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EXPERIENCE REPORT

Acupuncturiatry and chinese medicine in the family health strategy for comprehensive care

Acupunturiatría y medicina china en la estrategia salud de la familia para la integralidad del cuidado

Acupunturiatria e medicina chinesa na estratégia saúde da família para a integralidade do cuidado

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Abstract

This study analyzes the experience of integrating Medical Acupuncture and Chinese Medicine into the clinical practice of a Family Health Strategy team in Fortaleza, Ceará, Brazil. This qualitative study was based on content analysis and involved 30 patients treated at a primary healthcare unit. The study was approved by the Research Ethics Committee of the Federal University of Ceará under Approval No. 8.081.951. Data were collected through participant observation and field diary records from September 2025 to June 2026. The experience demonstrated the systematic application of dual-rationality diagnosis, which guided the therapeutic selection of acupuncture points for the management of chronic painful conditions, myofascial syndromes, and functional disorders. Healthcare users showed acceptance of the integrated approach. It is concluded that this integration may expand and strengthen comprehensive care and has the potential to promote strategies for the rational use of healthcare resources.

Descriptors: Primary Health Care; Family Health Strategy; Acupuncture; Traditional Chinese Medicine; Complementary Therapies.

Resumén

Este estudio analiza la experiencia de integración entre la Acupunturiatría y la Medicina China en la práctica clínica de un equipo de la Estrategia de Salud de la Familia en Fortaleza, Ceará, Brasil. Se trata de un abordaje cualitativo, fundamentado en el análisis de contenido, con 30 pacientes atendidos en una unidad primaria de salud. El estudio fue aprobado por el Comité de Ética en Investigación de la Universidad Federal de Ceará, mediante el Dictamen n.º 8.081.951. Para la recolección de datos se utilizó observación participante y registros en el diario de campo en el período de septiembre de 2025 a junio de 2026. La experiencia evidenció la aplicación sistematizada del diagnóstico de doble racionalidad, orientando la selección terapéutica de los puntos de acupuntura en el manejo de condiciones dolorosas crónicas, síndromes miofasciales y trastornos funcionales. Los usuarios demostraron aceptación del enfoque integrado. Se concluye que esta integración puede ampliar y fortalecer la integralidad de la atención, sugiriendo potencial para favorecer estrategias de uso racional de los recursos en salud.

Descriptores: Atención Primaria de Salud; Estrategia de Salud de la Familia; Acupuntura; Medicina Tradicional China; Terapias Complementarias.

Resumo

Este estudo analisa a experiência de integração entre a Acupunturiatria e a Medicina Chinesa na prática clínica de uma equipe da Estratégia Saúde da Família em Fortaleza, Ceará, Brasil. Trata-se de um estudo de abordagem qualitativa, fundamentado na análise de conteúdo e realizado com 30 pacientes atendidos em uma unidade de atenção primária à saúde. O estudo foi aprovado pelo Comitê de Ética em Pesquisa da Universidade Federal do Ceará, sob o Parecer nº 8.081.951. A coleta de dados ocorreu por meio de observação participante e registros em diário de campo, no período de setembro de 2025 a junho de 2026. A experiência evidenciou a aplicação sistematizada do diagnóstico de dupla racionalidade, orientando a seleção terapêutica dos pontos de acupuntura no manejo de condições dolorosas crônicas, síndromes miofasciais e distúrbios funcionais. Os usuários demonstraram aceitação da abordagem integrada. Conclui-se que essa integração pode ampliar e fortalecer a integralidade do cuidado, apresentando potencial para favorecer estratégias de uso racional dos recursos em saúde.

Descritores: Atenção Primária à Saúde; Estratégia Saúde da Família; Acupuntura; Medicina Tradicional Chinesa; Terapias Complementares.

Introduction

Primary Health Care (PHC) constitutes the main strategy for organizing universal health systems, being responsible for care coordination, the longitudinality of follow-up, and the organization of the Health Care Network (HCN)[1]. In Brazil, the Family Health Strategy (ESF) has established itself as the structural axis of Primary Health Care (PHC), committing to providing comprehensive, continuous care centered on the population's needs[2,3]. However, the growing prevalence of chronic conditions, persistent suffering, and complex health needs challenge care models centered exclusively on disease and demand approaches capable of integrating different dimensions of the health-disease process.

