

Health-seeking norms for tuberculosis symptoms in southern Angola: implications for behaviour change communications

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SUMMARY

SETTING: A passive case-finding strategy as present in the DOTS strategy presupposes a patient's willingness to seek care. This requires awareness of tuberculosis (TB) symptoms and the diagnostic process, and positive attitudes towards access and probability of cure.

OBJECTIVE: To measure parameters of health-seeking intention in Southern Angola and to inform the design of context-specific interventions to improve case detection.

DESIGN: A survey in four communities based on the cough-to-cure pathway represented by five domains with either one or two proxy measures. These were assessed for association with appropriate health-seeking behaviour (visiting a medical institution or service).

RESULTS: In total, 805 individuals were included in the study. Appropriate health-seeking behaviour was positively associated with knowing the disease (OR 3.1,

95%CI 1.4–6.8), knowing key symptoms (OR 1.4, 95%CI 1.0–1.9), perceived curability (OR 1.3, 95%CI 1.0–1.6), and the perception that TB services were free of charge (OR 1.9, 95%CI 1.4–2.7). Respondents who perceived a personal risk for TB were less likely to have an appropriate intended health-seeking behaviour (OR 0.7, 95%CI 0.5–0.9).

CONCLUSION: Knowledge about TB should include key symptoms, perceived curability and information on access to services when designing interventions to improve case detection. The study highlights the importance of advocacy, social mobilisation and communication strategies.

KEY WORDS: tuberculosis; health seeking; Angola; ACSM; KAP survey

SINCE 2002, Angola has been recovering from the effects of a 27-year-long civil war. Civil wars are known to be strongly associated with increased morbidity and mortality due to population displacement, food insecurity, the breakdown of infectious disease control programmes and erosion of health systems.^{1,2} These challenges are reflected in Angola's poor health and socio-economic statistics.³

The estimated incidence rate of tuberculosis (TB), all forms, in the country was 287 per 100 000 population in 2008.⁴ The cure rate is low, which is attributed to a lack of access to TB diagnosis and treatment using the DOTS strategy.

The National Tuberculosis Programme (NTP) prioritises the establishment of good quality TB diagnostic and treatment services throughout the country. However, a passive case-finding strategy as employed under DOTS presupposes a patient's willingness to seek care at an appropriate health facility. This implicitly requires adequate awareness of TB symptoms and the diagnostic process and positive attitudes towards access and probability of cure.

Since 2007, the Angolan NTP has been implementing a project with the main objective of expanding quality DOTS services and an emphasis on increasing TB awareness through advocacy, communication and social mobilisation (ACSM) activities.

There are no recent data available from Angola on attitudes and beliefs about TB and health-seeking behaviour for chronic cough. This makes interventions aimed at encouraging timely diagnosis difficult to design. There is emerging evidence from other contexts that communication and social mobilisation can contribute significantly to behaviour change, provided the intervention uses appropriate channels and reflects context-specific structural and social enablers, and confronts barriers to TB care.⁵

Surveys on knowledge, attitudes and practices (KAP survey) in the field of TB are often performed within specific populations or geared to specific health care providers. Information can then be used to design specific interventions.

We performed a KAP survey in relation to health-seeking intention for cough to be able to design

context-specific ACSM interventions for different communities in southern Angola.

METHODS

Setting and study population

The survey was executed between September and December 2007. In each community, a maximum of two adults (aged ≥ 15 years) from consecutively sampled households were enrolled. When no second adult respondent was available, an additional household was included. The starting point of the household sampling was randomly selected, while consecutive households were added in a door-to-door manner. Inclusion was stopped after 200 adults from each community were enrolled. No specific inclusion or exclusion criteria were defined, apart from age ≥ 15 years; however, where possible, heads of households were selected. The communities were purposely selected to represent distinct populations.

Conceptual framework and instrument

The conceptual framework for this study was based on the 'cough-to-cure pathway'. The pathway defines key steps in the diagnosis and treatment of TB, some of which are hypothesised drivers of individual health-seeking behaviour.⁶ This study focused on four of the six steps which pertain to knowledge and attitudes of the general population (Figure). We defined five domains with either one or two proxy measures representing each step.

