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The construction of nursing diagnoses for a community using the ICNP through the taxonomy of health needs

La construcción de diagnósticos de enfermería para una comunidad utilizando la CIPE a través de la taxonomía de necesidades de salud

A construção de diagnósticos de enfermagem de uma comunidade pela CIPE através da taxonomia das necessidades em saúde

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Abstract

Based on the experience of the PET-Saúde program in Niterói/RJ, this qualitative and descriptive research, developed between August 2010 and February 2011, mapped the Caramujo community to identify its health needs and develop community nursing diagnoses according to the ICNP (International Classification for Nursing Practice). Through the analysis of documents, epidemiological data, and interviews, the taxonomy of health needs was applied, identifying four critical dimensions: poor living conditions (precarious housing, deficient sanitation, low income, insecurity, and lack of leisure); difficulties in accessing health technologies (referral services, appointment scheduling, and care for minor emergencies); fragility in the creation of affective bonds (deficits in reception and information within the unit); and limitations in autonomy (little social mobilization). These needs were translated into nursing diagnoses such as compromised environmental and community health processes, deficient health services and transportation, compromised interactive behavior, and weakened social processes. It was concluded that community diagnosis is fundamental for identifying the health situation and supporting timely and effective interventions by professionals.

Descriptors: Nursing Processes; Nursing Diagnosis; Public Health Nursing; Family Health; Public Health.

Resumén

Basada en la experiencia del programa PET-Saúde en Niterói/RJ, esta investigación cualitativa y descriptiva, desarrollada entre agosto de 2010 y febrero de 2011, mapeó la comunidad de Caramujo para identificar sus necesidades de salud y desarrollar diagnósticos de enfermería comunitaria según la CIPE (Clasificación Internacional para la Práctica de Enfermería). Mediante el análisis de documentos, datos epidemiológicos y entrevistas, se aplicó la taxonomía de las necesidades de salud, identificando cuatro dimensiones críticas: malas condiciones de vida (vivienda precaria, saneamiento deficiente, bajos ingresos, inseguridad y falta de ocio); dificultades para acceder a tecnologías sanitarias (servicios de referencia, programación de citas y atención de emergencias menores); fragilidad en la creación de vínculos afectivos (déficits en la recepción e información dentro de la unidad); y limitaciones en la autonomía (poca movilización social). Estas necesidades se tradujeron en diagnósticos de enfermería como procesos de salud ambiental y comunitaria comprometidos, servicios de salud y transporte deficientes, comportamiento interactivo comprometido y procesos sociales debilitados. Se concluyó que el diagnóstico comunitario es fundamental para identificar la situación de salud y apoyar intervenciones profesionales oportunas y eficaces.

Descriptores: Procesos de Enfermería; Diagnóstico de Enfermería; Enfermería de Salud Pública; Salud Familiar; Salud Pública.

Resumo

Com base na experiência do PET-Saúde em Niterói/RJ, esta pesquisa qualitativa e descritiva, desenvolvida entre agosto de 2010 e fevereiro de 2011, mapeou a comunidade do Caramujo para levantar suas necessidades em saúde e elaborar diagnósticos de enfermagem comunitários conforme a CIPE. A partir da análise de documentos, dados epidemiológicos e entrevistas, aplicou-se a taxonomia de necessidades de saúde, identificando quatro dimensões críticas: más condições de vida (habitação precária, saneamento deficiente, baixa renda, insegurança e falta de lazer); dificuldades de acesso às tecnologias de saúde (serviços de referência, marcação de consultas e atendimento de pequenas urgências); fragilidade na criação de vínculo afetivo (déficit no acolhimento e na informação dentro da unidade); e limitações na autonomia (pouca mobilização social). Essas necessidades foram traduzidas em diagnósticos de enfermagem, como processo ambiental e saúde da comunidade comprometidos, serviço de saúde e transporte deficientes, comportamento interativo comprometido e processo social fragilizado. Concluiu-se que o diagnóstico comunitário é fundamental para identificar a situação de saúde e subsidiar intervenções pontuais e efetivas dos profissionais.

Descritores: Processos de Enfermagem; Diagnóstico de Enfermagem; Enfermagem em Saúde Pública; Saúde da Família; Saúde Pública.