The effectiveness of primary health care is determined by the presence of its essential attributes (first-contact access, longitudinality, comprehensiveness, and care coordination) and derived attributes (family orientation, community orientation, and cultural competence)[3]. Among these, comprehensiveness stands out, understood as the capacity of services to recognize and respond to individuals' multiple needs by coordinating various technologies and therapeutic strategies that go beyond the treatment of diseases[1].

In this context, the National Policy on Integrative and Complementary Practices in Health (PNPIC)[5], established in 2006, expanded the therapeutic options offered by the Unified Health System (SUS) by incorporating traditional and complementary practices into healthcare. Notable among these is Traditional Chinese Medicine (TCM); its integration into Primary Health Care (PHC) represents an opportunity to broaden the scope of care provided by the Family Health Strategy (ESF) and strengthen the principle of comprehensiveness, allowing diverse health needs to be addressed within the Basic Health Unit itself or, when necessary, coordinated with other components of the Health Care Network (RAS). TCM constitutes a distinct medical rationality, grounded in a specific system for understanding the health-disease process, diagnosis, and treatment. Unlike Western medicine, where clinical reasoning is organized around the clinical-nosological diagnosis of diseases, TCM employs syndrome differentiation (bian zheng), interpreting a patient's signs, symptoms, and individual characteristics through frameworks such as Yin-Yang, the Five Movements, Zang-Fu systems, Qi, Xue, and meridians. This perspective seeks to identify functional patterns of bodily imbalance and guide individualized interventions, considering the unique nature of the illness[6].

Although grounded in a traditional rationale, acupuncture is also being extensively investigated from a contemporary biomedical perspective. Experimental and clinical evidence demonstrates mechanisms related to pain modulation, the activation of neurophysiological pathways, the regulation of the autonomic nervous system, and the modulation of inflammatory processes, thereby supporting its use in various clinical conditions, particularly in the management of chronic pain and functional disorders[6].

In Brazil, acupuncture was recognized as a medical specialty by the Federal Council of Medicine through CFM Resolution No. 1,455/1995[7]. In this context, the term Acupunturiatria (Acupuncture Medicine) became established to designate the medical practice that integrates the clinical reasoning of Western medicine with the therapeutic resources of TCM. From this perspective, the needle insertion procedure represents merely one stage of a broader clinical process that encompasses patient history taking, physical examination, diagnostic formulation, prognostic assessment, and the development of a therapeutic plan[8].

This practice enables the construction of dual medical rationality, characterized by the simultaneous use of two diagnostic systems during the same clinical encounter: the clinical-nosological diagnosis of Western medicine and the syndromic differentiation of TCM. Far from representing competing models, these rationalities can function complementarily, expanding the diagnostic and therapeutic possibilities available to the primary care physician. This integration fosters a more comprehensive understanding of illness, allowing biological, functional, and subjective aspects to be considered in an integrated manner when planning care.

This perspective aligns directly with the Patient-Centered Clinical Method (PCCM), which proposes integrating the biomedical dimension with the subjective experience of illness, valuing the user's life context, expectations, values, and needs in the shared development of the therapeutic plan[1]. By aligning biomedical reasoning with the TCM approach of syndrome differentiation, Acupuncture Medicine expands the possibilities for individualized care, thereby strengthening essential attributes of Primary Health Care, particularly comprehensiveness, longitudinality, and clinical effectiveness.

Despite the growing incorporation of Integrative and Complementary Practices (PICS) into the SUS, the national literature still focuses predominantly on evaluating the clinical efficacy of acupuncture or describing public policies related to PICS. Studies describing how the integration between biomedical diagnosis and syndrome differentiation occurs in the daily practice of the Family Health Strategy (ESF), and the contributions this articulation can offer to comprehensive care and the MCCP, remain relatively scarce[9]. Thus, the question arises: “How can the integration of the clinical-nosological diagnosis of Western medicine and the syndromic differentiation of TCM contribute to comprehensive care and the quality of attention provided in Primary Health Care?”.

This is also justified by the alignment with the 2030 Agenda and the Sustainable Development Goals (SDGs), particularly SDG 3 (Health and Well-being), whose Target 3.8 advocates for universal health coverage, including access to essential, safe, effective, and quality health services, and whose Target 3.4 reinforces the promotion of mental health and well-being[10]. Given this context, the present study aims to analyze the experience of incorporating Acupuncture and Traditional Chinese Medicine into the clinical practice of a Family Health Strategy team.

Methodology

This is an experience report with a qualitative approach, grounded in participant observation and field journal records, which emphasizes the meanings and subjectivity of the professional experience regarding the integration of acupuncture and Chinese medicine into the care practice of a Family Health Strategy (ESF) team[11].

