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Implementation of the Indigenous Health Policy: an ethnographic analysis of healthcare practices in the Upper Solimões River

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Abstract *This study analyzes the implementation of the Indigenous Health Policy, focusing on the care practices of health teams of the Indigenous Health Care Subsystem in the Upper Solimões River in the Amazon region. Using ethnography as a methodological resource, the dynamics among participants, discourses, and power in the implementation of the policy are investigated, revealing a complex interconnection between practices and other contextual realities. Three phenomena emerge as critical influences on care practices: the medical-care model, the sanitation model, and the culture of performance. The medical-care and sanitation models are perpetuated. The culture of performance introduces a control paradigm based on quantitative indicators and pre-defined goals, affecting professional identity, social interactions, and the effectiveness of actions. On the margins of the institution, other daily practices are induced by temporal needs, subjective feelings, and local networks of power, thus challenging social structures and conventions. The Indigenous Health Policy was reformulated by practices influenced by old policies and was remodeled by techniques induced by bureaucracy, distancing itself from its ideological agenda.*
Key words *Indigenous health services, Health policy, planning and management, Healthcare models*

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Introduction

Twenty years after the National Policy for Healthcare for Indigenous Peoples (*Política Nacional de Atenção à Saúde dos Povos Indígenas* - PNASPI)[1] was developed, studies that tangentially address its implementation[2-4] indicate that one of its effects was the increase in the hiring of healthcare professionals to work in Indigenous areas, which facilitated the Indigenous population's access to healthcare services. However, as indicated in a report by the Office of the Comptroller-General (CGU)[5], although the Indigenous Health Care Subsystem's (*Subsistema de Atenção à Saúde Indígena* - SasiSUS) budget was directed mainly towards hiring healthcare professionals, the actions undertaken by its executing body, the Special Office for Indigenous Health (*Secretaria Especial de Saúde Indígena* - SESAI), failed to produce tangible results regarding the benefits of implementing the PNASPI, indicating possible problems in the subsystem management and care model.

The concept of public policy analysis adopted by public agencies, such as the CGU, leads us to the classic perspective of policy cycles[6,7], characterized by the sequential analysis of its phases, such as agenda formation, formulation, implementation, evaluation, and termination. According to the model logic, each phase involves different processes; hence, the formulation period would be the result of political action or influence from interest groups (politics), while its implementation would be the responsibility of the state technocracy (policy). This view assumes that government action is coordinated by experts and technocratic knowledge, operating in a rigid hierarchical structure, guided by rational goals, values, and objectives.

This idea of a policy cycle has been criticized for overestimating the strictly rational nature of the political process and for neglecting the coercive role of institutions and the individual strategies of the actors involved in the formulation and implementation of public policies[8]. Stephen Ball's approach[9,10] breaks with the functionalist perspective and proposes an interpretative analysis based on Foucault's theories of power and Bourdieu's notions of field. For the author, the split between the formulation and implementation of public policies reinforces a fictitious ideology that separates politics and practice, assigning greater importance to the former.

Ball emphasizes that policies are not only applied, but they also reinterpreted, negotiated, and shaped by the institution's micropolitical processes and the actions of professionals at the local level. He proposes an interrelated and non-linear analysis of the three main contexts that influence public policies: (1) the context of influence that translates as political action and that is generally attributed to the period of agenda preparation, but which, according to the author, permeates the entire implementation; (2) the context of text production that represents the policy itself and uses a language of broader public interest, which can be understood through institutionalized speeches and documents; and (3) the context of practice in which public policies are interpreted and recreated by subjects in interaction with old, already established policies.

Therefore, policy executors actively shape their directions. In this process, policy can be reconfigured and move away from its original formulation. From this perspective, the present study aimed to understand the process of implementing the Indigenous Health Policy in the region of the Upper Solimões River, based on the analysis of care practices provided by healthcare teams. By examining the final actions in SasiSUS, we can understand how policies are reinterpreted, negotiated, and shaped at the local level. This case study offers a perspective through which public policies can be evaluated and reformulated in a more informed and contextualized manner.

