
1	ESF NOVA OLINDA I	**7**	**42**	**67**	**90**	**88**	**86**	**100**	**100**	**100**
2	ESF NOVA OLINDA II	**29**	**56**	**100**	**83**	**87**	**75**	**100**	**100**	**100**
3	ESF Vila Nova	**0**	**0**	**100**	**67**	**80**	**83**	**100**	**100**	**100**
4	ESF HEADQUARTERS	**100**	**100**	**100**	**95**	**100**	**100**	**100**	**100**	**100**
5	ESF SANTA MARIA	**89**	**100**	**100**	**100**	**89**	**100**	**100**	**88**	**100**
6	ESF SÃO JOÃO	**71**	**82**	**89**	**77**	**100**	**100**	**95**	**87**	**100**
7	ESF ITAPIXUNA	**65**	**82**	**95**	**100**	**94**	**82**	**100**	**80**	**100**
8	ESF CIDADE NOVA	**90**	**100**	**95**	**59**	**71**	**94**	**90**	**76**	**100**
9	ESF Vila Verde	**100**	**100**	**100**	**100**	**100**	**80**	**100**	**60**	**100**
10	ESF PRATIAÇU	**8**	**25**	**36**	**36**	**40**	**77**	**69**	**100**	**94**
11	ESF ZÉ CASTOR	**25**	**62**	**95**	**100**	**71**	**60**	**100**	**85**	**94**
12	ESF ATURIAÍ I	**18**	**55**	**93**	**80**	**95**	**90**	**88**	**100**	**93**
13	ESF BUÇU	**80**	**78**	**87**	**100**	**100**	**100**	**100**	**100**	**93**
14	ESF PATAL	**60**	**65**	**94**	**81**	**100**	**91**	**93**	**93**	**93**
15	ESF ARAI	**50**	**71**	**100**	**100**	**100**	**100**	**91**	**100**	**91**
16	ESF LÍRIOS	**88**	**77**	**94**	**92**	**93**	**100**	**93**	**93**	**89**
17	ESF PERIMIRIM	**75**	**87**	**89**	**75**	**88**	**93**	**93**	**75**	**89**
18	ESF ATURIAÍ II	**20**	**43**	**69**	**50**	**64**	**69**	**100**	**100**	**86**
19	São Benedito Family Health Program	**91**	**92**	**88**	**100**	**100**	**93**	**75**	**92**	**82**
20	ESF TRAVESSA DO DEZ	**88**	**100**	**100**	**100**	**93**	**87**	**100**	**71**	**81**
21	ESF TREVINHO	**0**	**0**	**0**	**100**	**100**	**100**	**100**	**100**	**50**
OVERALL SCORE FOR THE MUNICIPALITY OF AUGUSTO CORRÊA (0–100)		**50**	**75**	**89**	**88**	**86**	**88**	**79**	**66**	**93**

Source: Adapted from the SISAB indicator panel[31].

The third indicator shows the proportion of pregnant women receiving dental care[31], measuring the comprehensiveness of oral health care during pregnancy. In 2022, coverage was only 50% in Q1, with the Trevinho and Vila Nova Family Health Units (ESF) recording no data for this indicator[31]. In 2024, the municipal average rose to 93% in Q3[31]. The incentive provided by the Nascer Urumajó Program — which made a dental checkup a mandatory requirement for the layette — was fundamental to strengthening compliance with the indicator; the Sede Family Health Strategy (ESF) and the Santa Maria Family Health Strategy (ESF) met 100% of their obligations[31].

The results observed during the analyzed period, 2022–2024[31] , show significant progress: the first Previne Brasil indicator — the proportion of pregnant women who had at least six prenatal visits, with the first occurring between the 12th week of pregnancy — rose from 26% to 72%; Previne Brasil's second indicator — the proportion of pregnant women tested for syphilis and HIV

— rose from 56% to 96%, and Previne Brasil's third indicator—the proportion of pregnant women who received dental care — rose from 50% to 93%, signaling not only a quantitative improvement, but also the consolidation of an evidence-based management approach, with the potential to optimize resource allocation, improve team planning, and enhance the local system's response capacity.

The increase in compliance with the Previne Brasil indicators and municipal prenatal care standards underscores the significant impact that the development of a structured public health policy has on the lives of SUS users. The implementation of the Program, featuring care pathways and an integrated multidisciplinary network[19] led to an increase in federal funding transferred to the Municipal Health Department and the municipality of Augusto Corrêa. The best practices implemented in the municipal public health sector led, from 2022 to 2024, to an increase in transfers from the National Health Fund to the Municipal Health Fund from R$ 15,190,000.00 to R$ 30,110,000.00, according to the InvestSUS dashboard[31].