The experience described took place within the context of medical care provided between September 2025 and June 2026, involving a convenience sample of 30 patients (20 women and 10 men). The number of participants corresponded to the consultations conducted during the observation period. Of the 30 patients, 15 sought care spontaneously, while 15 attended scheduled appointments as part of the routine operations of a Primary Health Care Unit (UAPS) in Fortaleza, Ceará, Brazil. Acupuncture treatment was recommended on an individual basis following a clinical assessment by the attending physician, considering each patient's therapeutic needs, the absence of contraindications to the procedure, and the patient's consent to undergo the therapy.

During the consultations, the MCCP approach was applied, integrating conventional clinical assessment with attentive listening to the users' needs, expectations, and life contexts. Following the medical history and physical examination, a Western clinical-nosological diagnosis was established alongside a TCM syndrome differentiation, grounded in the Eight Principles (Interior/Exterior, Cold/Heat, Deficiency/Excess, and Yin/Yang), the Zang-Fu systems (organs and viscera), and the relevant energy channels. Based on this dual diagnostic rationale, an individualized treatment plan was developed, guiding the selection of acupuncture points according to the association between local action (Biao) and systemic action (Ben).

The treatment was performed using sterile, disposable stainless-steel needles (0.25 × 30 mm), retained for a period of 20 to 30 minutes. When clinically indicated, the dry needling technique was also employed on trigger points (Ah-Shi). For chronic cases, a series of sessions was scheduled, considering clinical progression, therapeutic response, and each patient's individual needs.

Data collection took place between September 2025 and June 2026; participant[12] observation and field notes were used to obtain reliable data, which were subsequently organized and analyzed. Data were generated through systematic entries in a field journal maintained by the physician-researcher while monitoring the patients. Records included data regarding the "dual rationality" diagnosis applied in each case, presenting complaints, therapeutic strategies adopted, clinical progression, response to needling, and the patients' spontaneous comments on their experience with Acupunturiatria.

The records were subsequently organized and subjected to interpretive analysis, aiming to identify patterns related to the main clinical presentations encountered, predominant syndromic diagnoses, therapeutic approaches employed, and the contributions of integrating TCM with ESF clinical practice. This systematization supported the development of Chart 1 and the discussion of the results presented in this report. Generating data in the field diary served as a tool for critical reflection on professional practice, facilitating the analysis of the care process and the continuous improvement of the integration between clinical-nosological diagnosis and TCM syndromic differentiation[13]. To ensure participant confidentiality, all records were previously de-identified, retaining only the clinical information relevant to the analysis.

This study is linked to an umbrella project regarding the training and practice of physicians within the scope of the Mais Médicos para o Brasil (More Doctors for Brazil) Program; it was approved by the Research Ethics Committee of the Federal University of Ceará (UFC) under opinion No. 8.081.951 and CAAE No. 91948525.0.0000.5050, in accordance with Resolution No. 466/2012 of the National Health Council.

Experience Report

The correlation of medical rationalities revealed distinct epidemiological profiles and manifestations of energetic disharmonies within the territory. It was observed that, in chronic cases, the TCM syndrome diagnosis primarily addressed patients suffering from chronic low back pain (with or without radiation to the lower limbs), fibromyalgia, migraine, and plantar fasciitis, conditions frequently associated with patterns of internal energy deficiency (especially of the Kidney) combined with chronic stagnation of Qi and Xue in the Bladder and Gallbladder channels.

In contrast, acute presentations were predominantly characterized by myofascial pain syndrome, severely affecting the lumbar musculature, shoulder girdle, shoulders, and limbs, as well as functional episodes of nausea and dizziness, responding vigorously to patterns of local excess or Qi rebellion. Therapeutic selection of acupuncture points and the application of associated techniques were conducted in a systematized and physiologically grounded manner to address these demands, as summarized in Chart 1.

The systemic points Liver 3 (Taichong) and Large Intestine 4 (Hegu), a combination classically known as the "Four Gates" (Si Guan), were widely used to mobilize stagnant Qi, promoting general analgesic modulation and emotional regulation, particularly in patients with fibromyalgia and associated psychosomatic complaints. In cases of migraine, Liver 3 was paired with Gallbladder 34 (Yanglingquan), a point acting directly on the Shaoyang pathway, thereby reinforcing the treatment of disharmony between the Liver and Gallbladder channels, an interior-exterior (Biao-Li) relationship classically implicated in headaches affecting the temporal region. Stomach 36 (Zusanli) served as a potent systemic Qi tonic, proving especially relevant in conditions involving an underlying deficiency, such as fibromyalgia and functional dizziness; meanwhile, Kidney 3 (Taixi), by nourishing the "root" and supporting the Kidney-bone relationship, played a fundamental role in cases of degenerative osteoarticular conditions and plantar fasciitis[6].