Methods

This is a qualitative study with an ethnographic approach conducted in conjunction with the healthcare services provided by the Upper Solimões River Special Indigenous Health District (*Distrito Sanitário Especial Indígena Alto Rio Solimões* - DSEI ARS), located in the western region of the State of Amazonas, on the triple border connecting Brazil, Colombia, and Peru. The DSEI serves the largest Indigenous population in the Amazon and has a large team of healthcare professionals. Health services are also organized in a structured and continuous routine in Indigenous areas.

This is an ethnographic study guided by the conceptual and methodological approach of ethnographies in organizations explored by Teixeira and Castilho[11], which seeks to understand organizational spaces as producers of knowledge, taking as reference the concepts and values experienced by the subjects in the organization. Ethnographic moments aim to capture the organization's language through documents (reports,

forms, standards, etc.), interviews, informal conversations, and participant observation.

This study took place over a 12-month period. The fieldwork was conducted in the DSEI management sector and in healthcare units at an Indigenous Healthcare Base Hub (*Polo Base* - PB) in the Indigenous territory, totaling 3 months of observation. To preserve the participants' anonymity, the PB was not specifically identified. Healthcare in the villages is provided by teams called Multidisciplinary Indigenous Healthcare Teams (*Equipes Multidisciplinares de Saúde Indígena* - EMSI) linked to the PB and comprised of doctors (4), nurses (11), dentists (4), psychologists (1), pharmacists (1), nutritionists (1), laboratory technicians (4), nursing technicians (20), oral health technicians (2), oral health assistants (2), Indigenous health agents (55), and Indigenous sanitation agents (4). The DSEI management team consisted of 14 healthcare professionals, the majority of whom (8) were from the nursing field.

The data were recorded in a field logbook, along with photos, videos, and interviews with 25 professionals from the PB and 13 professionals from the DSEI headquarters. Copies of documents used daily for planning and recording the teams' production were also collected. The documents were approached considering their production, materiality, effects, and meanings[12], and emphasized their capacity to generate interpretations when appropriated by the other actors in the network of people within the organization. By treating them as subjects mediating social relations[13], we avoided classifying them as mere repositories of objective data.

This study's results enabled a descriptive and explanatory analysis by investigating the models and strategies that guide care practices in the DSEI. We then conducted an interpretative analysis focused on the relationship between the Indigenous Health Policy practices and the institutional routine. In this approach, the organization is considered to be a locus of culture, that is, a socially established structure of meaning[14], incorporating into the analysis the perspectives of the participants about the observed phenomena, taking into account the social, political, cultural, and historical context that gives them meaning.

This study was approved by an Ethics Committee (CAAE 64583822.5.0000.5016).

Results

Healthcare team and work routines

Healthcare in the communities is provided by health teams linked to the PB, in the Indigenous territory, and is managed by other professionals based at the DSEI headquarters, in Tabatinga. The health teams were either based at the main health unit in the PB or located in Basic Indigenous Health Units (*Unidades Básicas de Saúde Indígena* - UBSI) that cover communities further away from the main unit and along the tributaries of the Solimões River.

The teams were divided into two main categories: (1) professionals who remained in the Indigenous area for defined periods and (2) Indigenous professionals who lived in villages assigned to the DSEI. Those in the first group worked on a 30-day shift in Indigenous areas, followed by 15 days off. Local professionals worked 8 hours a day from Monday to Friday. There was at least one Indigenous Health Agent (*Agente de Saúde Indígena* - AIS) hired in each community. Larger communities might have had over 20 of these professionals. Most professionals were nurses and nursing technicians. Throughout most of the data collection period, no physicians had been hired to provide care. However, these professionals had been reinstated into the team at the end of the field investigation.