The questionnaire contained categorical and open-ended items,⁶ was translated into Portuguese and appropriate local languages, and verified by back-translation into English. The questionnaire was pre-tested by a central team of interviewers after receiving training in administering the instrument. Interviewers from the communities were added to ensure linguistic and cultural understanding.

Outcome and explanatory variables

The primary outcome variable was 'the intention to seek diagnosis for TB at a medical facility or service in the event of a chronic cough', denoted further as appropriate health-seeking behaviour. The five different domains in the conceptual framework acted as explanatory variables.

The domain of 'knowledge' included four dichotomised variables: 1) 'having heard of TB', 2) 'key TB symptoms knowledge', 3) knowledge that TB can be cured, and 4) 'perceived susceptibility to TB'. Knowledge of key TB symptoms was defined as the ability to mention at least cough for >3 weeks and/or coughing blood as key symptoms of TB. These symptoms were chosen because they are known to have a higher sensitivity (chronic cough) or specificity (coughing blood) for bacteriologically confirmed TB, compared to other symptoms.

In addition to this variable, we defined a composite 'symptom score' to assess whether knowledge of any symptoms of TB was associated with appropriate health-seeking behaviour. The score was based on the diagnostic odds ratio (OR) of common TB symptoms from population-based surveys.⁷⁻⁹ A diagnostic OR defines the relative strength of a variable based on combined sensitivity and specificity of the variable for an outcome.¹⁰ Using this methodology, chronic cough had the strongest association with TB, followed by weight loss. Weaker associations were seen for fever and haemoptysis. In our symptom score, the symptom cough was given 2 points, weight loss 1.5, fever and haemoptysis 1.0, and all other symptoms 0.5 points. The total symptom score for a participant was the sum of the points.

The domain 'disclosure' was represented by a dichotomised variable denoting the willingness to inform friends and family about having TB disease.

The domain 'access' was represented by a dichotomised variable denoting the perception that diagnosis and treatment of TB were free of charge.

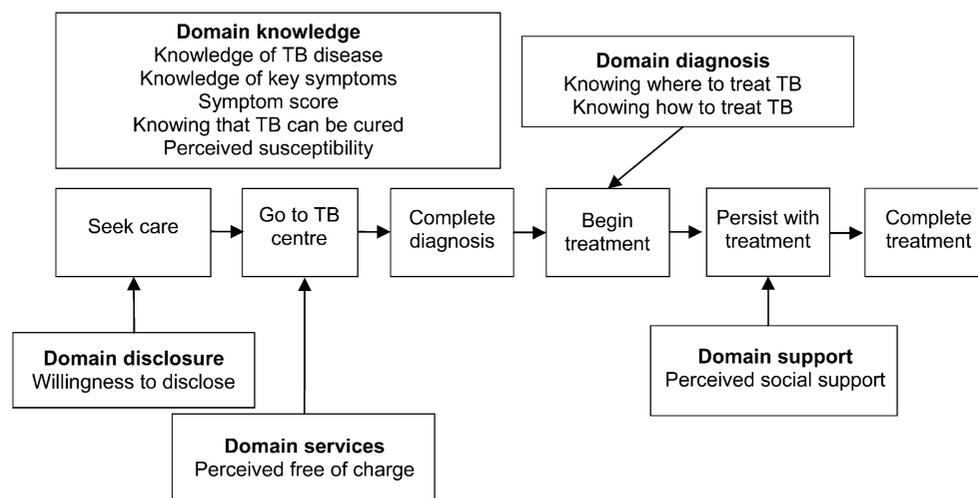


Figure Cough-to-cure pathway and questionnaire items. TB = tuberculosis.

The domain 'diagnosis' consisted of two dichotomised variables indicating knowledge about where TB can be treated and that treatment consists of prolonged intake of medication.

The domain 'support' was represented by a dichotomised variable indicating the perception that there would be social support when being treated for TB.

Demographic characteristics were sex, age group (<30, 30–49, ≥50 years), education (none, only primary, above primary) and occupation (farmer, trader, domestic, other).

The association between outcome and explanatory variables was assessed by logistic regression. Given the stratified design (four communities), we used a robust standard error in these analyses to adjust for clustering of data within a stratum. There were protocol deviations with respect to the inclusion of the number of participants per household, which might have introduced systematic errors in strata of cluster, age and sex. All regression analyses, therefore, included an interaction term for stratum and age group, and stratum and sex.