Introduction

Primary Health Care (PHC) constitutes the first level of contact between the population and the health system and is the structuring axis of the care network, guiding actions of promotion, prevention, diagnosis, treatment, and rehabilitation at the individual and collective levels. Based on the principles of universality, comprehensiveness, and equity, PHC promotes continuous and community-based care, as advocated by the Alma-Ata Declaration (1978) and reaffirmed by Brazilian public policies[1,2].

In this context, the Education through Work for Health Program (PET-Saúde), linked to the Ministry of Health, plays a strategic role in strengthening the integration of teaching, service, and community and promoting interdisciplinary practices oriented towards the real needs of the population. During the experience developed in a Family Health team, it was possible to identify complex demands related to living conditions, the health-disease process, and vulnerabilities present in the territory, reinforcing the importance of identifying health needs as a guiding step in the organization of care[3,4].

Identifying these needs involves understanding the social, economic, cultural, and environmental profile of the community, since these elements directly influence how different groups recognize and seek to meet their health demands. Studies indicate that interventions disconnected from territorial reality tend not to achieve community acceptance, compromising the continuity and effectiveness of health actions[5].

However, it was observed that, although the needs of the population were recognized by the team, nursing practice in Primary Care still presented gaps in the systematic use of the Nursing Process, especially in the stage of formulating nursing diagnoses. This stage is fundamental, as it forms the basis for clinical decision-making, standardizes professional language, and improves record-keeping and communication among members of the multidisciplinary team. The absence of diagnoses compromises the continuity of care and hinders the evaluation of results. The development of nursing diagnoses, understood as a clinical act that describes real or potential human responses, is enhanced using standardized classifications, such as the International Classification for Nursing Practice (ICNP®), which allows for the comparison of professional practices in different contexts and strengthens the visibility of the nurse's work[6,7].

Based on experience in the PET-Saúde program and the need to strengthen the systematic use of the Nursing Process, this study proposes to identify the health needs of a community according to Cecílio's taxonomy[8] and to develop the corresponding nursing diagnoses. This approach contributes to the planning of more precise actions, culturally appropriate and aligned with the real demands of the territory, strengthening the role of the nurse in the production of qualified care.

Methodology

This is a qualitative, descriptive study conducted in the Caramujo community in Niterói (RJ), a territory marked by social and health vulnerabilities. The choice of a qualitative approach was justified by the need to understand the subjective and contextual dimensions of the territory, allowing the identification of health needs based on the perceptions of residents and the team. The descriptive nature of the study made it possible to record and interpret observed phenomena, characterizing the territory, the population, and their demands[9,10].

The research setting was the area covered by the Caramujo Community Polyclinic, including regions such as Morro do Céu, historically affected by environmental events and precarious housing conditions. The selection of this field stemmed from the researcher's prior experience in the PET-Saúde program, which allowed for territorial mapping and recognition of local needs. Participants were residents of the area, over 18 years of age, after signing the Informed Consent Form. Data collection involved institutional documents (reports, demographic data, morbidity and mortality indicators, and health system information) and semi-structured interviews, used to complement and validate the needs assessment according to Cecílio's taxonomy[8].

The analysis was conducted in two stages: initially, content analysis was applied to systematize and interpret the documentary and interview data; then, based on the identified needs, nursing diagnoses were developed using the International Classification for Nursing Practice (ICNP®)[6].

The study was part of the project “Diagnosis of territories and health needs”, approved by the Research Ethics Committee of the Federal Fluminense University/Antônio Pedro University Hospital (UFF/HUAP), following Resolution No. 466/12, with opinion No. 299. All participants were guaranteed confidentiality and informed about the objectives of the research. The study did not receive external funding.

Results and Discussion

Community mapping is an essential tool for understanding the socio-spatial, cultural, economic, and health dynamics of a territory. In the case of Caramujo, this methodology made it possible to identify structural and subjective aspects that directly influence the health-disease process of the population. Through visits to the territory, interviews with long-time residents, community representatives, and health professionals, as well as document analysis, it was possible to understand the local history, forms of urban occupation, living conditions, and the main challenges that permeate the daily lives of residents. This type of analysis, as indicated by the National Primary Care Policy, allows health interventions to be guided by the singularities and vulnerabilities of each territory[11,12].

The historical process of occupation of the neighborhood, marked by construction on slopes, disordered expansion, and lack of infrastructure, has shaped a scenario of high socio-environmental vulnerability. The inadequate accumulation of solid waste and the presence of the landfill constitute serious problems, generating impacts such as soil contamination, alteration of the microclimate, proliferation of vectors, and increased risk of landslides,

phenomena widely observed in areas of precarious urbanization in Brazil[13]. The tragedy resulting from the 2010 rains, which caused landslides, deaths, and forced displacements, reinforces how urban and climatic inequalities directly affect the health and lives of marginalized populations.