The health team was organized to provide care both at the facility and on itinerant visits to the villages within its territory. In the units, procedure-centered practice guided the team's routine. Priority was given to emergency care, as reflected in urgent/emergency assistance provided, and appointments on spontaneous demand. Furthermore, the routine was also organized around programmatic actions aimed at specific groups, especially for prenatal and childcare services, and vaccination.

During visits to villages, professionals improvised their work in schools or churches, providing care to the population screened by the AIS. The activities were similar to those held in the healthcare unit but fewer supplies were available. Lectures, dental appointments, and other oral health activities varied by micro-area. Home visits were less frequent and focused on newborns, the elderly, or patients with some severity identified by the AIS.

At night and on weekends, teams were on call to respond to emergencies and worked on entering data into the Indigenous Healthcare Informa-

tion System (*Sistema de Informação da Atenção à Saúde Indígena* - SIASI) or filling out production spreadsheets.

Healthcare practices

Health practices in the PB units were divided into preventive actions, such as planned campaigns and activities based on biomedical knowledge, and individual assistance actions, including predominantly curative clinical appointments, care for spontaneous demands, and prenatal and postpartum care. Although these types of services are mixed in the daily routine, they are effectively distinguished in the recording strategies adopted at DSEI.

Spontaneous demand services were medical or nursing appointments aimed at evaluating, diagnosing, and treating the health conditions of Indigenous people, based on their complaints, called "morbidity appointments". The name refers to a practical reason in the organization of the work routine: this type of appointment generates data to complete in the "General Data Form for Confirmed Cases of Morbidity", the content of which is inserted in the "morbidity" module of SIASI, from which it would be possible to extract information about the population morbidity profile.

Furthermore, prenatal and childcare appointments, or even home visits by the healthcare teams, also generated records in the morbidity form. In these cases, professionals recorded the appointment as "Contact with healthcare service" (Chapter XXI of the International Classification of Diseases - ICD-10). Therefore, all care could be recorded on this form and professionals kept it with them at all times so as not to miss the opportunity to record it.

According to the interviewees, the records were used to prove the team's performance – number of appointments conducted – and as backup information in case they were called upon by other agencies, such as the Office of the Attorney General. They did not conduct a systematic analysis of the morbidity profile generated from the records and, therefore, epidemiological information was not commonly considered a strategic source for planning the PB activities. This does not mean, however, that such a profile was ignored, as some activities were guided by personal and empirical observations of the diseases and illnesses that affected the population. Furthermore, the DSEI headquarters had professionals whose daily duties included data analysis. Nevertheless, in the scope of service provision, the content of the analyses consisted more of monitoring the achievement of service targets.

In institutional documents, preventive actions were referred to as "primary care services" or "program actions". These were: vaccination; actions for the mother and child group, which included prenatal care, postpartum care, family planning, and control of malnutrition and other health problems; health education actions in the form of lectures, held at the unit or in the community; health surveillance actions focused on priority diseases; and health problems, such as sexually transmitted infections, tuberculosis, malaria, hypertension, diabetes, cervical cancer prevention; oral health actions; and, although incipient, some mental health actions.

Few interviewees knew or had read the PNASPI text and, to implement the programs, the majority said they sought support from sources such as the Health Surveillance Guide and the Basic Care Notebooks, published by the Brazilian Ministry of Health. However, they mentioned the lack of technical guides appropriate to the epidemiological and cultural profile of the Indigenous population. In this context, many relied on the knowledge shared by colleagues and their own experience.

The interviewees also said they were guided by the goals defined centrally by SESAI and supervised by DSEI "technical references" (RTs). The institution uses 37 cards (a term used to refer to SasiSUS forms) to record data on sheets of paper, which are later transcribed to SIASI or consolidated data spreadsheets sent directly to the RTs. The data generated contains information on services, procedures, and activities performed, allowing DSEI management to monitor healthcare professional performance in different areas and programs, as well as to feed other systems, such as the Management System for Agreements and Transfer Contracts (*Sistema de Gestão de Convênios e Contratos de Repasse* - SICONV), which informs the total number of services performed by professionals and categories.

