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Cover Page Footnote

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Project Rafiki: Consumer and Provider Perspectives on Food Assistance and its Impact on Quality of Life for Individuals Living with HIV/AIDS

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Abstract. *Project Rafiki* was designed to provide nonperishable food assistance to individuals living with HIV/AIDS in Tanzania, East Africa. The research study was developed to examine the extent to which the *Project Rafiki* food assistance program had impacted its participants over the course of one year. The aim of this research can be divided into five smaller objectives: 1) to gauge the effectiveness of the food assistance program; 2) to assist in the expansion of inter-professional knowledge of resource-development regarding health and nutrition for vulnerable communities or rural areas; 3) to involve and immerse students in learning on a global level; 4) to grow and develop cross-cultural collaborations; and 5) to improve the health and well-being of individuals living with HIV/AIDS. This study focuses on discussing whether the implementation of *Project Rafiki* made a difference, and to what extent, to the target population. Overall it is the research team's aim to study the benefits and challenges of *Project Rafiki* in order to improve, sustain, and replicate the program in global communities. The goal is to be able to share findings, with the purpose of hopefully creating more and similar sustainable food assistance programs in order to assist people living with HIV/AIDS both in America and outside of the country. The project aims to utilize the pilot data that was collected in Tanzania to build a foundation for future studies in this area.

Keywords: food assistance, global social work, HIV/AIDS, rural social work, rural collaborative practice, quality of life

In 2016, approximately 36.7 million people in the world were living with HIV/AIDS (UNAIDS, 2018). Service providers in underdeveloped countries, such as Tanzania, oftentimes do not have the correct or enough resources to successfully aid these individuals and their families. Stigmatization, unemployment, poverty, isolation, food insecurity, and discrimination all contribute to the oppression that many living with the disease face. Maintaining these individuals' health and well-being is challenging. By introducing social support and basic nutrition, psychosocial issues among this population can be diminished (George, et al., 2016; Oddo & Mabli, 2015; Prince, et. al, 2007; Thomson, et.al. 2014). Both medication compliance and overall health are positively impacted by improving the nutritional intake of these individuals (Maluccio, Palermo, Kadiyala, & Rawat, 2015). However, the lack of food resources and accessibility of nutrition to the HIV/AIDS population, especially in underdeveloped countries, leads to food insecurity. Subsequently, food insecurity adds another level of stigmatization to the individuals, often contributes to the cycle of transmission of the infection and is associated with poor overall quality of life (Thomson, et.al. 2014; Weiser, et.al., 2011).

The United Republic of Tanzania is among the countries hardest hit by HIV/AIDS in the sub-Saharan region of Africa. By 2017, Tanzania had 1.5 million people who were living with HIV/AIDS, and despite decades of community interventions on disease control, there are about

65,000 new cases of HIV infections that occur annually (UNAIDS, 2018). Despite the effort by the government of Tanzania and a myriad of donor countries and agencies in meeting the needs of people living with HIV/AIDS, there are deficiencies in attaining optimal levels of the demands presented by the patient communities. First, the growing numbers of HIV cases makes it hard to generate true estimates of the medical and social resources needed by the patients. In addition, the circumstances from which the infections occur based on geographic locations, sexual orientation, risk behaviors, and gender, create pockets of hard-to-reach individuals for meaningful intervention (Avert, 2019). Second, although antiretroviral treatment is freely available in the country, patients may not comply with the treatment regimen if they lack resources to support corresponding nutrition recommendations for the treatment. Therefore, promotion of food security becomes a key component for successful treatment adherence and improvements in quality of life. This article presents the development of *Project Rafiki* and the evaluative process of collecting the data and feedback from recipients of the program after a year of food interventions.

Project Rafiki

During the summer of 2017, students and faculty from Western Kentucky University were engaged in a global service-learning program in Dar es Salaam, Tanzania, East Africa through the Kentucky Institute for International Studies (KIIS). While taking a social work course, students interacted with a local non-governmental organization that supports HIV/AIDS patients in coping with different aspects of the disease. The agency, known as WAMATA, a Swahili acronym for *People in the Fight against AIDS in Tanzania*, provided an avenue for students to learn about its clients, their challenges and needs related to living with HIV/AIDS. It was determined that one of the main challenges faced by the patients was the lack of food and proper nutrition. Many WAMATA clients reported having adequate medication for treatment, but lacking food with which to take their medicines. A significant number of these WAMATA members had been abandoned by their families, as part of the common stigma attached to HIV/AIDS in Tanzania. The stigma against people living with this infection often stems from a lack of education about what HIV/AIDS is and sources and modes of HIV transmission. As a result of this stigma, most patients struggle to obtain or maintain employment, leading to poor living conditions and inability to earn income to manage their food requirements.