The neighborhood also presents significant social vulnerabilities. Local commerce is limited, access to leisure activities is scarce, and urban violence, especially associated with drug trafficking and gender-based violence, constitutes a serious factor in youth health problems. Recent studies demonstrate that the lack of cultural facilities, spaces for social interaction, and effective security policies contribute to youth vulnerability and the expansion of violence[14,15]. In the field of education, although schools and daycare centers exist, many families depend on services in neighboring districts, which directly impacts the routine and access of children and young people to school activities.

The analysis of the Health Unit reveals an important history, from its origin as an extension of the Azevedo Lima Hospital to its transformation into a Community Polyclinic with the implementation of the Family Doctor Program. However, challenges persist: a shortage of human resources, weaknesses in referral and counter-referral systems, insufficient information during initial assessment, and excessive delays in accessing specialized examinations and consultations. These problems are recurrent in Brazilian Primary Care and are associated with chronic underfunding and precarious employment conditions[16].

The epidemiological data obtained reveal a profile marked by the predominance of chronic diseases, such as hypertension, diabetes, and obesity, in addition to high rates of smoking and sedentary lifestyles. The persistence of communicable diseases, such as tuberculosis, syphilis, and leprosy, was also observed, reflecting social inequalities and difficulties in accessing health services, aspects reinforced in recent national studies on urban vulnerabilities and social determinants. Mortality remains higher among men, especially due to cardiovascular and respiratory causes and diseases related to excessive alcohol consumption, a phenomenon consistent with the national epidemiological profile[14,17,18].

Beyond these aspects, it is noteworthy that the mapping process allowed for an understanding not only of objective indicators but also of subjective elements of the territory. Narratives from residents reveal a strong sense of belonging, but also perceptions of abandonment by public authorities. Low community mobilization, the recent reorganization of residents' associations, and the emerging protagonism of female leaders signal a phase of social transition that deserves monitoring. The literature indicates that territories with less social organization tend to have greater difficulty in demanding public policies and less capacity for collective response to emergencies[11,12].

The study also highlights that the absence of urbanization and basic sanitation policies perpetuates cycles of illness, especially in territories marked by poverty. Poor sanitation, exposure to waste, food insecurity, and weak community ties are determining factors that reinforce the risk of infectious diseases, mental disorders, and environmental accidents, and are widely highlighted in urban health reports[19]. Thus, the mapping reaffirms that the health of Caramujo is intrinsically linked to the structural social inequalities that characterize Brazilian urban peripheries.

The territorial diagnosis allowed for the identification of the epidemiological, social, and cultural profile of Caramujo, highlighting its priority needs and potential. This information is fundamental to supporting health planning, guiding public policies, strengthening Primary Care, and promoting intersectoral actions capable of transforming the local reality. The data produced offers essential support for the formulation of strategies for health promotion, disease prevention, surveillance, and comprehensive care, which will be further explored in the following stages of the work.

Assessment of health needs

Health needs are situated within the realm of social issues present in the population and are expressed in the way individuals identify, perceive, and seek to satisfy these needs. This perspective highlights the close relationship between the individual and society: each person, belonging to groups such as family, neighborhood, religious collectives, or informal support networks, is continuously influenced by the values, norms, and cultural practices of their territory. Thus, understanding health needs implies recognizing that these go beyond the biological field, being shaped by living conditions, opportunities for access to goods and services, and the social relationships that structure daily life.

Seeking to systematize this understanding and offer a solid conceptual basis for the analysis of territories, Cecílio proposed a taxonomy composed of four groups of health needs. This classification has been widely used in public health studies because it allows for a broader reading of reality, integrating social, subjective, structural, and political dimensions. Based on this theoretical framework and the data obtained from the previously conducted territorial mapping, the health needs of the Caramujo community, a territory marked by significant socio-environmental and sanitary vulnerabilities, were identified[8].

