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Original Article

Evaluating the History-Taking Process of Sexual Reproductive Health Problems in Tanzania: Lessons from a Study of Health Students and Practitioners

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ABSTRACT

Building trust and therapeutic relationships between healthcare providers and patients is crucial for delivering high-quality, comprehensive sexual and reproductive health (SRH) services. Yet, while patients face substantial SRH disparities in Tanzania, little is known about health care professionals' [HCPs] SRH history-taking practices and experiences. This paper describes HCPs' interdisciplinary practices, experience in conducting SRH taking, and the critical lessons learned to optimize quality SRH care. We conducted 18 focus group discussions in June 2019 in Dar es Salaam, Tanzania, with 60 healthcare practitioners and 61 students in midwifery, nursing, and medicine. We implemented a purposive, stratified sampling design to explore the experiences and perspectives of HCPs regarding providing sexual health services. We employed a grounded theory approach to perform the analysis. We provided seven scenarios to participants to discuss how they would manage SRH health problems. The scenarios helped us evaluate the practice and experience of SRH in Tanzania. Four broad themes and sub-themes emerged during the discussion; 1) SRH history-taking practices and experiences in the health care facilities; 2) the perceived benefit of effective SRH history-taking; 3) Factors hindering the SRH history-taking process; 4) The power of confidence. These findings have implications for strengthening a sexual health curriculum for medical students and continuing education programs for practising health professionals designed to address the observed health disparities in Tanzania. These findings affirm that proper SRH history-taking requires a conducive environment, knowledge of relevant SRH-related laws and regulations, application of evidence-based techniques, and giving patients autonomy to make decisions for their health while making recommendations regarding standard care. Comprehensive SRH history-

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taking identifies critical data for illness diagnosis, provides foundational information for risk-reduction behavioural change counselling, and reduces medical costs. Therefore, the primary goal is to optimize health professional training on SRH issues and history-taking skills within the medical interview.

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INTRODUCTION

There has been a global increase in sexual health problems; however, neither healthcare professionals [HCP] nor patients feel confident or willing to discuss them (Ribeiro et al., 2014; Ross et al., 2021; Skelton & Matthews, 2001). Effective management of SRH problems requires comprehensive sexual history-taking to make accurate diagnoses and inform treatment plans. In Tanzania, health facilities often lack advanced diagnostic and therapeutic technologies compared to high–income countries but face substantial disparities in SRH outcomes (Davey et al., 2014; Government of Tanzania, 2017; President Office, 2017). Further, increased medical costs, including medical tests, pose a significant barrier to patients seeking health care services (Hamad, 2019; Nuhu et al., 2020). SRH history-taking skills are critical for correctly diagnosing and managing SRH problems at a low cost compared to using multiple medical laboratory tests to diagnose the illness (Oyedokun et al., 2016).

Unresolved SRH illnesses can affect people physically, mentally, psychologically, and emotionally. Optimizing the HCP-patient relationship is fundamental to facilitating open discussion, promoting shared decision-making, and patient autonomy over their health for continuity of care (Molina-Mula & Gallo-Estrada, 2020). Multiple studies have demonstrated that good medical histories alone result in substantial diagnostic accuracy before physical examination or laboratory testing (Peterson et al., 1992; Van Dijk et al., 2008). Even though medical history-taking skills are beneficial, medical students and practising health providers often fail to achieve or

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maintain and improve these skills (Skelton & Matthews, 2001), which results in over-reliance on diagnostic testing (McMahon et al., 2005). While these tests may enhance diagnostic accuracy, it is crucial to ensure that HCPs have communication strategies and skills to address SRH concerns in practice.

Gathering and documenting vital information from all domains, including the chief complaint, history of present illness, past medical history, family history, and social and behavioural history, is required for effective and holistic clinical decision-making. The detailed medical interview allows providers to show empathy to patients, which is associated with patient satisfaction (Ohm et al., 2013). The sexual history-taking process, often embedded in the social-behavioural history, allows HCPs to identify vital medical issues, establish a therapeutic relationship, and manage care (Elwyn et al., 2010, 2012; Ingram, 2017; Oyedokun et al., 2016; Ross et al., 2021). HCPs should ensure shared decision-making that facilitates and promotes patient engagement and respects patient autonomy. Productive communication is a safe and pleasant environment and is essential to encourage behaviour change for risk reduction (Elwyn et al., 2010; Mahlich et al., 2017) and improved adherence (Joosten et al., 2008).