A full multivariable analysis assessed the strength of the domains combined. A parsimonious analysis identified the domains that best explained the observed data.

Sample size

The sample size was based on the assumption that the ACSM activities in the study areas would increase the percentage of respondents with appropriate knowledge of TB by at least 50% from the baseline value of 30% when the KAP survey is repeated. For this increase to be statistically significant, the number of respondents needed was 640. Adjusting for clustering within the household ($\kappa = 0.35$) and missing data, the sample size was increased to 800.

Ethical clearance

The study was conducted after clearance from the NTP of the Angolan Ministry of Health. All participants were informed about the objective of the study and provided verbal informed consent.

RESULTS

The study was carried out in four purposely selected communities in southern Angola. Lubango is an urban community, and the first considerable town for transport/import from Namibia. Its population has sustained access to education, diverse employment and a variety of media. Lubango has a provincial referral hospital, a private hospital and several health posts. The complete package of DOTS is offered only in the public hospital and a few of the health posts.

The Rio de Huila community is mainly pastoral, with some agricultural subsistence activities. While not far from Lubango, residents do not necessarily con-

form to urban health-seeking norms. A small mission hospital offers TB services and does outreach activities, including health education. Access to education and employment is increasing.

The Muhino community resides in the pre-desert, is nomadic, pastoral and is adherent to a belief system that does not privilege cosmopolitan biomedicine. Sustained access to formal education and health information is limited by their nomadic culture. Access to formal health services is difficult, both geographically and culturally.

The Kuvelai community also inhabits remote, scarcely populated areas, practising agriculture. Access to education and health services is challenging due to poor infrastructure and lack of basic public services. Access to health information is restricted to radio and word-of-mouth.

The study enrolled 805 respondents from 637 households. In 486 (76.3%) households a single study participant was included, in 10 (1.6%) households three participants, in two (0.3%) households four participants, and in one (0.2%) household five participants.

Of all participants, 367 (46%) were male: 38% of the respondents were aged <30 years, 40% between 30 and 50 years, and 22% >50 years. Forty-four per cent of the respondents had not received any schooling, 50% had received only primary education, while only 6% had received additional education. Forty-one per cent of the study population were engaged in farming, while just 8% were working in the home (Table 1).

Domain 1: Knowledge

The majority (84%) of respondents had heard of TB. However, knowledge of the two key symptoms of TB was low and differed between the four communities (Table 2).

The knowledge that TB can be cured was present in 61% of the respondents. Slightly over 50% of the

Table 1 Characteristics of the study population

Characteristic	n (%)
Sex	
Male	367 (45.7)
Female	436 (54.3)
Age, years*	
<30	306 (38.0)
30–49	318 (39.5)
≥50	180 (22.4)
Education*	
None	354 (44.0)
Primary	401 (49.8)
Above primary	49 (6.1)
Occupation	
Farmer	333 (41.5)
Trader	158 (19.7)
Domestic worker	63 (7.9)
Other	249 (31.0)

*1 missing data point.

Table 2 Distribution of explanatory and outcome variables by community

Pathway, domain	Lubango <i>n</i> (%)	Rio da Huila <i>n</i> (%)	Kuvelai <i>n</i> (%)	Munhino <i>n</i> (%)	Total <i>n</i> (%)	Health-seeking behaviour	
						Appropriate [†] <i>n</i> (%)	Not appropriate <i>n</i> (%)
Seeking care							
Knowledge							
Heard of TB	145 (71.8)	191 (94.6)	167 (84.3)	173 (85.6)	676 (84.1)	496 (73.4)	180 (26.6)
At least one key symptom*	11 (5.5)	45 (22.3)	20 (10.1)	28 (13.8)	104 (12.9)	80 (76.9)	24 (23.1)
Symptom score, median [IQR]	0.5 [0–1.5]	1.5 [0.5–2.5]	1 [0–2]	0 [0–1.5]	1 [0–2]	0 [0–1.5]	1.5 [0–2]
Knows TB can be cured	118 (58.4)	152 (75.3)	105 (52.8)	116 (57.4)	491 (61.0)	368 (75.0)	123 (25.0)
Perceived susceptible for TB	110 (54.5)	95 (47.0)	100 (50.3)	105 (52.0)	410 (50.9)	259 (63.2)	151 (36.8)
Disclosure							
Willingness to disclose	108 (53.50)	113 (55.9)	142 (71.4)	130 (64.4)	493 (61.2)	360 (73.0)	133 (27.0)
Going to TB centre							
Access							
Perceived free of charge	96 (47.5)	17 (8.4)	90 (45.2)	35 (17.3)	238 (29.6)	164 (68.9)	74 (31.1)
Begin treatment							
Diagnosis							
Knows where TB can be treated	50 (24.8)	102 (50.5)	49 (24.6)	44 (21.8)	245 (30.4)	186 (75.9)	59 (24.1)
Knows how TB can be treated	12 (5.9)	15 (7.4)	9 (4.5)	4 (2.0)	40 (5.0)	32 (80.0)	8 (20.0)
Persist with treatment							
Support							
Perceived social support	77 (38.1)	93 (46.0)	64 (32.2)	43 (21.3)	277 (34.4)	200 (72.2)	77 (27.8)