The first set refers to needs related to good living conditions, including adequate housing, sanitation, transportation, food, security, and leisure. The mapping revealed that many residences are built on hillside areas due to a scarcity of flat spaces, and in a disorderly and precarious manner, creating a permanent risk of landslides, such as the one that occurred in April 2010. Garbage collection only occurs in the central areas of the neighborhood; in the higher regions, the truck cannot access them, leading to the accumulation of waste in a large valley that functions as an improvised dump. This practice generates multiple impacts: soil contamination, release of toxic gases, alteration of the relief and microclimate, increased risk of landslides and proliferation of disease vectors, compromising the health and quality of life of the population. Furthermore, a restricted local commerce was identified, reflecting low purchasing power, and the absence of leisure areas, which

can contribute to increased violence. Public insecurity emerged as a strong demand, reinforced by the growth of crime and insufficient policing.

The second set of issues refers to access to and the ability to consume health technologies. Significant difficulty was observed among the population in obtaining specialized consultations and more complex examinations, with waiting times that can reach up to a year. In many cases, results are lost, hindering continuity of care. Added to this is the reduced number of available medical appointments at the Family Health Unit, forcing users to seek care at emergency units in other neighborhoods. However, this alternative is limited for residents who lack the resources for transportation, widening access barriers, and deepening structural inequalities.

The third set of issues concerns the need for connection and acceptance between users and professionals. In the Caramujo community, the Family Health Program (PSF) plays a central role in this process, especially through home visits by community health workers, which strengthen the relationship with families and encourage access to the health unit. However, users report significant weaknesses in the reception process, particularly regarding the insufficient information provided by professionals, which compromises their understanding of treatments, referrals, and necessary care. This gap highlights the need to improve communication in health and enhance active listening within the service.

The fourth set addresses the autonomy of individuals to manage their own lives and fight for the satisfaction of their needs. In the territory analyzed, low social mobilization and limited community participation in collective agendas were observed. Participation tends to increase only during election periods, when exchange relationships with candidates emerge, demonstrating fragility in popular organizations and in the construction of spaces for continuous participation, such as community councils and forums.

In addition to the elements already identified, it is noteworthy that the interdependence between the four sets of the taxonomy reinforces the understanding that health needs cannot be analyzed in isolation. The environmental, structural, and socioeconomic precariousness of Caramujo directly impacts access to services, care experiences, and individuals' ability to exercise autonomy. Therefore, this is a territory that demands intersectoral interventions, participatory planning, and public policies that articulate health, education, social assistance, housing, and urban infrastructure.

Another relevant element concerns the role of primary care as the coordinator of care. The weaknesses found, ranging from limited resources to failures in reception and communication, indicate the need to strengthen the work process of the teams, increase the unit's problem-solving capacity, and more effectively integrate the services of the health network. The presence of community health workers, although fundamental, is not sufficient to fill the gaps in the continuous follow-up of users, especially those with chronic conditions or special needs.

It is important to highlight that identifying health needs should not be understood as a merely descriptive exercise, but as a basis for health planning. The systematization presented allows for a clear visualization of the priority problems in the territory and guides the development of intervention strategies that promote equity, comprehensiveness, and social participation. The following is a summary of the identified needs, organized according to the four sets defined by Cecílio[8].

Chart 1. Health needs identified. Rio de Janeiro, RJ, Brazil, 2025

Health needs, according to Cecílio[8]	Health needs identified
Good living conditions	Construction of houses on hillsides, in a precarious and disorganized manner, hampered garbage collection in the higher areas of the neighborhood, being one of the causes of the formation of the garbage dump, which generates several health problems in the region; low income of the population; precarious public security, and lack of leisure areas.
Be able to and have access to health technologies capable of improving and prolonging life	Difficulty accessing referral and counter-referral services; difficulty scheduling appointments, and a lack of services for minor emergencies.
Creating (a)effective links between users and a team and/or professional	Establishing a connection through community health workers, however, there is a failure in providing information and in creating a welcoming environment within the unit.
The need to have increasing degrees of autonomy in one's way of life	There is little mobilization around social issues, and they have difficulty fighting for the satisfaction of their needs.

Having identified the needs, it is possible to proceed to the next step, which involves developing nursing diagnoses for the community. In this case, we will use the ICNP (International Classification for Nursing Practice)[6].

Community nursing diagnosis

In this stage, we propose to develop community-focused nursing diagnoses, taking as a reference the health needs previously identified and using the ICNP (International Classification for Nursing Practice) as a conceptual and

methodological basis. The construction of these diagnoses is fundamental to supporting the planning of interventions in the territory, guiding clinical decision-making, and strengthening the work process of Primary Health Care teams[6].