Prior research demonstrates that HCPs lack confidence and comfort in addressing sexual health-related problems. Patients see this discomfort verbally and non-verbally (Ross et al., 2021), and it may negatively impact the patient experience and HCP effectiveness. Additionally, the HCPs lack a sense of the appropriate SRH questions leading to an increased chance of the ongoing unmet need for SRH care despite being in care (Heritage et al., 2007; Read et al., 1997; Skelton & Matthews, 2001).

Furthermore, cultural beliefs may affect the sexual history-taking process because one's culture influences sexuality and sexual self. The HCP cultural scripts/background are embedded within their practice (Hordern, 2016). In Tanzania, talking about sex is taboo and embarrassing, and the limited availability of sexual terms in Kiswahili affects the history-taking process. Further, the criminalization of some illnesses and sexual orientations undermines the ability of both HCPs and patients to discuss and gather in-depth information about the client's problems (Ross et al., 2021).

The Tanzania government has made several efforts to better ensure the delivery of high-quality care by HCP, such as the publication of sexually transmitted infection treatment guidelines. However, formal training in SRH history-taking hinders the provision of quality sexual health care. (Ross et al., 2021; Skelton & Matthews, 2001). Even though clinical history-taking practices are well-applied by HCPs for general illness, less is known about applying these principles to patients with sexual health concerns. Therefore, this research explores the training, practice approaches, and clinical experiences with SRH history-taking while caring for patients with SRH problems among nursing, midwifery, and medical students and practising HCPs in Tanzania using qualitative research methods.

MATERIAL AND METHODS

The formative qualitative research study was conducted to explore the experiences and perspectives of the experienced HCPs and students in three disciplines: nursing, midwifery, and medicine. This study was conducted under the oversight of the University of Minnesota, USA, the Muhimbili University of Health and Allied Sciences (MUHAS), and the National Institute of Medical Research (NIMR), Tanzania. Institutional Review Boards deemed the study exempt from human subjects' review since the focus was on clinical practice improvement. The methods for this work have been previously described (Mgopa et al., 2021; Mkonyi et al., 2021; Mwakawanga et al., 2021) but will be briefly reviewed here.

In June 2019, 18 focus groups were conducted in Dar es Salaam, Tanzania, with HCPs [health care practitioners and students in nursing, midwifery, and medicine]. The focus group interviews were

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designed to gather providers' experience and practices in managing sexual health and reproductive problems in health facilities. The research team employed a purposive stratified sampling design (Palinkas et al., 2015) to examine the experiences and perspectives of HCPs regarding the provision of sexual health across disciplines and levels of training. During the focus group discussions, participants were asked to identify what common sexual problems their patients had and who raised them as a clinical concern (the patients or the health care providers). Also, participants were presented with seven scenarios focused on sexual health problems. They were asked to state or describe how they would manage the patients using their current clinical experience and approaches learned within their training programs. These scenarios included 1) an adult man with erectile dysfunction, 2) an adult woman with dyspareunia and vaginal warts, 3) a 14-year-old adolescent girl seeking contraceptives, 4) a 9-years-old boy with bruising and anal discharge, 5) an adult man with rectal gonorrhoea, 6) an adult rape victim brought by police, and 7) a 14-years boy brought in by his father who is concerned his son is masturbating. Finally, participants were asked to provide their experiences and perspectives about factors that serve as barriers or facilitators for SRH discussions about SRH with their patients. Focus groups were mixed by gender and age. These characteristics allowed for diverse and contrasting opinions and experiences during the talk (Krueger, 2014). Researchers continued to conduct focus group discussions until we reached a saturation point.

Recruitment, Sampling, and Study Participants

Participants for this study were students who were at least in their fourth year recruited from MUHAS in Dar es Salaam. Healthcare practitioners who had at least five years of clinical experience were recruited from the major public and private health hospitals in Dar-es-Salaam. Students were recruited using fliers, WhatsApp groups, and announcements placed thorough the MUHAS campus. Healthcare providers were recruited using word-of-mouth within a known group of HCPs. Researchers used blocks to ensure providers come from different departments or clinics to ensure a diverse sample. When the team encountered more than one professional in a department who met the criteria, the provider with the highest number of years in the profession was enrolled in the study.

Each focus group consisted of five to eight participants and lasted between 60 and 90 minutes. Focus groups with students were conducted in Kiswahili, English, or both in a private room with no intruders within MUHAS, while with providers were conducted in the providers' private clinic. A moderator and an assistant moderator led each focus group. Participants were informed that the sessions were voluntary, they could discontinue at any time, all responses would be confidential, and the session was audiotaped.