* Respondent mentioned prolonged cough and/or haemoptysis.

[†] Visits medical centre, a health care worker or has sputum examined.

TB = tuberculosis; IQR = interquartile range.

respondents perceived a personal risk for TB, which was very similar in all communities.

The average symptom score in the study population was 1.0 (interquartile range 0–2), which indicates that the respondents often mentioned a single symptom, or a less important symptom.

Domain 2: Disclosure

More than half of the respondents would be willing to disclose having TB to friends; this was as high as 71% in Kuvelai.

Domain 3: Access

Overall, 30% of the study population perceived that TB services were free of charge; however, there were very large differences between the communities. In Rio de Huila, only 8.4% of the respondents thought that TB services were free, while this was as high as 47.5% in Lubango. Services that were perceived as not being free of charge included consultation fee ($n = 140$, 17%) and medication ($n = 134$, 17%).

Domain 4: Diagnosis

Just under one third of the respondents knew where TB could be treated, while just 5% knew that the treatment consisted of taking medications for a prolonged period of time. Home medication or herbs (7%), traditional treatments (3%) or just rest (3%) were mentioned as possible treatments for TB by a small percentage.

Domain 5: Support

Thirty-four per cent of the study population perceived that social support would be available if they had to be treated for TB.

Health-seeking behaviour

Appropriate health-seeking behaviour was reported by 564 (70.1%) participants overall, 145 (71.8%) in Lubango, 142 (70.3%) in Rio da Huila, 156 (78.4%) in Kuvelai and 121 (59.9%) in Munhino.

In univariable analyses (although including the two interaction terms based on age and sex), appropriate health-seeking intention was strongly associated with having heard of TB as a disease (OR 2.8, 95% confidence interval [CI] 1.6–5.2). Also knowing at least one of the key symptoms of TB was associated with appropriate health seeking (OR 1.6, 95% CI 1.0–2.6). The probability of appropriate health seeking increased with an increased symptom score. For each one point increase in score, the probability of appropriate health seeking increased by 60% (OR 1.6, 95% CI 1.1–2.5). Variables outside the domain of ‘knowledge’ were not statistically significantly associated with appropriate health-seeking behaviour (Table 3).

Assessing all domains at the same time in the full multivariable model (with the interaction terms based on age and sex) identified the domain ‘access’ as being also associated with appropriate health-seeking intention. Perceiving TB services as being free of charge almost doubled the chance of appropriate health seeking (OR 1.9, 95% CI 1.3–2.8). In the parsimonious multivariable model, only variables from these same two domains (‘knowledge’ and ‘access’) were associated with appropriate health seeking, with the strongest association for ‘having heard of TB’ (OR 3.1, 95% CI 1.4–6.8). Knowledge of symptoms that was associated with appropriate health-seeking intention was restricted to knowing one of the key