Chart 1. Key clinical correlations of dual rationality, point selection, and therapeutic application in Primary Health Care Units (UAPS). Fortaleza, CE, Brazil, 2025–2026.

Clinical Category	Clinical-Nosological Diagnosis	Primary Syndromic Diagnosis (TCM)	Selected Key Points / Techniques	Main Justification for the Therapy
Chronic	Chronic low back pain with or without radiation (5 cases)	Bi Syndrome (Painful Obstruction) due to Qi and Blood stagnation in the Bladder channels, with underlying Kidney Deficiency	Bladder 40 (Weizhong), Bladder 57 (Chengshan), Bladder 60 (Kunlun), Kidney 3 (Taixi), Large Intestine 4 (Hegu), Ah-shi (Dry Needling)	Clearing the distal Bladder channel (Bladder 40/57/60); Kidney 3 nourishes the "root" (the Kidney governs the bones) and supports the osteoarticular structure; Large Intestine 4 modulates pain systemically
	Plantar fasciitis (4 cases)	Bi Syndrome due to Qi and Blood Stasis along the distal course of the Bladder channel, with associated Kidney Deficiency	Bladder 60 (Kunlun), Bladder 57 (Chengshan), Bladder 40 (Weizhong), Kidney 3 (Taixi), Ah-shi (Dry Needling)	Bladder points unblock the Taiyang channel along the heel/sole pathway; Kidney 3 strengthens the Kidney Yin/Yang root for local tissue repair; Ah-shi points treat the fascia directly
	Fibromyalgia (3 cases)	Generalized Bi syndrome with an underlying deficiency component (Liver and Kidney Qi and Blood deficiency)	Liver 3 (Taichong), Large Intestine 4 (Hegu), Kidney 3 (Taixi), Ah-shi (multiple trigger points)	Liver 3 plus Large Intestine 4 (Four Gates) move stagnant Qi and Blood and modulate diffuse pain; Kidney 3 tonifies the underlying deficiency (fatigue, generalized pain); Ah-shi treats associated myofascial trigger points
	Migraine (3 cases)	Liver Qi stagnation, affecting the Shaoyang axis (Gallbladder channel)	Liver 3 (Taichong), Large Intestine 4 (Hegu), Gallbladder 34 (Yanglingquan)	Liver 3 (Source/Yuan point) regulates Liver Qi at the root of the imbalance; Gallbladder 34 (Hui-Meeting point of tendons) acts directly on the Shaoyang pathway, a classic choice for temporal headaches and Liver-Gallbladder disharmony; Large Intestine 4 enhances general analgesia and associated emotional regulation
Acute	Myofascial pain syndrome (lower back, shoulder girdle, shoulders, limbs) (8 cases)	Acute Bi syndrome due to invasion of external pathogenic factors into the collaterals (acute local stagnation)	Ah-shi (Dry Needling)	Immediate mechanical deactivation of taut muscle bands, restoring local microcirculation
	Functional nausea (4 cases)	Stomach Qi Rebellion	Pericardium 6 (Neiguan), Stomach 36 (Zusanli)	Pericardium 6 harmonizes the Stomach and descends rebellious Qi; Stomach 36 tonifies systemic Qi and reinforces digestive harmonization
	Functional dizziness (3 cases)	Deficiency of Qi and Blood failing to nourish the head, with a possible component of Qi Rebellion (when associated with nausea).	Pericardium 6 (Neiguan), Stomach 36 (Zusanli)	Stomach 36 tonifies Qi and Blood, nourishing the head and reversing underlying deficiency; Pericardium 6 stabilizes Shen and treats Qi rebellion when there is a concomitant nauseous component.

For the targeted treatment of back pain and plantar fasciitis, the points Bladder 40 (Weizhong), Bladder 57 (Chengshan), and Bladder 60 (Kunlun) acted distally to clear the affected Bladder meridian, reflecting the principle "for the lumbar region, seek Weizhong." Pericardium 6 (Neiguan) proved central to the acute management of functional nausea by harmonizing the Stomach and reversing the upward rebellion of Qi; it was also combined with Zusanli for dizziness cases where the etiology involved a deficiency of Qi and Blood insufficient to nourish the head. Regarding acute muscle pain, dry needling applied directly to myofascial trigger points (Ah-Shi points) promoted relaxation and immediate pain relief, restoring local microcirculation and leading to clinical improvement as reported by patients[6].

