GLOBAL JOURNAL OF
Community Psychology Practice
PROMOTING COMMUNITY PRACTICE FOR SOCIAL BENEFIT

Cultural factors and primary health care in Cuba. A view from community praxis

Alicia de la C. Martínez Tena
Universidad de Oriente, Cuba
alicia@cnea.uo.edu.cu

Key words: Colonialism, social identity, contact zone, history, racism.

Recommended citation:
Tena, A.C.M. (2012). Cultural factors and primary health care in Cuba. A view from community praxis. *Global Journal of Community Psychology Practice,* 3(1), 124-132. Retrieved XXXX, from http://www.gjcpp.org/.

Cultural factors and primary health care in Cuba. A view from community praxis

Abstract

The changes and transformations in Primary Health Care (PHC) developed in recent years from the implementation of the model of Physician and Nurse of the Family in Cuba, must be supported by a shift in perspective and move from an eminently biologicist paradigm to a biosociocultural paradigm. This makes it possible to explicitly situate the relationship between culture and health and explain the social and cultural factors related to healthy behaviors, and also to support interdisciplinary and transdisciplinary studies. The results presented in this paper corroborate the theoretical postulates of cultural anthropology, cultural sociology and medicine that argue that the gap between multidisciplinary health teams and social actors occurs, among other reasons, because of existing traditional cultural etiological models of health and disease. Cultural differences could be addressed through knowledge of the patient's culture, his cultural practices and his links with family members and other stakeholders in the community. It allows the productions of a process that includes cultural communication, listening carefully the patient's point of view rather than just ordering treatments that reflect scientific practices. The strategies and backgrounds presented in this study demand the presence of multiple perspectives and are very important to designing policies and models of intercultural health care to achieve satisfaction of patients, families and communities.

Introduction

During the early years of the revolutionary period in Cuba, the Integral Polyclinic was created. It was defined as the basic unit of the National Health System, which included all health activities within the assigned geographical area. At the same time the link between the Polyclinic and other levels of care in the National Health System was established and gave impetus to community participation through mass organizations.[2]

It was precisely in 1964 that the Integral Polyclinic emerged as the center of the activities in primary health care. Polyclinics were organized before this, in some cases, using the old health houses. The label "integral" was not used at first. The term "polyclinic" was taken from units of service in European socialist countries, but they did not have the same function. Several clinics in those countries were gathered in the same place (poly: pediatrics, internal medicine, clinical surgery, gynecology, dermatology ...), but the tasks of promotion and prevention were not performed, there as it was in our centers (Rojas, 2004).

The community polyclinics are the cornerstone of this system; there are 498 in the country, each of which gives service to 30 000 or 60 000 people. These polyclinics also operate as organizational nodes between 20 and 40 doctors and neighborhood family nurses' offices and as research and teaching centers for medical, nursing and other health sciences. (Luna, 2010).

Throughout the seventies, before the Declaration of Alma-Ata in 1978, polyclinics were established and incorporated the program of Family Doctors and Nurses in the mid-eighties. This made it possible to strengthen the capacity of the health system on prevention and analysis of community health and clinical services.

In 1982, the need was raised for a General Physician to provide services in different locations: a sugar mill, a boat, a school, an internationalist mission, or in a urban residential area. The new grogram was based on the designation of a physician and a nurse to take care of a number of families (approximately six hundred and seven hundred people) living in the same town or neighborhood. These professionals would combine the work in the community, in the hospital and in the office, and had to integrate into their practice the knowledge of the basic specialties (internal medicine, obstetrics, gynecology and pediatrics). The idea of the Family Physician had to to do with a complete and thorough knowledge of the environment and conditions in which people lived.[3]

In the nineties the program placed family physicians and nurses all over the country and managed to serve well over 95% of the population. In 2008, further changes were introduced in the primary care in Cuba. Since 2002, 241 polyclinics have undergone extensive renovation, a process that continues today. The purpose is to add services previously available only in hospitals. Currently, the average polyclinic offers 22 services, including rehabilitation, radiology, ultrasound, optometry, endoscopy, thrombolysis, emergency services, orthopedics, clinical laboratories, family planning, dental, maternal and child health, immunization and care for the elderly and people with diabetes. (Luna, 2010).The roles of the polyclinic and the offices of family physicians and nurses are also evolving. In this regard, Dr. Luna says:

"Since 2007, the polyclinics are expected to play a leading role in capacity building and quality control among health-related institutions in their communities. We have incorporated into our teams directors of pharmacies, nursing homes, maternity homes and others and we have also begun to offer more training to health workers from the Federation of Cuban Women, professionalizing their work in the community".