This study included students and health practitioners. Even though some of the moderators and interviewers were lecturers at the MUHAS, students who participated in the study were asked to participate freely and withdraw at any point if they chose to. Researchers assured participants that their honest opinion was crucial and important to the outcome of the study. Researchers also built a good rapport with participants prior to focus group discussion using various icebreakers. Snacks and beverages were provided, which helped to reduce tension among participants (especially student and teacher relationships).

The focus group interview guide consisted of 15 questions that addressed three broad areas: current practice or rotation, sexual health needs of patients, and curricula and training of health professionals. The interview guide was pilot tested among research experts prior to the study. The two groups of questions asked participants about their current practice (or, for students, their most recent rotation) and the sexual health challenges of patients in the country. In addition, participants were given several clinical case studies asking the members to discuss how

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each situation would be managed at their clinic/hospital. The outline was provided at the end of each focus group to allow participants to correct or clarify points to ensure the moderator presented their opinions.

Data Analysis

The 10-to-15-minute recap for each focus group was conducted at the end by facilitators and notes were saved on a shared drive. Labelled audio files, with the focus group's unique identifiers (ID), were uploaded onto a secured server. The audio files were transcribed verbatim and translated into English.

A deductive-inductive coding strategy informed by grounded theory principles was employed to develop the codebook and code the transcripts. A team-based approach to coding and codebook development was implemented (McQueen et al., 1999; Richards, 1999) following a three-step, iterative coding process (Saldana & Omasta, 2018): open coding, first coding cycle, axial coding. The coding and data analysis process was done manually. Pens, colour highlighters, sticky notes, and large flip charts were used during this stage to gather the early ideas and organize the codes under emerging themes. This approach to data analysis enabled a process of debate and reflection that generated a richer understanding of the providers' and students' experiences in delivering sexual health education. The group of experts from MUHAS and the University of Minnesota performed the coding and data analysis process. These experts contributed their experiences as practitioners and researchers to the team, enriching the data collection and data analysis process and serving as important member checks during the development of code definitions and data interpretations. This was accomplished via regular team meetings and the use of a Google Doc, where coders engaged in the process of continuous written feedback and updates to the codes and definitions that led to the reconciliation of disagreements and refinement of the codebook. Detailed data analysis for this work has been previously described in another published article titled, *The Management of Childhood Sexual Abuse by Midwifery, Nursing and Medical Providers in Tanzania* (Mkonyi et al., 2021).

Training and experience of the researchers: All researchers (moderators and assistant moderators) had prior knowledge of conducting FGDs. However, before the data collection process, they received a 4-day refresher training with qualitative experts at the University of Minnesota. During analysis, researchers had a boot camp for 5 days as well. Such training helped to improve the data quality and credibility of the study.

RESULTS

Sample Characteristics

A total of 121 HCPs participated in the focus group discussion; 61 were students, and 60 were healthcare practitioners. Most students were male (62%) and female practitioners (82%). The mean age of students was 25.5 years (SD years) as opposed to the practitioner (43.1 years (SD years). Students had four years of professional educational experience (in school), while practitioners had a mean of 14.6 years of clinical experience (SD). The demographic characteristics of the study participants are described in Table 1. This table was also published earlier in another manuscript (Mkonyi et al., 2021).

Figure 1 describes broader themes followed by subthemes that emerged during the analysis based on the scenarios presented to the participants. These themes namely: 1) SRH History-taking practices and experiences in healthcare facilities, 2) Perceived benefits of effective SRH history-taking, 3) Factors hindering the SRH History-taking Process, and 4) The power of confidence.