For example: if an elderly person sought healthcare services and was treated at the unit, in addition to the individual medical record, the professional would be responsible for entering data originating from the appointment in the "Morbidity Form", as well as in the form corresponding to the population group, in this case, in the form of the "elderly healthcare program". While many elderly people experience situations of violence, suffer from mental disorders, and are

not exempt from diseases such as tuberculosis, diabetes, high blood pressure, and STIs, intersections or overlaps arise between program recording instruments, forcing nurses to fill out several forms. Professionals claimed difficulties in reconciling bureaucratic activities and the daily healthcare routine.

To better understand the dynamics of actions in this context, let us also take as an example the activities developed by the PB within the scope of the "Child Healthcare Program". The program is designed to reduce infant mortality from preventable causes, with the main strategy being to offer access to childcare appointments (Growth and Development - CeD) following the guidelines of the Child Health Booklet. The Ministry of Health recommends[15] seven appointments before the child's first year of life in periods that coincide with vaccination and testing. However, this number may be increased or reduced based on the child's vulnerability.

The established goal was to ensure that 60% of children under one year old have access to seven appointments by 2023. At the DSEI headquarter, the program's RT monitored this data in SIASI through a dashboard that showed the PB's progress toward the target. According to the records on the SIASI dashboard, the DSEI had not yet met the target. In 2020 and 2021, it reached 40% and 44% respectively, while 2022 recorded the highest coverage in the period, at 52%. Care professionals were informed about target results and then sought to create strategies, many of them individually, to improve their performance. In the consulted documents and in the interviews, no criteria for defining the established target were provided.

Some professionals claimed to be frustrated with childcare appointments, as they understood that Indigenous women were unable to understand the guidance given to them, for linguistic reasons and other factors that would require the nurse to have greater contact with the family's living conditions. However, they said they faced a significant burden of management activities that overlapped with assistance activities, diverting attention from the problems and challenges inherent in executing the actions.

In the DSEI management, programs also related to child health, such as vaccination and nutritional surveillance, were managed by different professionals, who monitored them independently from other programs. However, even though it operates in isolation, the vaccination program has clear objectives, well-defined target criteria, intervention protocols, training, and its own resources. A more accurate evaluation of the program generated feedback, and the professionals who worked on it felt more valued.

Practices on the margins of the organization

In the ethnographic process, our study identified other practices that conform to the organization but are not conceived in documents, guidelines, work processes, or official DSEI planning. Among these practices, we highlight territorialized planning, the functions of the PB coordinator, and urgent and emergency care.

Observing the activities of a nurse, it was noticed that her routine was different from that of other professionals. She frequently made house calls and made several stops during a boat trip. The stops had different purposes, such as monitoring specific cases, checking the health of newborns, collecting blood tests, or talking to the AIS. She once traveled by boat to care for a baby with diarrhea and possible malnutrition. During the visit, which lasted almost an hour, the nurse conducted a clinical analysis of the child, assessed the care provided by the mother, toured the house, interacted with the residents, and identified aggravating factors. She then provided guidance, such as using IV fluids and potable water, working closely with the family and the communitarian health agent resulting in a care adapted to local needs. To record this information, she used personal notes in a notebook and, upon returning to the unit, transcribed a summary into the child's medical record, abandoning the production forms at that time.

This experience differed from the approaches in individual appointments conducted daily in health units. In an interview, the nurse reported that she considered her role to be providing basic care to the community and that, in her perception, meant closely monitoring the population and trying to resolve problems before they worsened. She considered her performance good since no child died or became seriously ill to the point of being transferred to the city during the two years she had been working in that area. However, this required her to create a routine and a specific action plan for each community, but this was her initiative and not an institutional guideline.

Although the employee demonstrated dynamism, commitment to the population's needs, and autonomy in her work, the organizational

structure established in the workplace, centered on complaint-conduct appointments and quantifiable production, did not favor the adoption of a standard of care aimed at the early identification and prevention of health problems in individuals, families, and communities. Thus, identifying the main health problems of the population depended on the employee's personal engagement and not on expectations set forth by the organization.