It is important to highlight that developing an adequate community diagnosis requires the collection of broad and systematic data, encompassing demographic, social, economic, cultural, and environmental aspects, with special attention to basic sanitation conditions. These elements are essential for a thorough understanding of the community profile, allowing the identification of vulnerabilities, potential, and determining factors that influence the health-disease process in the territory. Thus, the community diagnosis is not limited to describing the local reality but constitutes a critical step for the development of coherent and contextualized nursing actions[7,20].

The International Classification for Nursing Practice (ICNP), as an internationally standardized language, is an important tool to support the systematization of nursing care and the organization of information within health information systems. Its structure allows for the precise and understandable representation of the essential elements of nursing practice, contributing to more complete records, effective communication between professionals, and comparability of data in different contexts[6].

In essence, the ICNP encompasses three fundamental components of nursing practice: diagnoses, interventions, and outcomes. These elements express what nurses do, based on identified human needs, to produce positive effects on the health status of individuals, families, and communities. By using this classification, it is possible to translate the needs observed in the territory into structured diagnoses, which in turn guide specific and measurable interventions, favoring the continuous improvement of the quality of care[6].

It is composed of seven axes (focus, judgment, client, action, means, location, and time). To develop diagnoses based on this classification, we use these axes and may include additional terms from other axes when necessary. These axes will be used, through combinations between them, by nurses to create statements (phrases) about nursing diagnoses, interventions, and outcomes, for use in practice.

In the previous stage of this research, some health needs present in the Caramujo community were identified and categorized according to Cecílio8. In this stage, we developed nursing diagnoses by combining the axes based on the identified health needs. Below, we present a table outlining the identified health needs and the resulting diagnoses.

Chart 2 Health needs identified and nursing diagnoses. Rio de Janeiro, RJ, Brazil, 2025

Health needs according to Cecílio[8]	Health needs identified	Nursing diagnoses from the Caramujo community
Good living conditions	Construction of houses on hillsides, in a precarious and disorganized manner, hampered garbage collection in the higher areas of the neighborhood, being one of the causes of the formation of the garbage dump, which generates several health problems in the region; low income of the population; precarious public security, and lack of leisure areas.	Compromised environmental processes; Compromised community health; Compromised police service; Low family income; Poor residential infrastructure.
Be able to and have access to health technologies capable of improving and prolonging life	Difficulty accessing referral and counter-referral services; difficulty scheduling appointments, and lack of services for minor emergencies.	Healthcare institution with compromised service; Poor transportation service.
Creating (a)effective links between users and a team and/or professional	Establishing a connection through community health workers, however, there is a failure in providing information and in a welcoming environment within the unit.	Interactive behavior compromised; Patient rights interrupted.
The need to have increasing degrees of autonomy in one's way of life	There is little mobilization around social issues, and they have difficulty fighting for the satisfaction of their needs.	Committed social process, Social participation is dependent on politics.

Previous analysis has shown that, in the daily routine of Primary Care services, the nursing process is not always executed systematically in all its stages. Frequently, it is observed that professionals, based on experience accumulated over the years and concrete experience in the territory, tend to intervene directly on emerging demands, without recording or formalizing fundamental steps such as building a history (community mapping), identifying problems (assessing health needs), and developing diagnoses. Thus, the process is reduced to immediate intervention, which weakens the organization of care and the production of qualified information for health planning.

During this stage of the research, it became evident that the development of nursing diagnoses contributed

significantly to the construction of a unified language among professionals. The use of standardized terms allowed for the alignment of the team's perceptions, favoring a more convergent view of the real problems in the community. Even if different strategies are used to address the identified issues, the existence of clear and shared diagnoses strengthens decision-making and expands the capacity for integrated action.

The adoption of CIPE as a methodological tool proved particularly relevant in this process. The terminology allowed for adjusting the conceptual axes of the classification to the specific reality of the territory, enabling the inclusion of terms that were not originally in the nomenclature. This flexibility favored the construction of diagnoses more faithful to the situation experienced in the community, contributing to a greater degree of precision and relevance in defining care priorities. In this way, the subsequent stage, the development of interventions, tends to be more assertive and effective[6].

It also became evident that the construction of these diagnoses was only possible due to the information provided by the residents and the knowledge produced from the social, political, economic, and cultural history of the area. Authors[21] emphasize that social participation is essential in diagnosis, prioritization, monitoring, and evaluation of health actions. The authors also highlight the active role of health workers in creating environments conducive to community mobilization, reinforcing the transformative potential of active listening and ongoing dialogue with the population.