The interdisciplinary perspective in Primary Health Care

Primary Care is the basic and initial level of attention. It which guarantees the globality and continuity of care throughout the patient's life, acting as manager, case coordinator and flow regulator. It includes research, health promotion, health education, disease prevention, health care, maintenance and restoration of health and physical rehabilitation. It requires a working concept that goes beyond the bounds of a profession, a field of knowledge and a scientific discipline. In Cuba's conditions, this concept acquires more dimensions if one takes into account the following elements:

1. The introduction of a new formula in the reorganization of the system as a result of the presence of more than 20,000 Cuban physicians living abroad, mostly in Africa and Latin America. Its characteristic feature is the rapid formation of new family physicians: "We are now training 42% more family physicians in order to meet all our commitments and to improve levels of patients' satisfaction" (Luna, 2010).
2. The changing nature of new health problems. Urbanization, globalization and other factors speed the worldwide spread of communicable diseases and increase the burden of chronic disorders.
3. Climate change and food insecurity shall have a major impact on health in the years ahead, so that the articulation of an effective and equitable response will involve huge challenges.
4. The development of interdisciplinary social sciences research within the framework of community development.
5. The presence of a variety of Centers of Studies and Research whose results point to improving the quality of life for Cubans.

Working for more than 25 years in Cuban communities, through research focused on studies of cultural processes, has made it posible to introduce, validate and support the importance of the cultural perspective in social analysis. In the case that concerns the author of this paper the socio-semiotic concept of culture is a valuable tool for understanding the problems of health and disease.

The socio-semiotic concept of culture for understanding the culture-health link in Primary Care.

The analysis of contemporary processes in healthcare needs an approach that goes beyond disciplinary boundaries.The transformation of communication processes, the eating habits induced by the media, and the constant renewal of the social scene, lead to rethinking the traditional paradigms that are still being used to address health problems within the framework of community development.

It is increasingly evident that contemporary cultural phenomena the emergence of the Internet, the issue of consumption and its significance, the intensification of multicultural relations, the emergence of new cultural practices – demand to go beyond the traditional divisions and scientific methodologies, introducing new concepts and approaches to promote greater cultural and health dialogue clamored for by more and more voices from the communities and public institutions.

All of these elements require complex readings, interpretations that go beyond the alleged theoretical support provided by traditional paradigms, and therefore, highlight the need for greater presence of cultural discourses on the development of a healthier attitude.

Thus, it is necessary to weigh the subjective dimension represented by the area of structured and socially established consciousness with its particular set of distinctive symbolic codes with the necessary constitution of society's critical sense (Alexander, 2000).

For the present case, the socio-semiotic concept of culture appears, then, as a useful theoretical approach for achieving a greater understanding of issues relating to healthy living in communal areas. This lies in an approach focused on a cultural analysis of health phenomena that are framed in the context of community development. An analytical perspective is here introduced which permits the affirmation that culture projects the area of priority of the symbolic dimensions, and therefore, this approach stands as a criterion for disease research and health prevention.

In his book *Different, Unequal and Offline. Maps of multiculturalism* – (2004) Néstor García Canclini takes up in detail the issue of multiple definitions of culture. This text assumes a more inclusive concept of culture. This is because in the late 90's, important valuations were introduced, founded on the new contexts, in which Latin American multiculturalism is produced and sustained by a significant scientific production, very diverse, beginning with its epistemic constructs. García Canclini has pointed out that:

As there are more sociological studies of culture and anthropological studies on cultural modernization, convergence is observed primarily with respect to the object of study. Coinciding with other disciplines and trends in the social sciences, linguistics, semiotics, communication studies, many anthropologists and sociologists now define culture as the ***sphere of production, circulation and consumption of significant****s. (García Canclini, 2004: 233).*

In the work mentioned above, Néstor García Canclini makes an important contribution to cultural studies when he incorporates new trends. Because of their importance, they are located in this section.[4]

The first trend is one that sees culture as the instance in which each group organizes its identity. Culture is presented in everyday use when it is identified with education, enlightenment, sophistication, vast information. In this line, in the words of García Canclini, culture is the accumulation of knowledge and intellectual and aesthetic skills. (García Canclini, 2005: 30).