Regarding the subjective dimension of care, a notable—and at times surprising—receptiveness was observed among local service users. Patients showed themselves open to incorporating the technique into their therapeutic plans. More than 50% reported having previously heard of Chinese Medicine and acupuncture through the media or word-of-mouth, although the vast majority had never experienced the treatment themselves. This initial curiosity and mutual openness helped break down cultural barriers associated with conventional medical care. The transition from initial apprehension regarding needles to a stance of trust was facilitated by physiological and energetic explanations of each procedure during the consultation, transforming a sense of unfamiliarity into an invitation for shared responsibility and active participation in the healing process.

This integrated and expanded clinical practice showed potential for the routine care of patients treated at the Primary Health Care Unit (UAPS), evidenced by a trend toward reduced reports of pain. In some cases, the use of analgesics, anti-inflammatories, and psychotropic drugs decreased thanks to acupuncture and Chinese medicine therapies; this directly contributed to mitigating iatrogenic effects and potential adverse reactions, thereby actively promoting quaternary prevention within primary care. Viewed through the lens of the Patient-Centered Clinical Method (PCCM), the alignment with the rationale of acupuncture provided patients with a space for attentive

listening, strengthening the therapeutic bond, encouraging shared responsibility for self-care, and substantially bolstering individual autonomy. Consequently, it was possible to expand the essential attribute of comprehensiveness, enabling the resolution and management of complex complaints directly within UAPS.

The experience reported here engages with a body of Brazilian studies, discussed below, regarding the integration of acupuncture into Primary Health Care (PHC). Although such studies are scarce in the literature, each presents distinct methodological and institutional approaches that help contextualize the contributions and limitations of the present work. One study, which interviewed 21 acupuncturists working in the primary care network of Campinas (São Paulo), found a clinical practice anchored almost exclusively in the traditional Chinese framework, with no significant mention of a medical-scientific approach stripped of its energetic foundations[14].

What those authors did not achieve, and what the present study sought to formalize, was a protocol for simultaneous, systematized diagnosis (Western and Chinese syndromic) applied side-by-side during each consultation, featuring an explicit correlation between acupuncture points and their physiological and energetic rationales (as shown in Chart 1). While the Campinas study describes a traditional practice that is intuitive and personal to each practitioner, this experience proposes a replicable systematization of the dual medical rationale. On the other hand, that study identified an issue that this report did not explore: a legal and professional dispute, historically recurrent in Brazil, among professional groups regarding the right to practice acupuncture.

In another study, acupuncture was implemented in a group format, through a weekly session integrated with discussion circles, with data generation based on field notes and transcribed interviews[15]. In this regard, a significant methodological convergence is observed between the two studies, given that both employed the field diary as a tool for data generation and for reflection on their own practice[12]. The difference lies in the purpose of this instrument in each study: while in one of them the diary recorded the process of facilitating conversation circles and the group dynamics, in the experience described here, it supported the individual refinement of the dual-rationality diagnosis during each consultation.

What that study accomplished, and what the present report did not address, was the deliberate exploration of the dimension of collective health promotion and group dynamics as a therapeutic strategy; participants reported valuing the space for exchange just as much as the venipuncture itself[13]. In this study, care was maintained on a strictly individual basis within routine medical consultations; while this favors the diagnostic rigor of the dual rationality described here, it fails to explore the potential for strengthening community bonds and optimizing scheduling, benefits that collective experience has shown to be feasible. The decision not to adopt a group format represents a limitation to be overcome in future iterations of this initiative, rather than merely a neutral difference in methodological design.

In a documentary study, no direct clinical practice was implemented. The investigation analyzed a backlog of acupuncture referral forms at health units in Porto Alegre, identifying median wait times that reached nearly 1,800 days at one of the evaluated units, while pain accounted for over 94% of the reasons for referral. The study indirectly highlights the model that the present report sought to avoid: referring a Primary Health Care (PHC) user to an external specialized service, subject to long waiting lists, instead of resolving the clinical condition within the unit itself through the Family Health Strategy (FHS) physician. This contrast serves as a key point of dialogue between the two studies, demonstrating a structural problem that the practice described here seeks to mitigate by integrating acupuncture services directly into the PHC unit, thereby fostering comprehensive care[16].