Most members at WAMATA discussed their main conflict and concern. Individuals with food insecurity who are living with HIV/AIDS can either stop taking their medications for the fear of suffering from severe side effects if taken with little to no sustenance; or they can choose to take the medications, in attempt to comply with treatment, with the consequences of getting sick from its effect. Either way, medical treatment directions would not be followed, and members reported their overall health and well-being was at major risk due to the lack of proper diet. After discovering this main concern and learning that the Swahili word “rafiki” means “friend,” the social work students came up with *Project Rafiki*, a food assistance program that would collaborate with WAMATA to identify eligible members who would benefit from the program. The model of the project is to encourage global communities to participate in channeling at least \$150 (one hundred and fifty U.S. dollars) worth of nonperishable food items to at least six families each month for one whole year. The funds would be collected from the students, organizations, churches, school clubs, and fundraising activities. Each month, the

funds are allocated to WAMATA, which in turn purchases the food locally in Dar es Salaam and distributes it to eligible families through its staff, volunteers, and interns from the Social Work Program at Hubert Kairuki Memorial University (HKMU) in Tanzania. Non-perishable foods purchased for *Project Rafiki* recipients include items such as beans, cooking oil, powdered milk, rice, salt, sugar, tea bags, water, and whole meal flour. Detailed monthly reports, which itemize the purchases and include receipts, names of beneficiaries and success stories are sent to the project board by the WAMATA Executive Director. This model has been in effect since July 2017.

Project Assessment

With nearly two years of data, a grant was sought to assess its effectiveness and to learn from the clients and providers about their perception of the *Project Rafiki* program. Funding was obtained from a Western Kentucky University (College of Health and Human Services) Research and Creative Activities Program (RCAP) grant for this purpose. A joint effort between the departments of social work and public health led the effort through a research team that composed one faculty and one graduate student from each unit.

A cross-sectional, qualitative research study entitled “*Improving Well Being and Quality of Life of People Living with HIV/AIDS: Results from a Food Assistance Program in Tanzania*” was carried out with the purpose of collecting data in order to measure the impact that *Project Rafiki* had on its recipients over the course of one year. This was a study that triangulated data; referring to combining approaches of data collection in order to garner a more holistic view of the data that is being collected (Flynn & McKermott, 2016). During this process, all data was collected by audio recording and direct typing into a laptop computer. Some data was collected in hand-written notes. Data collected from all sources have been, and will continue to be, securely kept confidential and anonymous.

Method

As aforementioned, the methodology of this study was qualitative and cross-sectional in nature. The phenomenological approach was used, as the research team looked to dig deeper into the everyday lives of the participants. Phenomenology refers to the study of people’s perceptions, meanings, and interpretations of their experiences (Flynn & McKermott, 2016). The researchers conducted the study with no prejudices or predeterminations. Additionally, the sample size was kept small on purpose because of the vast amount of data that was generated and collected.

Sample

The purposive sampling strategy was applied in order to capture the experiences of the beneficiaries during the study period to determine to what extent *Project Rafiki* had benefitted or challenged those WAMATA members living with HIV/AIDS over the course of one year. Twenty-nine members participated in the study, all of whom had received food assistance from *Project Rafiki*. These participants were voluntary members and ranged in age from twenty-two to seventy-three years. In order to be eligible to participate in the focus groups, members had to

have received food from *Project Rafiki* at least once and been attending regular Saturday meetings at WAMATA for at least one year. Participants were given two options in regard to which focus group they could attend in order to ensure researchers were mindful of participants' other responsibilities and schedules.