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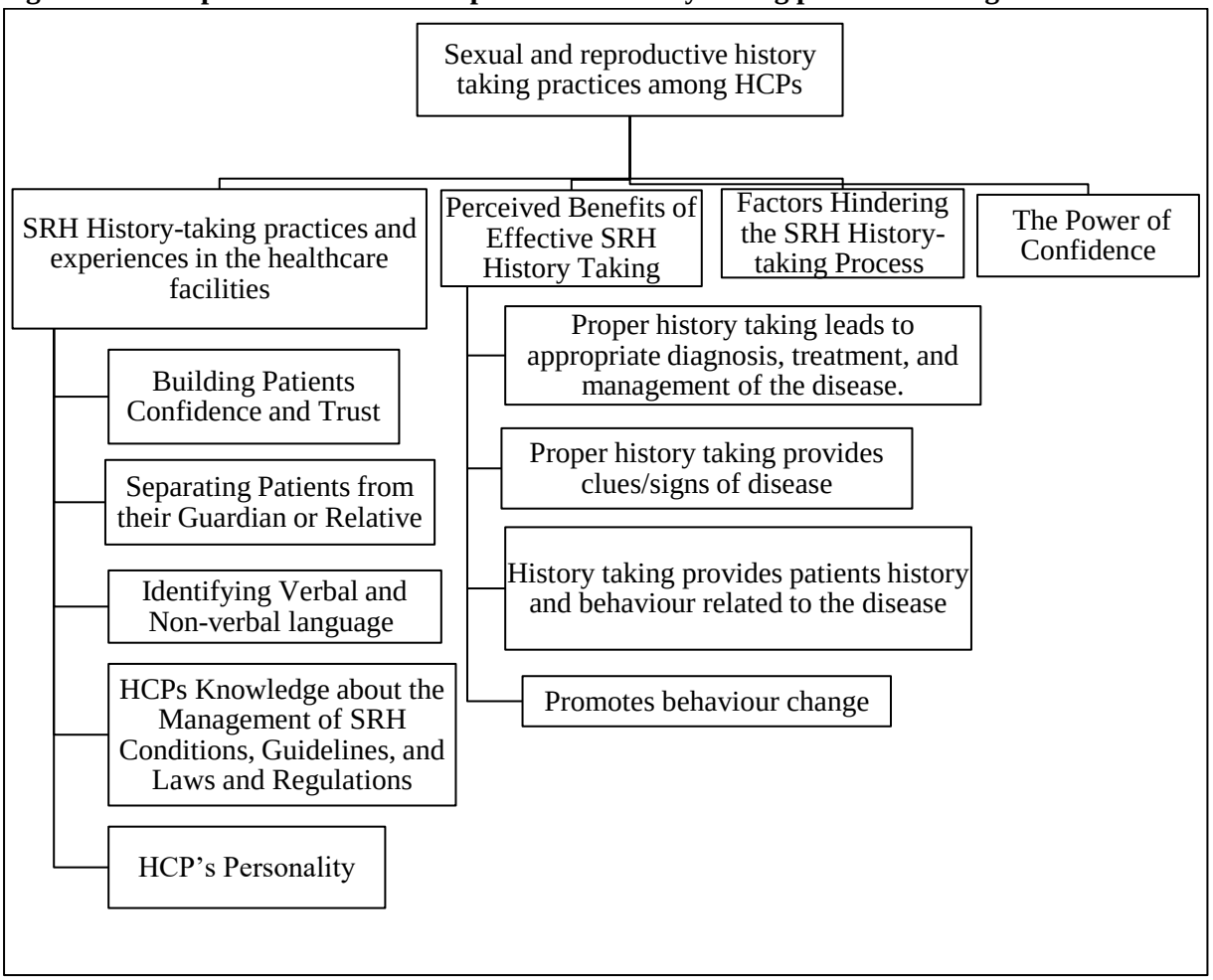
Table 1: Demographic Characteristics of the Sample (N=121 health care students and practitioners, Tanzania)

		Midwifery	Nursing	Medicine	Total
Sample Size	Students	20	19	22	61
	Practitioners	21	21	18	60
	Total	41	40	40	121
Gender	Students	14 M; 6 F	13 M; 6 F	11 M; 11 F	38 M; 23 F
	Practitioners	0 M; 21 F	5 M; 16 F	6 M; 12 F	11 M; 49 F
	Total	14 M; 27 F	18 M; 22 F	17 M; 23 F	49 M; 72 F
Age (in years)	Students: Mean	27.7	25.1	24.0	25.5
	Range	23-37	23-27	22-28	23-37
	Practitioners: Mean	44.5	41.1	43.5	43.1
	Range	26-58	24-59	31-62	24-62
Experience (in years)	Students	4	4	4	4
	Practitioners: Mean	18.0	13.1	11.9	14.6
	Range	4-38	2-30	4-25	2-38

Figure 1: Description of sexual and reproductive history-taking practices among HCPs



Note: This figure was developed using themes and subthemes generated from the Focus Group Discussion.

SRH History-Taking Practices and Experiences in the Healthcare Facilities

Under this theme, several sub-themes emerged: 1) building patient confidence and trust, 2) separating patients from their guardians or relatives, 3) identifying verbal and non-verbal language, 4) HCPs knowledge about the management of SRH conditions, guidelines, and

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Laws and Regulations, and 5) the HCP's personality.

Building Patients' Confidence and Trust

Participants across groups reported that most patients lack the confidence/fear to share their SRH stories with a stranger. However, the more time healthcare providers dedicate to caring while applying listening skills and respect for patients; it increases the chances for patients to open up and provide detailed narratives about the primary concern that brought them to the healthcare facility. For example, the following is a statement revealing this woman's sexual violence scenario:

> *Again, it lies in history-taking ... She comes bruised and beaten, and she says she fell in the bathroom. But looking at the nature of the injuries. It does not look like somebody who fell in the bathroom. That is where you need to create confidence in the patient for her to tell the true story* (Group 7: Medical Doctor Practitioners).