An analysis of data extracted from SISAB[33] demonstrates the effectiveness of the Nascer Urumajó policy in addressing gaps in healthcare and improving the quality of maternal and child care.

Health Law and the Unified Health System: Primary Care Policy for Prenatal Care and Maternal and Child Health, and Municipal Government Capacity

Public health initiatives and services form part of a regionalized and hierarchical network, organized as a Unified Health System, guided by three structural principles in accordance with Article 7 et seq. of Law No. 8,080/90: I. Decentralization, with a single leadership structure at each level of government; II. Comprehensive care, with priority given to preventive measures, without prejudice to curative care; and III. Community participation.

These guidelines form a model of public health law that aims to combine federal coordination, administrative rationality, and social oversight, constituting the normative core of the SUS. Responsibility for implementing these actions and services is divided among the various levels of government and their agencies, in accordance with the framework proposed by Krishina Ribeiro and Taissa Damasceno[34], as well as Campos[35].

Even in the early years of the constitutional consolidation of the right to health, Sueli Gandolfi Dallari[24] warned that its effectiveness could not be reduced to the mere creation of services or the quantitative expansion of healthcare provision. On the contrary, ex iged the construction of a distinct legal framework capable of supporting, protecting, and promoting public health in a continuous and structured manner. The author's warning remains relevant today, as this institutional framework continues to be marked by federal territorial asymmetries, which are particularly evident in peripheral and vulnerable regions of the country, such as the municipalities of the Amazon.

At the federal level, public health policies reveal a structural tension between the constitutional division of powers and the effective implementation of actions in the face of fiscal constraints[24]. At the state level, the municipality the entity constitutionally responsible for the direct implementation of basic health care is the institutional space where the contrast between the vulnerability of the populations served and the state's available capacity to respond to these demands is most acutely manifested.

The Primary Care Policy for Prenatal, Maternal, and Child Health Care[36] addresses this vulnerability by providing care for pregnant women, postpartum women, and children in their first

months of life[36]. That is why one of the Ministry of Health's main objectives is to strengthen Maternal and Child Health Care Networks throughout the country and reduce the still-high rate of maternal and child morbidity and mortality in Brazil[36].

Consequently, regulations regarding legal certainty must be aligned with the internal flow of government procedures. This alignment is crucial for promoting habits that contribute to the baby's health; for identifying risk factors; and for formulating prevention strategies based on epidemiological evidence and treatments for morbidities[36].

Since prenatal care is an essential phase of health care during pregnancy, continuous monitoring by health professionals enables the early identification of risk factors that could compromise the health of the pregnant woman and the baby. In addition to providing essential guidance on necessary care and potential risks during this period, it ensures greater safety for the mother and the newborn[36].

In Brazil, approximately half of pregnant women have more than six prenatal visits, while in the North and Northeast regions, this percentage is about 40%[37]. The Ministry of Health recommends a minimum of six visits during pregnancy, with the first occurring in the first trimester and monthly visits through the 34th week[36]. Despite the challenges, studies indicate that prenatal care coverage in Brazil exceeds 90%[37], with more than 75%[36] of pregnant women beginning care before the 16th week, highlighting the positive impact of this policy on the promotion of maternal and child health[37].

In the Northern region, geographic dispersion, transportation and communication challenges, and a shortage of specialized professionals exacerbate the obstacles to monitoring and meeting health indicators as is the case in the Basic Riverine Health Units[38].

The consolidation of health law as an autonomous legal field in Brazil is due, to a large extent, to the contributions of legal scholars such as Lenir Santos[22] and Fernando Aith[23], who for decades have advocated for the need to strengthen studies on the specific body of law focused on public health. This theoretical approach views health law as a cross-cutting branch of public law, responsible for providing a legal framework for health policies, regulating jurisdictions, defining intergovernmental responsibilities, and ensuring the implementation of the constitutional principles of the SUS[22, 23].

Ohlweiler's contributions[39], in addressing the social history of police power, the author argues that state action in health cannot be limited to a merely normative or control-oriented logic but must incorporate a socio-legal dimension capable of recognizing the different contexts o vulerability and the unequal effects of public health measures on certain population groups.