Urgent and emergency care, which occurred quite frequently, was also not provided for in the organizational arrangements. Such care is crucial in Indigenous areas, where distance does not allow many patients at risk of death to be easily transferred to hospitals or Emergency Care Units (*Unidades de Pronto Atendimento* - UPAs). Although the main PB unit has a 24-hour infirmary/emergency room, this activity was not officially recognized as part of the work process of primary care units, since the healthcare system rules attribute urgent and emergency care to units in urban area, which are not part of the DSEI.

Employees, motivated by moral responsibility towards patients and given the persistence of these cases, take on the responsibility for providing care, even without official delegation or sufficient resources. To achieve this, the team follows a parallel shift system, balancing the routine in the unit and urgent/emergency care, which includes the night shift. As a result, even after working the night shift, the team followed the institutional routine the following day. Most interviewees considered emergencies as the main difference between working in a primary care unit in the city and in an Indigenous area and thus believed that those who choose to work in the DSEI should have some experience or training to deal with these situations.

The employees also organized themselves in a supportive manner to purchase and prepare meals for patients admitted to the unit ward and their companions. Furthermore, the unit serves as a hub for the departure and arrival of users from other communities who are scheduled for appointments at the municipal headquarters. Therefore, these individuals often spent the night in designated room within the unit, and the team also arranged food and lodging for these Indigenous users.

Additionally, the coordination of PB activities was informally handled by a nurse who served as the PB coordinator. However, this role was not officially recognized in the position profiles outlined in the Work Plan of the hiring entity. As a result, the PB coordinator is a nurse employed for direct care but is appointed by the DSEI administration to take on management responsibilities.

Because he was in close contact with healthcare teams, leaders, and local demands, the coordinator was the link between the PB and the DSEI headquarters. His activities were both tactical and operational aimed at aligning with DSEI strategies. This included official tasks, such as ensuring that logistics and scheduling ran smoothly and requesting production spreadsheets from the team. Additionally, he handled unofficial tasks, like sourcing necessary medicines for urgent and emergency care, which could not be procured through SasiSUS. This ability to secure essential medicines for the PB distinguished the coordinator and gave him distinction and power in relation to the others[16].

Discussion

Our study identified the presence of two key elements that are configured as care practice variable matrices: formal practices and informal practices. Their components were then classified into three axes. First, we listed the activities that occur regularly in the scenario of services performed by the local healthcare team. Based on this survey, we identified the predominant techniques, methods, and approaches. Then, to deepen our perception, we explored their meanings from the perspective of phenomena, mechanisms of action, and persistent elements that shape or characterize their practical and symbolic functions[16] (Chart 1).

Using Victor Turner's concept of structure and anti-structure[17], we considered formal practices as the roles and actions that reinforce the norms, values, and hierarchies intrinsic to the organization's structure. Informal practices are seen as anti-structure moments when norms are suspended and subjects can explore new forms of identity and interaction. In terms of organizational structure, care practices are guided by three main phenomena: the clinical-care model, the health campaigns model, and the culture of performance.

The logic behind organizing user care in the unit followed principles similar to those observed in primary care facilities in urban centers. Individual care is centered on the clinical-care model, although the lack of doctors in the region being frequent. This model continues to be a strong political and cultural influence in the

Chart 1. Components of care practices.