Another midwife said,

And normally, when we admit patients--- the way you talk and create a good relationship and ask questions, she opens up and tells you more of her issues and inner things together with her social problems (Group 2: Midwife's Practitioners).

Separating Patients from their Guardians or Relative

Participants stated that some scenarios seem to be challenging to conduct proper history taking in the presence of relatives, such as child sexual abuse, erectile dysfunction, and sexual violence. Participants said that it is essential for providers to separate patients from accompanying persons to collect a comprehensive sexual history. This approach of separation approach is particularly important for child sexual abuse cases. When perpetrators or relatives threaten children seeking care, the child cannot fully disclose the abusive incident.

> *Because this is the boy who can a little bit talk himself, I usually tell the mother to stay out; then I talk to the boy for him to build confidence. First of all, I will talk about other issues, about schooling, and about friends so that he gets used to me to build confidence. Then we come back to the subject matter of what has brought him to the hospital, what happened, and whether he has informed anybody* (Group 7: Medical Doctor Practitioners)

Identifying Verbal and Non-verbal language

During sexual history-taking, providers must be more knowledgeable and skilled enough to observe and identify the patient's verbal and non-verbal cues. Identifying these clues is vital, especially when patients share their narratives, for providers to ask appropriate follow-up questions to understand better the course of events, related issues, severity, and impact on their patients' lives. Observing patient cues was a skill that was mostly reported when participants discussed the scenario of child sexual abuse, masturbation, rectal gonorrhoea [homosexual males], and contraceptive use among adolescent girls. For example, one of the medical doctors presented the following statement during the discussion of the CSA scenario.

> *The challenge comes when you assess such a young person and look at them in the eyes, you see that something is going on. Then I ask the parents to leave to allow me to have a confidential conversation. I remember my colleague here one day; mom and dad came with their 19-year-old daughter, saying Dr, please, we request you to confirm whether this our daughter has ever had sex. Such a girl cannot accept to say anything in the presence of her parents. So, I requested the parents to leave… She started telling me how she had a lover, and they had had sex twice, but unfortunately, her parents wanted her to marry someone else* (Group 10: Medical Doctor Practitioners).

HCPs Knowledge of the Management of SRH Conditions, Guidelines, Laws and Regulations

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Knowledge about the medical management of SRH conditions, available treatment guidelines, and the legal statutes governing care can positively or negatively affect SRH history taking. Unfortunately, there was limited knowledge in handling some of the SRH problems across groups and disciplines. For example, participants expressed uncertainties and dilemmas in addressing sexual health topics such as managing the care of homosexual patients with sexually transmitted infections, teen masturbation, contraceptive management for adolescent girls, and child sexual abuse. The following statement reveals poor knowledge of legal issues and available treatment guidelines.

> *First of all, a 14-year-old girl under Tanzania's regulations is a student. After I did history taking, I found out that this is still a student. I will not give her contraceptives because she is not allowed to engage in sex. I will counsel her not to do such a thing [sex] and ask her to focus on her study* (Group 3: Nursing students).

Another provider said,

> *I get confused about that question; a girl like 14 years old comes alone for contraceptives; I could think maybe she comes with her parents, or perhaps I can ask for the guidelines because she is young she cannot consent* (Group 17: Nursing Students).

Additionally, several participants in different groups said that the homosexual patient with rectal gonorrhoea *"would treat him and ask him to stop his behaviour because it is against the Tanzanian law."* (Group 18. Nursing Practitioners)

Providers with more excellent knowledge, experience, and confidence about the illness are more likely to provide quality treatment to the patient. Using the case of the 14-year-old seeking contraception, these providers shared:

> *I am a bit different because she has come [to the health facility], which is a sign she is already involved in sex; I will educate her on the pros, cons, and proper use of family planning methods. I will give her because… is a positive aspect that she needs to protect herself* (Group 6: Medical Doctor Students)

Even for students in training, confidence about the outcomes was compelling.

> *I wonder if a person is sexually active and does not want to use any contraceptive, ...I do not know what she is thinking. But unfortunately, people who do not use any contraceptives most of the time end up having pregnant and practising unsafe abortions; therefore, I will offer her a method* (Group 2: Nursing students).

Findings show that most participants across groups, regardless of discipline, were not knowledgeable about masturbation issues, especially handling teenagers' issues. As an evidence, participants raised some uniform statements during the discussion, such as "*masturbation has side effects rather than benefits" or "masturbation is not suitable for health; it would enlarge the penis".* This type of knowledge and perception might mislead the whole conversation during the history-taking and treatment process.