From Ohlweiler's perspective[39], public health policing power serves as an instrument for protecting public health, especially in contexts of vulnerability and emergency, from a human rights perspective. Thus, public health policing authority comes to be understood not only as a limitation on individual freedoms but as an instrument for promoting social justice, reducing inequalities, and improving institutional responses in public health crisis scenarios.

Recognizing the municipality's leading role in realizing the right to municipal health, state capacity also known as "governance capacities" refers to the abilities of federal entities regarding the selection and definition of strategies for the efficient allocation and management of resources, as well as the mobilization of and contributions from the population toward management[40]. Defined as

policy-capacity, it is a set of competencies and resources essential for the implementation of public policies by the government[40].

According to Menicucci[41], the implementation of public policy involves a process of adaptation in the face of constant changes resulting from the very autonomy of public authorities in the decision-making process. Betranou[42] aligns with this framework by stating that state capacity does not imply only the outcomes produced; it is also associated with the necessary and satisfactory conditions that make it possible to achieve the expected results.

Primary Health Care (PHC) is the main gateway to the Unified Health System (SUS) and plays a strategic role in ensuring universal access and comprehensive care. The National Primary Care Policy (PNAB), established by Administrative Order No. 2,436/2017[43], constitutes the main regulatory framework for Primary Care, as it revises its guidelines and reaffirms its role as the organizing force for health care networks and the preferred entry point to the SUS.

SISAB, the official Primary Care information system for the purposes of financing, monitoring, and adherence to PNAB programs and strategies, demonstrates progress in the standardization, reliability, and strategic use of health data within the primary care setting. The system aims to improve the management of health information through process automation, improvements in technological infrastructure, and the refinement of work processes for Primary Care teams, thereby strengthening the capacity to plan, monitor, and evaluate actions carried out in the regions[44].

The establishment of the Previne Brasil Program, through Administrative Order No. 2,979/2019, modified the PHC financing model by replacing the strictly per capita criterion with a model based on population registration, performance on specific indicators, and incentives for strategic actions. Subsequently updated in 2024 and 2025, the program began to link a significant portion of federal transfers to the achievement of targets related to access, quality, and effectiveness of primary care, thereby strengthening transparency and accountability in health management[45].

By establishing seven national performance indicators, Previne Brasil reinforces the central role of municipal government capacity and local institutional arrangements in realizing the right to health, highlighting that the sustainability of the SUS depends, to a large extent, on the coordination between financing, governance, and institutional frameworks at the local level[28].

Public Policy on Primary Care for Prenatal and Maternal-Child Health: The Nascer Urumajó Program and Municipal Law No. 1,994/2023 in the Municipality of Augusto Corrêa

The Nascer Urumajó Program is a public health policy of the municipality of Augusto Corrêa, Pará, that implements initiatives to provide access to quality prenatal care that ensures a healthy pregnancy and a safe delivery. The program began in 2022, when the municipality recorded 14 preventable deaths among children under five[46] and it was found that the absence of a structured prenatal care policy resulted in inadequate monitoring of pregnant women and the failure to identify cases of preventable mortality.

With the advancement of this public policy, the initiative was institutionalized by Municipal Law No. 1,994/2023[19]. This municipal legislation, aligned with the Sustainable Development Goals[7], established in the municipality an initiative to promote safe prenatal care through the "Nascer Urumajó" program, which constitutes a public policy measure aimed at consolidating the right to a healthy pregnancy and a safe childbirth.

The Nascer Urumajó Program has as its defined objective, as set forth in Article 4 of the Municipal Law, to ensure the promotion and maintenance of physical and emotional well-being throughout pregnancy through humane and high-quality care. This objective is fundamental to maternal and neonatal health, achieved through the implementation of measures to monitor pregnancy and encourage the completion of all necessary tests, in order to reduce preventable complications during prenatal care, ensure compliance with the basic requirements for prenatal care as recommended by the Ministry of Health, and meet the goals established by the "Previne Brasil" Program[45].

These facilities provide qualified and continuous health care for women during the prenatal and postpartum periods, working to prevent maternal deaths, miscarriages, stillbirths, neonatal deaths, and sequelae resulting from complications occurring during pregnancy and the postpartum period.

The Program also has an integrated protocol[47] that outlines the approach every Family Health Strategy (ESF) must follow to ensure that prenatal care policies are implemented. Implementation is structured through an integrated multidisciplinary network, whose responsibilities are legally defined and standardized by municipal clinical protocols[20,49], with municipal management responsible for ensuring the necessary budgetary allocation and intersectoral coordination for the policy's sustainability[30,48], with the Primary Care Coordination Office responsible for the continuous monitoring of indicators and the organization of referral pathways, especially for the management of high-risk pregnancies[30,48].