In contrast to uses of culture that were held to establish the distinction between culture and civilization, another theory exists that suggests a confrontation of the pairs nature-culture and society-culture. There is a complex and intense, overlapping between social and cultural processes and one of the main thesis emerges: All social practices contain a cultural dimension, but not everything in these social practices is culture. The book of Pierre Bourdieu, *Practical reasons on the theory of action;* the one of Clifford Geertz, *The Interpretation of Cultures,* and the one of Jean Baudrillard, *Critique of Political Economy of the Sign,* have shown from different scientific perspectives, the symbolic aspect of social life produced by culture. Thus the world of meaning is attributed to culture. Culture encompasses all the social processes of meaning, or stated in a more complex way, culture embraces all social processes of production, circulation and consumption of significance in social life (García Canclini, 2005: 34). Culture is the space of social reproduction and organization of differences.

What epistemological implications are encompassed by this definition? What is its scope for the development of health research? What methodological tools does it offer to scholars, researchers, and technicians involved in the studies of primary health care?

The sociosemiotic concept of culture is presented as social processes of what is produced, what is learned and what is consumed in social history. This procedural and changing conception of culture becomes evident when we study complex societies, not only from cultural production, but also from the established interconnections in the social fabric at the micro and macro levels.

Culture, understood as the space of construction of meaning, prevents us from the uncritical use of words, especially those that have the ability to establish facts, as they are accompanied by coercive or persuasive actions.

In short, *culture* as a concept is useful to name the whole process of production, circulation and consumption of meanings, with the following specifications:

1. Culture and symbolic mediations play a role in structuring the functions of social and cultural

practices. From this perspective, the instrumental resources offered by the concept are also presented as a dynamic knowledge area where codes, meanings and symbols underlie and structure society. This makes apparent changes, mobility and order, that different individuals, groups and social classes incorporate in their worlds of feelings, perceptions, representations and imaginariums.
2. The symbolic dimension refers to field processes, as the processes involved in everyday life. Cultural analysis is applied to the organized production of knowledge, information, images and speeches; it is also applied to the continued production of meaning at the level of everyday relationships and interactions located where individuals are involved with others and themselves.
3. Symbolic production in private and public spaces is conditioned by the processes of the dominant social life, by a mode of production that organizes the development over time of a set of structured and contradictory social relations, or that organizes a social process in its development. The patterns of significance are elements of that process, and part of the dynamic and complex factors of social life, forming entities of meaning that participate in the general process of social production and reproduction.
4. In community frameworks where Primary Health Care is established, individuals, families and social groups project their cultures, i.e., the set of meanings that guide a way to produce a reality suited to their interests, traditions, practices and representations.This accounts for the different and various explanations on behaviors and their interpretation.
5. The growing autonomy of specialized fields of symbolic production confines the spaces in which the struggle for social construction of meaning takes place, because if it is true that in capitalist societies the ruling class owns the means of production in the economic sense, and also most of the means of symbolic production, it should not to be thought of as an act of total and crushing domination. Subaltern classes and groups are not totally without resources; capitalism, the logic of value, does not cover all areas of social life.
6. The analysis of culture, understood as a set of processes of meaning, can choose as the focus of its study the identification of situations of symbolic violence, that is when it comes to imposing the existence of a meaning on others.
7. Cultural analysis can be translated into models of communication that would consider the meeting (horizontal, vertical or oblique) between subjects with different meanings on a single practice, object or cultural institution. The theoretical construction of horizons of interpretation would investigate the sociological origin of meaning, and question the relationships established between individuals and social contexts in which they participate.

If the above specifications are agreed upon, the necessary elements for designing a model of cultural analysis to understand the determinants of health are present. These include:

a. **A relational approach**, because we are interested in studying situations where the processes of significance are transformed into symbolic violence: What happens between signs, meanings and interpretations?
b. **An inquiry into language**, because language is an institutionalized power.
c. **Contextualization**, because the processes of meaning are embedded in specific contexts. Temporal and spatial dimensions are not only criteria of delimitation but symbolic ordering constraints of the individual life, imposing timetables, rhythms and age groups, or establishing a distinction of places, regions and territories.
d. **Diverse formalization procedures** in order to study the internal structure of the processes of meaning, to know what is its capacity to symbolize.
e. Finally, **a hermeneutic practice** that allows rebuilding, creatively, the overall sense of purpose, practice or discourse analyzed.