Based on the above-mentioned examples for the participants with or without proper knowledge of the laws and regulations and disease/sexual health problems, findings show that HCPs are controversial in managing one patient. HCPs would detect these differences during history-taking leading to different diagnoses, treatments, and therapeutic care.

> *Aaaah...! I'm not very far from what my friend has said. Usually, we face many challenges: the patient cannot directly share information about sexual issues. In my experience, within four years, I did not meet with any patient affected by sexual problems who has ever directly decided to tell me openly about her/himself. For stance, gays are most common in our communities, but we do not know how to interview the client to give you*

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> *the true information* (Group 1: Nursing students).

HCP's Personality

HCP's personality is essential in health care delivery. The participants said that trust and a good relationship during history taking between health care providers and patients begin from the first time the provider sees the patient. For example, the way health care providers convey the message (language used, i.e., verbal and non-verbal), position, or present themselves to the patient for the first time, might facilitate patient disclosure of information. Likewise, the same patient may choose to speak or not, depending on how the HCP approaches them.

One participant from the nursing students group commented that

> *Patients' disclosure during history taking process depends on how we health care providers approach the patients, e.g., smiling or listening. Your initial contact may detect the level of cooperation you will get from your patients… There are some problems, like pornography is not easy for a patient to inform you that I was practising this. But… builds trust in you… a client feels comfortable and is ready to share* information (Group 1: Nursing Students).

Perceived Benefits of Effective SRH History Taking

Participants in this study noted the several benefits when healthcare providers utilize the proper history-taking technique routinely. This theme generated four subthemes that are discussed.

Proper history-taking leads to appropriate diagnosis, treatment, and management of the disease.

Participants across all groups interviewed and the scenarios presented consistently noted the importance of history-taking as the first step toward problem diagnosis and treatment. All the groups highlight the usefulness of conducting thorough sexual history and environmental assessment to ensure providers address all the patient's needs and concerns. For example, in discussing a male scenario with sexual dysfunction, one medical doctor said that these sexual health problems result from multiple factors that the patients may not tell you upfront. One of the medical doctors has this to say, in addressing sexual dysfunction,

> *We are focusing on the biological, psychological, and social aspects. So, first, take history followed by an assessment. We usually first go for the basics like morning erection to understand if he is fit biologically before giving him a referral to the doctor. Then I will manage the psychological aspect if any* (Group 7: Medical Doctor Practitioners)

Proper History Taking Provides Clues/Signs of Disease

Participants claimed that an HCP is looking for clues on what led to the patient's problems during history-taking. The process requires time to understand the leading cause. Despite the time spent per patient, the provider would understand what brought the patients to the clinic and thus provide proper quality care, as revealed in a scenario of a nine-year-old boy who was sexually abused.

> *I see the case differently because having a discharge and bruises in the perineum does not directly mean a rape case. I have uncounted the case where a child has bruises and scratches but was not raped. Another child has similar signs but has been raped… As a health care provider, it is good to look for other clues and make a thorough history taking… to identify any suspicious signs of rape [sperms]; the clinical management and psychological management have to go with the legal management* (Group 3: Medical Doctors Practitioners).

History Taking Provides Patients' History and Behaviour Related to the Disease

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Participants argued that through sexual history taking, providers could understand the history and behaviour of the patient. Some providers said many patients do not disclose their problems, such as the nine-year boy with annual bruising.

> *In many cases, out of a hundred children brought due to sexual abuse, it is only 30% of who are coming in early. In most cases, they are brought late, and if you examine the child clinically, you find no evidence. Although the child can talk about what happened, you are forced to fill in a scenario that occurred in a police form, and that form will be taken to court* (Group 7: Medical Doctors Practitioners).

Promotes Behaviour Change

The respondents reported that the trust and good relationship between provider and patient might contribute to patient behaviour change, especially if the patient's specific concerns are addressed and proper solutions to their problems are provided, as shown in this statement,

> *Most [patients] are keen on correcting the sexual dysfunction rather than the underlying cause. However, if you spend time educating them about the causes of the sexual problem, they are more likely to follow your guidance* (Group 7: Medical Doctors Practitioners).

Another medical doctor respondent had this to say regarding the behaviour change for adolescents who seek contraceptives.

> *I think coming for a contraceptive is a positive thing; as a provider, I will first congratulate her on her behaviour. However, as a provider, you are not limited to sharing with her the best method to protect herself [contraceptives] but also abstaining* method (Group 7: Medical Doctor Practitioners).

Factors Hindering the SRH History-taking Process.