At the point of care, physicians and nurses are responsible for providing longitudinal care, ensuring a minimum of seven scheduled visits, gestational risk stratification, and the prescription of mandatory prophylaxis[19]. Comprehensive care is reinforced by the work of dental surgeons, who are required to provide three quarterly visits focused on preventing sources of infection, and by a multidisciplinary team (nutritionists and psychologists), which is activated based on criteria of clinical or social vulnerability[19].

Operational support is provided by nursing technicians during triage and vaccination, and by community health agents (ACS), who play a key role in early identification and active case finding[19] . Finally, intersectoral collaboration is realized through a partnership with Social Services (SEMAS) to manage the program's incentive logistics[19,47].

The Program introduces a new feature to the prenatal care policy: the possibility for pregnant women to receive a layette as an incentive to ensure they comply with all the requirements set forth in the municipal prenatal care policy, as determined by Article 6 of the Law[19]. As an incentive, a standard baby bag is provided as a gift at the end of the pregnancy to expectant mothers, except in exceptional cases that are duly substantiated with supporting documentation submitted with the application justifying their noncompliance[19].

The structure of this Program meets the requirements of the 2025 federal "Saúde Brasil" funding model, ensuring early achievement of critical performance targets[32,47]. The requirement for early enrollment (Goal A) is met by the legal requirement to begin prenatal care by the 12th week to be eligible for the maternity kit benefit; the continuity of care (Goal B) is ensured by the requirement for at least seven alternating visits with a doctor and a nurse[31,32,47], clinical monitoring of blood pressure and anthropometry (Goals C and D) is integrated into the screening and clinical consultation protocols at all visits[32,42].

In the context of laboratory and immunological surveillance (Goals F, G, and H), the policy requires that rapid tests for syphilis, HIV, and hepatitis be conducted during the recommended trimesters and that the adult-type acellular triple bacterial vaccine (dTpa) be administered as conditions for remaining in the program[32,47]. In addition, the program exceeds national oral health targets (Target K), requiring three dental visits instead of just one educational session. Continuity of care during the postpartum period (Goals I and J) is ensured by protocols for early follow-up and home visits to support breastfeeding[32,47].

Public policies as legal-institutional arrangements: from modeling to the importance of adaptive flexibility in the Nascer Urumajó Program

The replication of public policies in different territorial contextsneven within the same region poses a complex challenge for government management. The transfer of state intervention models between different localities requires not only the simple replication of actions but also an understanding of various aspects, such as legal, institutional, and public policy modeling elements[28].

Regarding the possibilities for replicating public policy, the regulatory framework must serve as a tool for structuring government action; and the legal-institutional arrangement must serve as *the* foundation for public and public-private relations in public policy. From a legal perspective, public policies represent programs of state action resulting in regulated processes that coordinate the resources available to the state and private activities to achieve socially relevant and politically determined objectives[48].

Regulatory modeling refers to the set of norms, procedures, and institutions that govern state activity. Regulation is, in fact, the contextual administration of legal and sub-legal norms; it involves the selection of institutional models that define the distribution of powers, the coordination among different levels of government, and the instruments of state coordination[49].

The choice of model decisively influences the possibilities for replicating public policies[27]. Centralized models, with strong central coordination and the establishment of minimum standards, tend to facilitate the vertical replication of policies but may hinder adaptation to specific local contexts. On the other hand, decentralized models, which grant significant autonomy to local contexts, allow for greater adaptive flexibility; however, in many cases, they will essentially require more robust local institutional capacities and effective cooperation mechanisms[50].

The material foundation of public policies, the locus of relationships, is the legal-institutional framework, comprising the aggregate of provisions, measures, and initiatives surrounding government action, as well as the institutions involved and the way they relate to one another; this framework is legally expressed through sets of norms produced at different times, at different levels of government, and with different legal natures[51].

Public policies, as institutional arrangements, involve dynamic processes with coordination and articulation mechanisms that are governed by or recognized under the law, capable of ensuring the arrangement's continuity and the achievement of the desired effects[49]. To ensure their effectiveness and the achievement of their intended results, as well as in cases of replication, they must address three analytical levels: a) the macro-institutional level, which deals with the general regulatory framework and the distribution of powers; b) the meso-institutional level, focusing on the legal-institutional arrangements themselves; and c) the micro-institutional level, which analyzes fragmented action and intersubjective relationships[51].