Culture determines the socio-epidemiological distribution of disease in two ways, namely:

- From a local perspective, culture shapes the behavior of individuals that predispose people to certain diseases.
- From a global perspective, the political-economic forces and cultural practices make people act with the environment in ways that can affect health.

All activities of our everyday lives are conditioned culturaly. Culture shapes our behavior homogenizing social behavior and, in turn, making us distinguish differences and inequalities. Therefore culture is a variable to explain these differences and inequalities at different levels of society.

Culture is a social construct, and therefore the habits that are constituted as cultural and socially acceptable norms also change. The more or less healthy behaviors acquire a different dimension in terms of social significance that they have at a given time.

Towards a proposal for a tool from cultural factors in Primary Health Care

One of the changes in primary care in Cuba was the creation of multidisciplinary teams who used the philosophy of a comprehensive health care, understood as the effect of the interaction between biological, psychological, social and cultural factors. This implied the consideration, research, and intervention in all of these factors from the experience, knowledge and participation of different groups who influence the health-disease beyond the traditional health care concept.

During the late 1980's, the organization of interdisciplinary teams linked to social and cultural institutions began to be used on a more permanent basis. The more effective experiences have been in rural settlements, semi-urban and coastal areas of the municipality of Guamá in the province of Santiago de Cuba, which are the initial points of reference from the Universidad de Oriente.

The experiences and the subsequent development of social sciences at the Faculty of Social Sciences at the Universidad de Oriente has enabled the introduction of a variety of alternative methodologies aimed at improving the quality of life of hundreds of families, groups and individuals of those areas of the eastern region of Cuba. One of them is precisely the work with cultural factors.

The incorporating of cultural factors in diagnostic health studies on primary care, report essentials of human behavior: they also endow greater integraly in their analysis, reflections, reviews and epistemological structures, complementing the studies of diseases that are the object of inquiry.

Cultural factors facilitate the perception of distinctive features that make up different human groups and settlements within the same geographic and social space. They also help to understand significant trends and explain possible links established between the actions of individuals and groups and social dynamics. Cultural factors are not dimensions, or elements. They are defining conditions reported as essentials of human behavior. Issues such as religion, customs and traditions provide a set of meanings that cannot be ignored in studies of health and disease (Martínez and Illescas, 2007).

A deeper study of these meanings, leads to discern which factors are dynamic and which are static, taking as basic criteria the stability, permanence in time and rupture. Thus, language and customs are part of the first group; communications and technology, of the second.

The use of these factors in health studies supports obtaining a summary of all the accumulated and socialized experience by different social groups, individuals and families in their daily lives.The new elements that are incorporated as a result of modernity, also express the levels of development of cultural values that are evolving. Professional, administrative, technological and productive levels are carriers of new forms of cultural creation and reveal other ways of establishing relationships, new roles, attitudes and procedures; and therefore the new diseases that are contracted as a result of multiple interactions of human groups with their environment.

The introduction of cultural factors also demands the incorporation of anthropological, sociological, psychological and semiotic perspectives in health studies.

Methodological approaches

The experiences presented are the results of a research paper prepared by the Center for the Integral Development of Culture[5], that has studied since 1996, issues of culture and community development from a variety of disciplines.

The methodological approaches. That are included, are results of interdisciplinary work that is being developed in several neighborhoods of the city of Santiago de Cuba, where the concepts of health and illness have had and still have significant presence. The aim is to provide a conceptual and methodological framework for working with the community, from the binomial culture-health. The tasks in the organization of work of the interdisciplinary team are:

- Recover the history of the group and make a diagnosis on the present situation, include new members and discover the degree of closeness and commitment to the community's health proposal.
- Promote interdisciplinary spaces where work will be focused on the difficulties and ways to resolve them.

- Analyze the daily difficulties, the obstacles to the realization of scheduled tasks, reviewing the slogans raised in team meetings.
- Record activities and projects and collaborate in setting priorities and planning activities.
- Incorporate the cultural and historical dimension within the team in order to broaden its conception of the processes of health-disease-care.
- Encourage processes of reflection on the institution: its history, organization, policy, power relations.
- Provide information on the program area's population in terms of demographic composition, history, organizations, groups and institutions.
- Reflect on strategies of community work to coordinate externally.