Table 3 Factors associated with appropriate health-seeking behaviour*

Pathway, domain	Univariable		Full multivariable		Parsimonious	
	OR (95%CI)	P value	OR (95%CI)	P value	OR (95%CI)	P value
Seeking care						
Knowledge						
Heard of TB	2.8 (1.6–5.2)	<0.001	3.1 (1.6–6.9)	0.007	3.1 (1.4–6.8)	0.005
At least one key symptom [†]	1.6 (1.0–2.6)	0.038	1.1 (0.7–1.5)	0.754	1.4 (1.0–1.9)	0.047
Symptom score, median [IQR]	1.6 (1.1–2.5)	0.027	1.3 (0.9–2.0)	0.168		
Knows TB can be cured	1.9 (1.1–3.1)	0.018	1.2 (1.0–1.4)	0.048	1.3 (1.0–1.6)	0.019
Perceived susceptible for TB	0.5 (0.4–0.7)	<0.001	0.7 (0.5–1.0)	0.041	0.7 (0.5–0.9)	0.014
Disclosure						
Willingness to disclose	1.4 (0.8–2.6)	0.275	0.8 (0.5–1.4)	0.411		
Going to TB centre						
Access						
Perceived free of charge	0.7 (0.5–1.1)	0.138	1.9 (1.3–2.8)	0.001	1.9 (1.4–2.7)	<0.001
Begin treatment						
Diagnosis						
Knows where TB can be treated	1.6 (0.9–2.9)	0.148	1.1 (0.7–1.9)	0.618		
Knows how TB can be treated	1.7 (0.3–10.2)	0.582	1.4 (0.3–7.4)	0.694		
Persist with treatment						
Support						
Perceived social support	1.1 (0.6–2.2)	0.763	0.9 (0.5–1.4)	0.523		

* Visits medical centre, a health care worker or has sputum examined.

[†] Respondent mentioned prolonged cough and/or haemoptysis.

TB = tuberculosis; IQR = interquartile range; OR = odds ratio; CI = confidence interval.

symptoms of the disease, rather than a comprehensive 'knowledge score' of all TB symptoms.

DISCUSSION

The study showed that the intention to engage in appropriate health seeking in the event of a chronic cough is high in each of the four communities surveyed. Having heard of TB, knowing key symptoms, perceiving curability and perceiving diagnosis and treatment as being free of charge are instrumental in initiating health seeking in formal health services. These factors need to play a key role in ACSM strategies. This is not to say that ACSM messages should be restricted to creating awareness to key symptoms and service delivery.¹¹

Regarding the knowledge of TB symptoms, it is interesting to see that only knowledge of the two main symptoms is related to health-seeking intention. This observation can help to craft specific health messages.

Under the DOTS strategy, diagnosis and treatment of TB are supposed to be free of charge. Our study showed that this perception is not widespread. This is likely not only attributable to lack of knowledge about the payment strategies of the health system, but may also reflect the reality of differential health-financing practices among health facilities.¹² It has been shown that user fees in Angolan health facilities are unregulated and have a negative effect on access to care.^{12,13}

More difficult to interpret is the finding that the perception of personal susceptibility for TB (rather than specific risk groups) is associated with a decrease in health-seeking behaviour for prolonged cough.

This might be due to fear of the diagnosis, especially if it entails disease that is highly stigmatised in the society.^{14–16} With this interpretation, it is important to include messages regarding the curability of TB and to gear the messages towards specific audiences.

Where there is a high degree of willingness to report to an appropriate health facility when having a prolonged cough, it is critical that these facilities provide an appropriate level of care. This includes identifying TB suspects based on symptoms and initiating adequate diagnostic procedures. Clear guidelines for identification of TB suspects and diagnosing of TB patients are presented in the 'International Standards for Tuberculosis Care'.^{17,18} Reductions in health system delay are likely to include investments in the field of sputum collection,¹⁹ laboratory performance²⁰ and skills of health staff.²¹

There can be some doubt as to whether the health system in the four communities would be capable of responding to this high demand for investigation of prolonged cough. An assessment of the performance of all Angolan public municipal hospitals in 2001–2002 showed low efficiency scores.²² Although the state of the health care sector is improving, there is still a lack of human and institutional capacity and inputs for service delivery.²³

The study respondents were those who were at home during the (repeated) visits of the interviewers. This can be a limitation, as in many settings people at home during the day have been found to differ from those who are away. Despite this, we feel that the expressed perceptions and attitudes can provide valuable guidance in the design of ACSM strategies. It remains to be seen whether the findings would have

been very different if a more representative sample had been obtained.

We reported the findings for the total study population, although possible differentiation between communities was dealt with in a statistically adequate manner. The actual future strategies need to be geared towards the respective communities, guided by the prevalence of the different factors associated with adequate health-seeking behaviour.