Formal Practices		
Activities	**Predominant techniques, methods, and approaches**	**Phenomena, mechanisms of action, and persistent elements**
Clinical consultation of spontaneous demands (complaint-conduct) - medical and dental	Management by productivity goals Individual support	Performance culture Medical care model
Prenatal and childcare consultations	Management by productivity goals Individual care Fragmentary practices of programmatic care	Performance culture Medical care model
Other Primary Care actions: immunization actions; actions for the mother-child group - prenatal and postpartum; family planning and control of malnutrition and other health problems; health education actions in the form of lectures held at the unit or in the community; health surveillance actions focused on some priority diseases and health problems, such as Sexually Transmitted Infections, Tuberculosis, Malaria, Hypertension, Diabetes, Cervical Cancer; oral health actions; and mental health actions.	Management by productivity goals Individual care Health campaigns Fragmentary practices of programmatic care	Performance culture Medical care model Sanitary model
Non-Formal Practices		
Activities	**Predominant techniques and approaches**	**Phenomena, mechanisms of action, and persistent elements**
Exchange of medicines	Meeetings with municipal managers	Individual empowerment
Urgent and emergency care	Medical and hospital care	Moral responsibility for action, solidarity between professionals and challenging existing norms
Hospitalization	Medical and hospital care	Solidarity between professionals Medical-hospital model
Patient food and accommodation	Embracement	Solidarity between professionals
Planning based on local health conditions	Scheduled care	Personal engagement
Local care with family consultation	Embracement Family Health Strategy	Personal engagement

Source: Authors.

context of care practices, evidencing Gramsci's concept of hegemony[18], in which the subordinate social group adopts the worldview of the dominant group, even when it is in contradiction with its practical reality.

The Health Reform Movement criticized the clinical-care model for not effectively meeting the healthcare needs of the Brazilian population[19,20]. The political agenda that guided the formulation of PNASPI was influenced by these remarks[21,22], seeking to overcome the healthcare system's predominant curative and individual approach, prioritizing the integration of services and an intercultural approach.

Nevertheless, the persistence of the structural conditions inherent to the clinical=care model, materialized in complaint-conduct types of appointments within the institution, continues to be one of the major contradictions to be addressed. In addition to distancing and disregarding other traditional practices and knowledge[23], the hegemony of this model ultimately limits the effective scope of the policy and the possibility of truly address the needs and particularities of Indigenous communities. Clinical care focused solely on diagnosing diseases excludes individuals and groups who may not be aware of existing health issues.

Formal practices are also guided by the logic of programmatic care, currently practiced in the non-Indigenous primary care units[24,25]. As a health technology, programmatic care has the potential to organize the provision of care when aligned with the epidemiological priorities of the territory[26]. Conversely, when the practice focuses on performing mechanical tasks and quantifying services without the practical use of the generated information, as described in the results of this study, it loses its original purpose. This may in fact increase the demand for medium and high complexity health services, but it doesn't mean an increase in the resolution of primary care[27].

In conjunction with programmatic care, preventive actions in SasiSUS continue to be influenced by outdated health policies. Although campaigns have evolved into programs, the essence of the predominant healthcare model in Brazil at the beginning of the 20th century[28], which also guided healthcare practices in the context of the Indigenous policy prior to the New Republic[29], remains preserved. Preventive actions are focused on specific technologies aimed at addressing various factors, pathologies, or population groups, organized in a vertical and centralized manner. This approach relegates non-biological factors that impact health to a secondary role, reflecting the predominant healthcare model of periods before the SUS[30].

Performance culture encompasses the adoption of techniques, methods, and tools to monitor individual or collective performance. This shift replaces the formation of a professional identity based on ethical-cultural values with an approach centered on calculations and achieving externally defined targets[31]. This culture shapes the norms, patterns of behavior, and social interactions within the institution's formal activities and is strongly expressed in the organization's language. This bureaucratic aspect of institutional management reinforces the influence of mercantile logic on healthcare policy, a phenomenon also observed by Morosini *et al.*[32] in documents that guide changes in the management of primary care within SUS.

Performance-focused managerialism distorts the fundamental purpose of care practices. Childcare appointments, for instance, should encompass procedures and actions that have proven to be effective in the health of children[33], one of which is preventive guidance. The effectiveness of this guidance is closely tied to families' ability to access relevant information[34]. In an intercultural context, mediated by linguistic difficulties, good communication with mothers poses a challenge, as expressed by the interviewees. The employees reported a lack of strategies to deal with the situation. Despite their doubts about the practical effectiveness of their approach, they continued to conduct appointments following the organization's demands for technical efficiency.