Despite the usefulness of SRH history-taking, participants mentioned that it is often rushed due to time constraints following the number of patients providers need to attend to per day. As a result, providers lack enough time to spend with patients to establish trust and rapport as recommended by international guidelines. The groups had mixed opinions about the barriers and how providers could overcome these barriers.

You need more time for a provider to get in-depth information for this case (CSA). At some point, you need time to talk to the parent and child separately. Because the perpetrators or family members have threatened kids, it requires time for them to build trust before they give you a deep story (Group 17: Midwifery Practitioners).

Participants also identified social demographic factors such as age, gender/sex, areas of residence (urban vs rural), marital status, religion, and lack of privacy and confidentiality due to the nature of the clinical setting as barriers to effective SRH history-taking. Across groups, age and gender were perceived to be the main barriers. For example, one of the midwife students noted that

> *"I'm [female student] very confident to talk about sex when attending women than men…!"* (Group 9: Midwife Students).

Another participant had this to say regarding privacy and how it impacts history-taking and care practices:

> *The privacy that the patient sees would determine the direction of the conversation. For example, if the patient sees two nurses taking a history, she cannot be free. Still, if she sees an area not populated, just a nurse and a room is locked, just a table and two chairs surrounding her, she can speak* (Group 2: Midwifery Practitioners).

Other participants from different focus groups had this to say:

> *Another thing that causes the patients to fear giving us their information is the issue of age; you found that he is a man like your daddy, and when he saw you, he discovered that you are like his son. So, the patients lack the*

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> *freedom to share their information* (Group 3: Nursing Students).

Likewise, other participants from the medical doctor's group supported the claim by saying that,

> *Gender issues are also a problem for some health workers, especially if they attend to a patient of the opposite sex. Sometimes you may want to take a medical examination of your patient, but it is of your opposite sex, you feel strange and think like, 'how can I do this?* (Group 5: Medical Doctors Practitioners)

Despite the discussion that participants had about the mentioned barrier, other experienced HCPs view it as less of a concern because of their experiences. One of the Midwives said;

> *In addition, for me, I was doing midwifery, and I was 25 years old. So finally, I find myself attending to this mother [older patient]. The first exposure is always challenging. You do not know how to start, but as time goes on, you get used to the process and move on, but the first time is scary because that mother's age was like my mother's* (Group 8: Midwifery Practitioners).

The Power of Confidence

There were mixed responses from participants when they were asked how confident they were in discussing issues of sexual health with patients. Some participants said that they were less confident, while others said they were confident. The differences were observed more across disciplines and years of experience. Midwives and medical doctors felt more confident than nursing participants, while years of experience increased confidence. Some of the participants said they were not confident because they did not learn how to take a sexual history. The type of SRH problem, knowledge about the problem or illness, age, gender, and environment, further shaped HCPs' confidence.

> *For me, it depends on whom I am talking to? and what problem are we talking about...? In the case of HIV, I may talk to anybody with all confidence. In some incidents, also I can talk about unplanned pregnancies and sexual violence. When we are coming to the issue of sexual dysfunction, issues of masturbation, and homosexuality, I am not confident. Maybe to a young patient, at least I can try to talk to them, but if the patient is in the 40s and above it is harder, especially for males)* (Group 1: Nursing Students).

Comprehensive SRH-taking requires a conducive environment, clinical knowledge about sexual health concerns and legal statutes, privacy, confidentiality, confidence, and time. It also requires that HCPs are sufficiently skilled to employ different strategies to optimize SRH history taking, including allowing the patient alone time with the HCP, identifying verbal/non-verbal signs of concern by patients, and provider personality.

DISCUSSION

This qualitative study reveals the core areas of impact of sexual history taking by HCP in Tanzania and its role in SRH problem management. These study findings align with other published research conducted in Africa and support the models described by public health agencies such as the Centres for Disease Control and Prevention (Reno et al., 2022) and the PLISSIT model (Annon, 1976). Optimizing SRH-history-taking may be a key strategy to reduce disparities by facilitating better, more comprehensive care for patients.