Demographics

Twenty-nine members of WAMATA made up the two participant focus groups (Table 1). The first focus group held with recipients of the food assistance program consisted of 15 WAMATA members. This group was made up of 4 males and 11 females. The second recipient focus group was made up of 14 total WAMATA members, 2 males and 14 females. Average age of the participants was 49 years (Table 1). The average age at which members had been diagnosed with HIV was 32.9 years (Table 1). The average time spent as a WAMATA member averaged to be 13.8 years (Table 1). Between the two groups combined, 13 members were employed, while 16 were unemployed (Table 1). It is important to note that members' definition of employment might have cultural implications. Their perception of employment often referenced self-employment (i.e. selling foods or handmade items). Marital status varied, with most of the members (n=14) being widowed (Table 1). Eight members were married; 4 were single; and 3 were divorced (Table 1).

Design

Since the design of the project was qualitative, rich and informative data was collected as both WAMATA members and service providers spoke about their experiences and the impact of the program. Three focus groups were facilitated by the Primary Investigator and translated by a Social Work Professor from HKMU. The focus groups were recorded on a digital audio recorder by the Social Work Graduate Research Assistant and the responses were typed by the Public Health Graduate Research Assistant on a laptop computer. Some handwritten notes were taken by all members of the research team. Two of the focus groups were held with WAMATA members who had been recipients of food from *Project Rafiki*. The third focus group was conducted with service providers connected with both WAMATA and HKMU. Each focus group included approximately 10-15 participants and met for approximately one hour.

A protocol of eleven questions guided the focus groups for the two member sessions (See Appendix A). A separate protocol of ten questions guided the service provider focus group (See Appendix B). These questions were available in both English and Swahili. As expected, additional information emerged from each focus group as conversations took place. This free-flowing nature of the focus groups generated additional questions and furthered discussion. By allowing for this, the research team was able to encourage and record the complexity and wide range of the participants' experiences.

Table 1

Sample Characteristics of Project Rafiki WAMATA Member Focus Groups (n = 29)

Participant Characteristics	f (Valid %)	Range	M
Age		22-73	49.04
Average Age of Diagnosis		30.3-35.4	32.9
Time in WAMATA		12.7-14.9	13.8
Gender			
Female	23 (79.3)		
Male	6 (20.7)		
Marital Status			
Married	8 (27.6)		
Single	4 (13.8)		
Divorced	3 (10.3)		
Widowed	14 (48.3)		
Employment Status			
Employed	13 (44.9)		
Unemployed	16 (55.1)		

Procedures

The staff at WAMATA recruited participants. To be eligible to participate, participants had to meet the criteria of 1) having been chosen to receive food from *Project Rafiki* within the past year, and 2) having been regularly attending Saturday meetings at WAMATA. After being selected, participants were given details regarding time (10:00AM and 2:00PM) and location (WAMATA conference room) of the focus groups. Before beginning any of the focus groups, purpose, risks, and benefits were explained via translator to the participants. These members were each given an informed consent document, which were written in Swahili, and each signed a statement of understanding and consent, of which they got to keep a copy for themselves. Before delving into the questions with the two participant focus groups, the research team collected demographic information including factors such as current age, age at diagnosis, how many times they had received food from the project, number of children, employment status, and marital status. During the member focus groups, the participants were provided with bottles of water, bananas, and peanuts.

Water was provided at the service providers' focus group. These participants were chosen based on their position at WAMATA or HKMU and their participation in *Project Rafiki*. All participants (both members and providers) were invited to attend a Cultural Ceremony the evening after all three focus groups had concluded as a form of closure. This ceremony took place in the facility where the research team was staying during their time in Tanzania. Thirty-two people attended the ceremony. Twenty-seven of these were WAMATA members. The rest were service providers and members of the research team. Meals, drinks, and music were provided. After the meal, the research team presented the director of WAMATA with \$150 USD for the *Project Rafiki* July fund. All participants were presented with certificates of completion and a hygiene bag as a means of thanks for participating in the focus groups. These bags included a toothbrush, tube of toothpaste, one handkerchief, two bars of medicated soap, one

deodorant stick, three Band-Aids, a mini jar of Vaseline, and four snack bags of peanuts. Items for the hygiene bags were chosen after discussing needs with service providers and the individuals living with HIV/AIDS themselves.