With the diagnoses in hand, it becomes possible to visualize in a broader way the problems affecting the community, their probable causes, and their most immediate and long-term consequences. This in-depth understanding allows for the generation of strategies more relevant to the local reality, enhancing more effective interventions and contributing to positive results in resolving the problems. Thus, the diagnostic construction process based on the International Classification for Nursing Practice and anchored in social participation is configured as a structuring axis for a more integrated, effective nursing care that is consistent with the concrete needs of the territory.

Final Considerations

Based on the research conducted, it was found that mapping the community was a fundamental step in understanding the local reality. Gathering information about the history, population composition, predominant age group, socioeconomic conditions, and cultural aspects allowed for the identification of essential elements for understanding the transformations that have occurred in the territory over the years. Furthermore, issues related to basic sanitation, social dynamics, and community participation proved crucial for understanding current living conditions.

The analysis revealed that the transformations occurring in the territory produced diverse impacts on distinct groups within the community, bringing benefits to some and significant harm to others. The situation of the landfill is an emblematic example: while it represents a source of income for part of the population, it also causes serious damage to health and the environment, affecting even the workers who depend on this activity. Another relevant element refers to the cultural influences on the health-disease process. Some behaviors, considered inappropriate in other realities, are experienced as natural and acceptable by the local community. Teenage pregnancy, for example, although highly prevalent, is perceived by many young women and their families as an expected and sometimes valued event.

The findings reinforce that health actions should be guided by the specificities of the territories, recognizing the sociocultural and environmental singularities of each community. The mapping made it possible to identify existing problems more clearly, their origins and their impacts, providing greater precision to the analysis of health needs. These needs encompass biological dimensions, linked to the clinical responses of individuals, families or communities, and social dimensions, strongly associated with the historical context of the community.

The use of the taxonomy proposed by Cecílio[8] proved strategic by integrating different dimensions of health needs, from living conditions and environmental factors to access to technologies, emotional connection with services, and individual autonomy. This broader approach facilitated the understanding of the causal factors involved and made the multiplicity of needs present in the community more evident, favoring the subsequent construction of diagnoses.

Among the groups identified in the taxonomy, the needs related to good living conditions stood out, especially the problems arising from the garbage dump, the precariousness of basic sanitation, the lack of leisure spaces, and security challenges, as well as those related to autonomy, marked by the low mobilization of the population for relevant social issues. Identifying these needs directly contributes to strengthening comprehensive health care, based on the principles of the Brazilian Unified Health System (SUS), by enabling the planning of continuous, articulated actions appropriate to different levels of complexity. Understanding the health needs of a community is essential for workers and services to develop practices based on active listening, placing the population at the center of interventions. In this sense, the taxonomy proved to be a consistent instrument to support the construction of nursing diagnoses, allowing for a broader and more integrated view of the identified needs.

Based on mapping and taxonomy, it became possible to develop community nursing diagnoses, a fundamental step for planning and organizing health actions in the territory. The ICNP[6], used as a classification basis in this study, proved adequate both for constructing diagnoses and for standardizing language among nurses and other team professionals. Its terminological flexibility made it possible to adapt the terms to the real conditions of the community, bringing the content of the diagnoses closer to the concrete situations experienced by the residents. The ICNP also stood out for unifying and integrating all the previous stages of the nursing process - social history and

problem identification - offering structured support for the next stage, focused on interventions. Thus, it has consolidated itself as an essential tool for interdisciplinary practice in Primary Care.

In conclusion, this study achieved its objectives and presented results of scientific and practical relevance, constituting a significant contribution to Nursing and Public Health. As a natural continuation of this research, it is recommended that studies focused on the analysis of nursing interventions related to the identified diagnoses be carried out, considering that scientific publications addressing this topic at the community level are still scarce.

This study is expected to contribute to teaching, especially in Public Health, given the limited literature on the subject. Furthermore, the concepts presented can aid in professional training by demonstrating the importance of community diagnosis grounded in consistent theoretical and methodological bases. In practice, the application of Cecílio's taxonomy[8] in the community diagnosis process can strengthen actions for promotion, prevention, and care, expanding the capacity to respond to the population's needs. It is recognized that the results presented here contribute to the scientific development of the area; however, the need for further studies that deepen the subject and reinforce the relevance of using community diagnoses based on the taxonomy of health needs as a tool for improving care and strengthening actions in the territory is highlighted.

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