A model of analysis was drawn up which contains the theoretical dimensions and the analytical concepts for the explanation of health behavior and disease. The dimensions incorporate the socio-semiotic conception of culture; the cultural conception of health and the cultural conception of Primary Health Care. The analytical concepts are: a) Cultural practices, meanings and orality that correspond to the socio-semiotic conception. b) Family, group, individual and community, that in turn, correspond to the cultural conception of health. c) Concepts of cultural differences, inequalities and communication related to cultural competence.

In regards to the community, this meant increasing the knowledge its history, its forms of organization, institutions, leadership, networks, forms of communication, existing logic, symbolic violence, orality. Reflecting on the community and its relationships to the health center and taking into account the degree of approximation, images, expectations, experiences and applications in health care and programs, we sought to strengthen existing links and develop an appropriate methodology of work.

Categories to take into account

- Secondary orality.
- Rites.
- Legends.
- Magical-religious feast days.
- Food traditions.
- Feeding practices.
- Use of technological devices.
- Labor tradition.
- Forms and conditions under which commuters travel.
- Social spaces created.
- Consumption of green medicine.
- Cultural practices associated with hygiene.
- Sexual practices.
- Use of fashion.
- Community cultural dynamics.
- Symbolic violence.
- Patriarchal model.
- Matriarchal model.
- Socialized model of disease.
- Family space distribution.
- Social background and cultural consumption.
- Shared symbols.

Methods and tools

On the theoretical level. The analysis-synthesis, for the purpose of the review of the literature and the development of synthetic ideas, as well as the historical-logical method. Sociological and anthropological theories are used as methods.

On the empirical level. The use of statistical inferences from existing documentation, and the application of tools developed from interviews, ethnographic methods and questionnaires on the basis of methodological triangulation in terms of data and techniques. The use of questionnaires for patients and people in the community. The use of records of observation in public spaces, of social, food, and health facilities. And also the use of conceptual maps.

Bridges of communication should be built between the different disciplines that share the space of primary health care, facilitating the exchange of knowledge based on respect for the diversity of views that flow into one complex and evolving subject; the utopia to which we have referred as multidisciplinary teamwork could then be possible. This would result in an improved quality of services provided to citizens, making the philosophy of a comprehensive health care a reality. Disease and health are two internal concepts of each culture. To get a better understanding of the prevalence and distribution of health and illness in a society, we need a comprehensive approach that combines sociological and anthropological issues in addition to biological and medical knowledge about health and disease. We also have to create networks and work with the concept of coordination at various levels of the local structure.

Notes

1. Professor, Center for Integrated Development Studies of Culture. Faculty of Social Sciences. Universidad de Oriente, Cuba. alicia@cnea.uo.edu.cu
2. A movement towards the development of primary health care was being implemented in close coordination with the Ministry of Public Health (MINSAP) and driven by the activities of health education. It created the popular community actions. This was first expressed in the rural health posts of the volunteers of the National Malaria Eradication Service (SNEP), and a little later with the Health Officers of the Committees for the Defense of the Revolution and the Health Brigades of the Federation of Cuban Women. The "Schools of Health" were created for them. Community officials gave support for primary care services through the Ministry of Social Welfare.
3. In September 1983, a document entitled "Considerations about linking the health team to the block" stated the need to divide the population according to the political-administrative structures.Two main objectives were pursued: Focus on faster and more effective solutions to epidemiological problems and environmental health; and facilitate and promote the participation of mass organizations in healthcare in order to boost the role of local government bodies, strengthening the link between general practitioner and family groups organized in the community. Thus, on MINSAP 10 doctors were selected to implement the pilot program. The Polyclinic chosen was "Lawton" in the Township of Ciudad de La Habana because of the effective performance of doctors in that place and because of its geographical location and the characteristics of its population, mainly a working-class neighborhood. The three-month pilot study used a group of nurses who worked in the different sectors of the political-administrative division at the Defence Committees of the Revolution (CDR). In this way, the basic unit of community health was restructured.
4. In the book "D*ifferent, disparate and disconnected. Map of multiculturalism";* García Canclini proposes three key elements to address the issue of multiculturalism and globalization: difference, inequality and disconnection. He wondered not only how to recognize the differences and to correct inequalities, but also how to connect the majority of global networks.
5. Center for Integrated Development Studies of Cultural Development affiliated to the Faculty of Social Sciences at Universidad de Oriente. The following academic programs were developed: Master of Community Cultural Development; Ph.D. in Sociological Studies of Culture; Popular Education Diploma and Community Work. More than 500 professionals have graduated from these programs. Culture and mentality of society in Santiago was the topic of research. Dr. Martínez Tena has received several national scientific awards for her research and teaching.