Literature reviews indicate that the expansion of acupuncture in primary health care still faces significant obstacles, such as a shortage of trained professionals, insufficient infrastructure, and resistance from a segment of the medical community, as demonstrated by database-based synthesis studies[17,18]. By describing a practice already implemented and functioning within the routine of the Family Health Strategy (ESF), this study demonstrates the feasibility of incorporating medical acupuncture into this context, while also highlighting the limitation of schedule time, identified in reviews as one of the main obstacles to the consolidation of this practice in Primary Health Care (PHC).

International clinical evidence, based on controlled clinical trials, demonstrates the benefits of acupuncture for low back pain, knee osteoarthritis, chronic neck pain, and headache, with a Grade A level of evidence and effects sustained for up to six months[19]. What this article offers, and what Brazilian studies on the experience do not provide, is the body of quantitative evidence scientifically underpinning the choice of clinical conditions addressed in this report, particularly chronic low back pain and migraine; this is an aspect that the Brazilian discourse, largely focused on issues of access and institutionalization, tends to relegate to the background.

The quality of Primary Health Care (PHC) is measured by the presence and extent of its essential and derived attributes[4]. The assessment of these attributes using the PCATool-Brazil instrument, conducted with professionals from the Primary Health Care network in Fortaleza, within the same territory where the experience described here took place, identified an overall score of 6.34 (on a scale of 0 to 10) and scores of 6.32 and 6.74 for the comprehensiveness sub-attributes regarding available services and services provided, respectively. These values were classified as satisfactory, although they indicate room for improvement[20].

Although the instrument used by Rolim does not include specific items regarding PICS, his findings confirm that the comprehensiveness of the Family Health Strategy (ESF) in Fortaleza, while satisfactory, does not yet reach

scores near the top of the scale. This fact underscores the importance of investigating the expansion of the ESF physician's therapeutic scope, such as the incorporation of medical acupuncture and Chinese medicine described here, as a complementary strategy to strengthen this attribute within the local network[20]. In this regard, while the research provides a quantitative diagnosis of the extent of this attribute within Primary Health Care (PHC) in Fortaleza, the present report offers a qualitative and clinical response situated in the same context, demonstrating the expansion of the range of interventions available to Family Health Strategy (FHS) physicians as a concrete strategy to align PHC more closely with the theoretical model proposed for this level of care[4].

In summary, a comparison of these experiences reveals that this study offers a response rarely found in the national literature: it is more systematized regarding dual diagnosis than the practice described in Campinas, more individualized than the collective experience in Santos, and structurally more effective at resolving issues than the referral model documented in Porto Alegre, even though it shares the same challenges regarding scheduling, infrastructure, and institutional sustainability faced by the reviewed studies in consolidating Acupuncture and Chinese Medicine within the Family Health Strategy (ESF).

Final Considerations

The reported experience suggests that integrating medical acupuncture, Traditional Chinese Medicine (TCM), and the clinical practice carried out within the Family Health Strategy (ESF) proved feasible and can expand therapeutic possibilities in Primary Health Care (PHC). The concurrent use of Western clinical-nosological diagnosis and TCM syndrome differentiation proved compatible with the Patient-Centered Clinical Method (PCCM), fostering a more comprehensive approach to patient needs and reinforcing the principle of comprehensive care.

The findings of this report indicate that adopting a dual medical rationale can help broaden the scope of practice for ESF physicians, particularly in managing chronic pain conditions and functional disorders frequently encountered in PHC.

Furthermore, the experience demonstrated high user receptiveness and suggested potential for facilitating the development of more individualized therapeutic plans, as well as for supporting strategies regarding the rational use of medications, the judicious ordering of diagnostic tests, and quaternary prevention. However, the results must be interpreted considering the limitations inherent to the study design. As this is an experience report conducted at a single Primary Health Care Unit (UAPS), based on participant observation and field journal records, it is not possible to establish causal relationships or generalize the findings to other care settings. Moreover, the high service demand within the Family Health Strategy (ESF) poses a challenge to the systematic integration of acupuncture practice into clinical routine.

Therefore, it is recommended that future studies explore this approach using more robust designs, including multicenter research, implementation studies, pragmatic clinical trials, and cost-effectiveness analyses, capable of comprehensively evaluating its impact on the problem-solving capacity of Primary Health Care, health service utilization, and the sustainability of the SUS.

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