The study's findings indicate that the observed performance is associated, first and foremost, with a cross-cutting policy structured around the coordinated action of multiple municipal agencies, notably those responsible for social assistance, women's policies, administration and finance, education, and legal and institutional advisory services. This intersectoral approach served as a mechanism for efficiency by reducing decision-making fragmentation, providing greater administrative predictability, and strengthening the legal and institutional security necessary for the program's continuity, including its regulatory institutionalization.

Second, the program established itself as a new model for maternal and child care, based on the creation of a multidisciplinary network and care pathways/protocols focused on prevention and the systematic monitoring of pregnancy. The integration among professionals and services (doctors, nurses, and other health support staff) fostered a more consistent standard of care and monitoring, helping to reorganize care practices and reduce variability in access to and the quality of care provided.

This study analyzes the experience through the dual interpretive lens of state capacity and the capacity for arrangements. On the one hand, state capacity was evident in the municipality's ability to conceive, coordinate, institutionalize, and manage a public health policy with a unique design, compatible with the territory and local constraints[48]. On the other hand, the capacity for institutional arrangements was expressed in the ability to combine instruments and incentives, organize workflows, and mobilize intersectoral actors, producing verifiable performance and, consequently, better conditions for sustainability, especially in a federal system where the acquisition and maintenance of resources depend, in part, on the achievement of results[50].

This is a successful initiative due to the chosen model and the definitions of its legal and institutional framework, as well as the three analytical levels. In fact, its replicability will require adapting its elements, actors, norms, channels of relational communication, etc. to account for local specificities and contexts, combined with the institutional robustness of coordination mechanisms and the adaptive flexibility of the legal-institutional frameworks, to ensure political and operational sustainability.

This experience has the potential to be replicated in other Amazonian municipalities, provided that local specificities are respected. What proves to be replicable is not a rigid model, but rather the structural elements of the policy**:** indicator-driven planning, integration between management and health teams, strategic use of federal funding incentives, and a priority focus on maternal and child health as the backbone of primary care. These elements constitute a relevant institutional lesson for contexts marked by similar administrative limitations and logistical challenges.

Final Considerations

The Nascer Urumajó Program, in the municipality of Augusto Corrêa, Pará, is a public policy for primary care focused on prenatal care and maternal and child health, implemented through the establishment of institutional arrangements capable of coordinating actors, tools, and resources around measurable health objectives.

The analyzed data show a progressive improvement in strategic indicators related to prenatal follow-up, care for pregnant women, and comprehensive early childhood care, demonstrating that the municipal public policy was able to translate abstract national guidelines into administratively tailored local practices. This result stems not only from formal compliance with federal targets but

also from a unique institutional design, guided by the identification of local vulnerabilities, the reorganization of primary care workflows, and the centrality of pregnant women and children as rights-holders.

The interventions under the Previne Brasil Program can mitigate structural inequalities, particularly those observed in small municipalities in Brazil's Northern region, which are characterized by socioeconomic limitations and historical difficulties in accessing essential public services.

This research fills analytical gaps by linking constitutional norms, public policies, and institutional performance, offering relevant insights for both the academic debate on improving public health policies in Amazonian municipalities and the strengthening of local leadership. As Previne Brasil indicators evolved between 2022 and 2024, a reduction in infant mortality was observed, aligning institutional arrangements and management processes to generate coordinated services for promotion, protection, and recovery within the state's capacity.

Considering research on the replicability of this municipal public policy model, the evolutionary analysis indicates feasibility; however, this is not automatic, as it depends on the presence of specific structural, regulatory, and administrative conditions. Thus, simply importing the model without local contextual adaptations may compromise its effectiveness and its adherence to the principles of universality and regionalization inherent to the SUS.

This is a dynamic process of adaptation, shaped by discretionary choices, institutional negotiations, and continuous reconfigurations, in which formulation and implementation often overlap. In the field of health, the implementation of public policies cannot be understood as the mere mechanical execution of previously made decisions; it must also be analyzed in light of its capacity for replication in different territorial contexts, which requires institutional flexibility, regulatory adaptation, and compatibility with local government capacities.

It reinforces the leading role of Amazonian municipalities as spaces for innovation and the realization of social rights, demonstrating that, even in the face of structural constraints and a shortage of human and financial resources, it is possible to develop more efficient, coordinated and dignified public health policies, provided they are supported by intersectoral governance, a multiprofessional network, and systematic monitoring of outcomes.

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Authors' Contributions

M.C. Vasconcelos: conception/design of the article, data analysis and interpretation, writing of the article and approval of the final version of the article.
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