The broad themes that emerged from this analysis include SRH history-taking practices and experiences in the health care facilities in Tanzania by HCPs across common patient scenarios; the perceived benefit of effective sexual history-taking across patient types; factors hindering the SRH history-taking process; and the power of confidence. Specifically, HCPs across disciplines and levels of training in Tanzania recognize that building rapport and trust, knowledge about SRH illnesses and conditions, legal statutes, and treatment guidelines were crucial for management. The SRH history-taking

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process requires an HCP to build rapport, trust, and confidence with clients, and at times that may mean separation of patients from individuals who accompany them to visits (e.g., parents, relatives, friends) to allow the patients the space and opportunity to ask questions, discuss their concerns and feelings. Like other studies, patients needed to feel welcomed, respected, and autonomous, not rushed, and ultimately perceive confidence and respect from their HCP. HCPs need to be less talkative and good listeners to allow the patients to describe their problems (Annon, 1976; Fawcett & Rhynas, 2012; Reno et al., 2022). By encouraging patients to share their thoughts, questions, and concerns, providers validate the SRH issue as a legitimate health matter and this is foundational for building a trusting relationship. This action may also empower patients to take a more active role in the promotion of their health. These findings are in line with other scholars (Elwyn et al., 2012; Joosten et al., 2008; Mahlich et al., 2017) who support the notion that fully engaged patients who are given the autonomy to make decisions and make choices with the range of treatment strategies, can possibly change their risk behaviour and embrace positive health strategies.

This study also supports the literature demonstrating that HCPs need to have working knowledge about the specific SRH topics to answer patient questions and dispel misconceptions. As presented in the results sections, there is insufficient knowledge about SRH problems, treatment guidelines, and legal statutes for common case scenarios. Most professionals did not utilize published treatment guidelines to address SRH issues with patients. The finding of non-adherence to the published guidelines, legal statutes, and other regulations among HCP aligns with the work of other scholars (Palaiodimos et al., 2020; Ribeiro et al., 2014) who found that HCPs often use their personal judgment rather than consulting the clinical evidence or guidelines.

In the second theme: providers provided the useful role of SRH history-taking. Parallel with other studies, this study confirms that HCPs know that comprehensive medical history-taking leads to the appropriate diagnosis, treatment, and optimal management plan. However, the findings also demonstrate a lack of confidence in discussing sex, sexuality, and SRH among HCPs. Consistent with other work, they also face time constraints given the volume of patients needing to be seen (Frumence et al., 2013; Mkonyi et al., 2021; Moore et al., 2013; Sirili et al., 2019) and may lack adequate privacy to facilitate patient-sharing. Factors such as HCP discipline, type of condition or problem, age of patient vs HCP, gender or cultural and religion mismatch, area of residence, and years of experience appeared to influence the level of confidence of HCPs as observed in other settings (Frederick et al., 2018; Hordern, 2016).

Even though most HCPs expressed low confidence in initiating or having a conversation about SRH issues, it was not the case for medical doctors with more clinical experience. A presentation of confidence allows HCPs to initiate conversations and ask sexual health questions during history taking, diagnosis, and management of patients regardless of disease (Ross et al., 2021). Ross et al. (2021) argued that discomfort among providers in asking about and addressing sexual health issues could be identified by patients verbally or non-verbally; this triggers fear in the patients to continue with the conversation. Analogues to other studies (Annon, 1976; Reno et al., 2022; Ross et al., 2021), confidence is considered the main driver of influencing behaviour change. This implies that proper training and continuous education, and professional development about sexual health and good sexual history would build the HCP's confidence.

Strength & Limitations of the study: The findings from this study should be viewed with caution as transferability to other parts of Tanzania or sub-Saharan Africa. While participants were encouraged to share differing views, some participants might have withheld sharing experiences involving non-standard care. This study utilized the qualitative method only; therefore, a broader study with measurable

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provider outcomes would be required to fully assess SRH history-taking among HCPs in Tanzania.

CONCLUSION AND POLICY IMPLICATION

To increase competent HCPs (students and practitioners), training on the clinical management of sexual health issues, the use of guidelines, and related regulatory and policy issues is necessary. Given the focus group identified gaps, professional development activities, including primary training and continuing education, may potentially contribute to the increased use of standard approaches to SRH history-taking among providers. Specifically, patient-centred SRH history-taking requires a conducive environment, privacy, confidentiality, knowledge about common SRH problems, and sufficient time for relationship-building, collection of the social and SRH narrative history, clinical assessment, and shared decision-making related to interval care between HCPs and patients (Ross et al., 2021; Skelton & Matthews, 2001). While additional work is needed on the optimal curricula for training and the effectiveness of different pedagogical approaches, these findings have implications for strengthening SRH care designed to address unmet SRH needs and to reduce SRH disparities in Tanzania.

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Statement of Authorship

Writing-Original draft, Reviewing and Editing, Visualization, Formal Analysis, EM; Writing-Reviewing, and Editing, Formal analysis, NBS, JW, AFM, MWR, GGL, IM, DLM, SEM, and LRM, ZEB; Investigation, Conceptualization, Funding Acquisition, BR.SR, MT, MWR, and DAM; Supervision, BR.SR, GGL, and EM; Methodology, ZEB

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