References

Alexander, J. (2000). *Sociología cultural. Formas de clasificación de las sociedades modernas*. [Cultural Sociology. Forms of classification of modern societies]. Barcelona: Anthropos.

Ander-Egg, E. (1989). *Metodología y práctica del desarrollo de la comunidad. 10ª ed.* [Methodology and practice of community development 10th edition]. Mexico City: El Ateneo.

Espina Prieto, M. P. (2005). Re-emergencia crítica del concepto de desarrollo. In *Trabajo Comunitario. Selección de lecturas.* [Community work. Selection of readings]. La Habana: Editorial Caminos.

Expósito García, E. (1998). *Hacia una conceptualización del desarrollo.* [Towards a conceptualization of development]. Trabajo inédito. [Unpublished manuscript]. Santiago de Cuba: Universidad de Oriente.

García Canclini, N. (2005). *Diferentes, desiguales y desconectados.* [Differents, unequals and disconnected]. Mexico City: Gedisa.

García Canclini, N. (2004). Los estudios culturales de los 80 a los 90: Perspectivas antropológicas y sociológicas en América Latina. [Cultural studies of the Eighties and the Nineties. Sociological and anthropological perspectives in Latin America]. In *Sociología de la Cultura. Compilación*. [Sociology of Culture. Compilation]. La Habana: Editorial Félix Varela.

García Canclini, N. (1989). La crisis teórica en la investigación sobre cultura popular. [Theoretical crisis on cultural popular research]. *Nuestra América.* 13 (1).

García Canclini, N. (1988). Teoría e investigación en la antropología social mexicana. [Theory and Research on Mexican Social Anthropology] *Cuadernos de la Casa Chata 160*. Mexico City: CIESAS, UNAM.

García Canclini, N. (1990). *Culturas híbridas. Estrategias para entrar y salir de la modernidad*. [Hybrid cultures. Strategies to enter and get out from modernity]. Mexico City: CNCA-Grijalbo.

García Canclini, N. (1999). *La globalización imaginada*. [Imagined globalisation]. Buenos Aires: Paidós.

García Canclini N. (1979). *La producción simbólica. Teoría y método en sociología del arte*. [Symbolic production. Theory and method in the sociology of art]. Mexico City: Siglo XXI.

García Canclini, N. 1(995). *Consumidores y ciudadanos. Conflictos multiculturales de la globalización*. [Consumers and citizens. Multicultural conflicts in globalization.]. Mexico City: Grijalbo.

Hernández, N. C. (2005). *Trabajo comunitario. Selección de lecturas*. [Community work. Selection of reading]. La Habana: Editorial Caminos.

Delgado García, G. (2005). Antecedentes históricos de la atención primaria de salud en Cuba. [Historical antecedents of primary health care in Cuba]. *Revista Cubana de Salud Pública*. 31(2).

Rojas Ochoa, F. (2003). Orígenes del movimiento de atención primaria de salud en Cuba. [Origins of the movement of primary health in Cuba]. *Revista Cubana de Medicina General Integral.* 19(1) 56-61.

Rojas Ochoa, F (2004). *La atención primaria de salud en Cuba 1959-1984*. [Primary health care in Cuba 1959-1984]. Conferencia leída en el Simposio "Mario Escalona, in Memoriam: Teoría y práctica de la atención primaria de salud". ["Mario Escalona, in Memoriam: Theory and practice of primary health care]. La Habana: Escuela Nacional de Salud Pública. [National School of Public Health]. June 11th. (Accessed 19th May 2010).

Luna, C. (2010). *La revolución de la atención primaria en Cuba cumple 30 años*. [Thirty years of the Revolution in primary care in Cuba]. Entrevista a la Dra. Cristina Luna, Directora Nacional de atención ambulatoria en Cuba. [Interview to Dra. Cristina Luna. National Director of Mobile Care in Cuba]. (Accessed 19th May 2010).

Más Hernández, A. M. (1998). *Atención Médica Primaria en Cuba: su organización y evolución histórica*. [Primary Medical Care in Cuba: Organization and historical evolution]. Tesis de Especialización. La Habana: Facultad de Salud Pública.

Martínez Tena A. & Illescas Nájera I. (2007). *Los estudios de la cultura en el desarrollo comunitario.* [Cultural studies of community development]. Santiago de Cuba: Monografías de la Universidad de Oriente. [Universidad de Oriente Monographs].