The dedicated nurse event reported above demonstrates resistance to both the management model of care practices and the hegemonic models of health care. The employee aimed to broaden her impact and gain a deeper understanding of the health conditions of the individuals receiving medical care, thereby providing more comprehensive support. This approach focused on live work[35] and effectively utilized light technologies, such as creating a welcoming environment, offering warm reception, and practicing attentive listening. Her methods aligned with the best practices expected within the Family Health Strategy[26] and with the PNASPI guidelines. However, they did not have affinities with the means established for achieving the defined targets.

There are no clear rules, guidelines, or organizational definitions applicable to informal practices such as emergency care and the activities that stem from them, including feeding and lodging patients, hospitalization, and the need for medications not included in the list sent by the DSEI headquarter. Nevertheless, these practices empower and engage the individuals involved. The moral responsibility of employees in the face of ~~a~~ serious events makes them experience forms of interaction and solidarity that contrast with the disengaged instrumentalism[31] of performance culture. However, because these actions occur in institutional silence, they often unfold in an improvised manner, lacking regulation and adding to the employees' workload.

Conclusion

In light of Ball's[9,10] approach to the policy cycle, the present study reinforced the understanding that there is a significant gap between the ideological agenda that drives the formulation of a public policy and the processes of influence and production of governmental texts. In the implementation process, only some influences and agendas gain legitimacy, and only some voices are heard, depending on the political forces that exert influence within the context of practice. PNASPI was formulated in an environment eager for transformations, influenced by the ideas that guided the Health Reform. The text that materializes within the DSEI does not emerge in isolation; it carries a historical legacy, in the same way, it is not introduced into a social and institutional vacuum. The PNASPI text, its readers (the professionals implementing the policy), and the context of its implementation (the organization or the DSEI) all have their own stories that may converge or diverge depending on the political skills of their key interpreters (managers).

The execution and routine of care practices express the process of implementing Indigenous Health Policies in a DSEI. In the context analyzed in this study, three phenomena – the clinical-care model, the health campaigns model, and the performance culture – emerge as critical influences. The clinical-care and the health campaigns models persist, despite the social, geographic, and cultural characteristics inherent to the Indigenous context, revealing their hegemonic strength that is rarely altered by those implementing the policy.

The performance culture, in turn, was the most recent phenomenon that was institutionalized during the process. It also introduced a control paradigm based on quantitative indicators and pre-defined goals, affecting professional identity and social interactions. However, this instrumentalized and repetitive approach found in institutional texts diverts the focus from local health dynamics and needs, perpetuating healthcare models that have long been criticized. Furthermore, it reveals the coercive power of managerialist politics within government organizations.

However, apart from this culture, other practices are induced by temporal needs, subjective feelings, and local power networks that challenge the formal structure but operate outside of regulation and in an improvised manner. From this experience in the liminality of the organizational structure, subjects explore other forms of interaction with their contextual reality, despite institutional expectations.

This study's results question the linear perception of public policies as simply implemented by state technocrats after their formulation. Rather, they are reformulated in practice, which means that they are influenced by old policies and reshaped by bureaucracy-induced techniques. Based on this understanding of contextual reality, and using ethnography as a methodological and theoretical path, it seems possible to question established social conventions and forecast possibilities for change.

It is pertinent to highlight the need for future research that explores management and administration models within the scope of SasiSUS. The complexity and dynamics of Indigenous healthcare require adaptive, integrated, and effective strategies to optimize results and the quality of care for Indigenous users. Thus, the development of studies that evaluate, compare, and propose an advanced analysis of management practices implemented in SasiSUS is encouraged.

Collaborations

The authors developed the study in full partnership, contributing equally to the discussion of the results. RA Cerri was responsible for writing the manuscript, while L Garnelo contributed to reviewing the content and writing the manuscript's final version.

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