CONCLUSIONS

Motivation for adequate health seeking in response to prolonged cough was high in the surveyed areas. This was associated with having heard of TB, knowing key symptoms, perceived curability and the perception that services for diagnosis and treatment were free of charge. These should be messages in future ACSM strategies that focus on improved case detection, and indeed highlight the importance of ACSM.

Acknowledgement

Funding for the project was provided by the Canadian International Development Agency.

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R É S U M É

CONTEXTE : Une stratégie de dépistage passif comme celle adoptée dans la stratégie DOTS présuppose une volonté de recherche de soins. Ceci exige une bonne connaissance des symptômes de la tuberculose (TB), du processus de diagnostic ainsi que des attitudes positives à l'égard de l'accès aux soins et de la probabilité de guérison.

OBJECTIF : Mesurer les paramètres de l'intention de recherche de soins au sud d'Angola afin de servir d'information pour le schéma d'interventions spécifiques au contexte afin d'améliorer la détection des cas.

SCHÉMA : Une enquête dans quatre collectivités basée sur le cough-to-cure pathway représenté par cinq domaines comportant une ou deux mesures d'approximation. Celles-ci ont été évaluées pour leur association avec un comportement approprié de recherche de soins (visite à une institution ou à un service médical).

RÉSULTATS : On a inclus 805 répondants. Un comporte-

ment approprié de recherche de soins est en association positive avec le fait de connaître la maladie (OR 3,1 ; IC95% 1,4–6,8), avec la connaissance des symptômes-clé (OR 1,4 ; IC95% 1,0–1,9), la perception de son caractère curable (OR 1,3 ; IC95% 1,0–1,6) et la perception que les services TB sont gratuits (OR 1,9 ; IC95% 1,4–2,7). Les répondants qui ressentaient un risque personnel de TB ont été moins susceptibles d'avoir une intention appropriée de recherche de soins (OR 0,7 ; IC95% 0,5–0,9).

CONCLUSION : Lorsqu'on élabore des interventions en vue d'une amélioration de la détection des cas, les connaissances en matière de TB devraient comprendre les symptômes-clé, la perception de son caractère curable et une information sur l'accès aux services. Cette étude souligne l'importance de plaidoyers, de la mobilisation sociale et des stratégies de communication.

R E S U M E N

MARCO DE REFERENCIA: La búsqueda pasiva de casos, como se ejerce en la estrategia DOTS, presupone una buena disposición a solicitar la atención médica. Esta condición exige conocer los síntomas de la tuberculosis (TB) y los procedimientos diagnósticos y tener una actitud positiva frente al acceso a la atención y la probabilidad de curación.

OBJETIVO: Medir las variables relacionadas con la intención de buscar atención sanitaria en el sur de Angola, con el fin de documentar el diseño de los métodos de intervenciones específicas de contexto, dirigidas a mejorar la detección de casos.

MÉTODOS: Se llevó a cabo un estudio en cuatro comunidades, con base en el modelo 'de la tos a la cura' constituido por cinco esferas, cada una con una o dos variables representativas. Se examinó la asociación de estas variables con un comportamiento adecuado de búsqueda de atención de salud (acudir a un establecimiento de atención o a un servicio médico).

RESULTADOS: Se incluyeron en el estudio 805 personas que respondieron a la encuesta. La búsqueda adecuada de atención sanitaria se asoció claramente con el conocimiento de la enfermedad (OR 3,1; IC95% 1,4–6,8), el conocimiento de los principales síntomas (OR 1,4, IC95% 1,0–1,9), la percepción de curabilidad (OR 1,3; IC95% 1,0–1,6) y la percepción de la gratuidad de los servicios de atención de la TB (OR 1,9; IC95% 1,4–2,7). En los participantes que percibieron un riesgo personal de padecer la enfermedad fue menos probable observar la intención de una búsqueda adecuada atención sanitaria (OR 0,7; IC95% 0,5–0,9).

CONCLUSIÓN: Cuando se diseñan intervenciones destinadas a mejorar la detección de casos, los conocimientos sobre la TB deben incluir los síntomas principales, la percepción de curabilidad y la información sobre el acceso a los servicios. El presente estudio destaca la importancia de las estrategias de promoción de la causa, movilización social y comunicación.