Data Analysis

The research team utilized an open coding system so that common themes could freely appear. The themes were identified and examined for both consistency and frequency. There were three reviewers to account for interrater reliability. The three major themes that emerged from the focus groups held with food recipients were 1) Increased Adherence to Treatment; 2) Sense of Community (including subthemes of socialization, education, and decreased stigma); and 3) Biopsychosocial Benefits (including subthemes of self-worth and value). Themes that emerged from the focus group held with providers from HKMU and WAMATA were 1) Health Improvement; 2) Community and Support; and 3) Need for More Services/Challenges, which led to specific needs that should be addressed in order to improve the food assistance program and its lasting effects among *Project Rafiki* food recipients. All three focus groups with both food recipients and service providers expressed a theme of gratefulness.

Results

Participants

Increased adherence to treatment. In regard to the theme of Increased Adherence to Treatment and Medication Compliance, WAMATA members reported that the food assistance program had been helping them adhere to their treatment for HIV. This was due to their ability to better tolerate the medication because of the intake of the received food. A powerful testimony from one member spoke to this theme of adherence: “I wouldn’t take medicine because I wasn’t sure of the food. So now because I have the food, I [can] take medicine that is required.” Another member claimed that they had “less to worry about” as members now knew that “once [they] eat, [they] can properly take the pills.” Further, one individual claimed they would recommend the food assistance program “to all the government hospitals and NGOs that offer services to HIV positive clients” since the swallowing of pills alone will not work properly if there is no food with which to take the medication. “Project Rafiki has really helped [members] in adhering to treatment because it is very difficult to take the medications if [one has] not eaten.” Additionally, treatment refers to more than simply taking medication. Attending weekly Saturday meetings at WAMATA also serves as an element of treatment for these individuals. By spending time together and discussing similar experiences, members educate and inform each other about “how to properly adhere to treatment.” At the meetings, members also are able to “tell each other how to help [their] children not to get the virus...[and] show each other how to properly live with [loved ones] so that [they] don’t get them infected.” The implementation of the food assistance program increased attendance at these meetings and therefor increased adherence to this form of treatment as well.

Sense of community. A sense of community emerged as the *Project Rafiki* food assistance program began and continues. Food recipients discussed that the chance to receive food encouraged WAMATA members to attend Saturday meetings more regularly. Saturday

meetings at WAMATA allow members to come together, support each other, spread information to others living with HIV, and reduce stigmas against the infection. The project benefitted its recipients in that it gave members “an opportunity to meet [and] daily share different ideas on how to live positively.” Members were also able to begin to trust since they shared similar experiences and challenges. Members shared this sense of catharsis as they “[got] rid of the fear of sharing things.” *Project Rafiki* encouraged members to keep attending weekly meetings and, in turn, decreased stigma among its members. This was explained by one individual as “different from when we are at home where we are so much stigmatized and discriminated.” This member went on to explain that feelings of stigmatization were almost nonexistent at WAMATA meetings as there the members are surrounded and “loved by WAMATA and all its people.” One member of WAMATA stated that the *Project Rafiki* food assistance program had “really helped [members] to communicate with other people that [they] know that are also HIV positive.” In doing so, members spread the word about the chance to receive food if a person attends WAMATA meetings, therefor increasing the chance for HIV-related education, and the members’ sense of connectedness.

Not only did the implementation of *Project Rafiki* food assistance produce a sense of community at the WAMATA location. Members also discussed their neighbors and families being happier and more willing to gather with members as a result. One member explained that “once you bring food home, everybody becomes happy” while another stated the joy of being able to share with neighbors who had helped her in the past. Another discussed her past experience of family members not answering her phone calls due to the fact that they assumed she would always be asking them for food. However, after receiving food from *Project Rafiki*, this member claimed that “since [her family] knows that [she now has] the food... they will pick up the phone” when she calls.

Biopsychosocial benefits. Recipients of the *Project Rafiki* food assistance program also reported a change in their biopsychosocial health. Many members reported gaining weight after receiving the food aid. One individual in particular reported that they “used to [weigh] 50 KG’s but now I [weigh] 70 KG’s.” One WAMATA member reported being unable to work and buy food for her child due to being sick. However, after receiving food from *Project Rafiki*, this member was able to feed herself and her child, get well, and begin working again. Another member claimed that, after visiting the clinic, their nutrient levels had increased “because of the food [they had taken] from the project.” Members also reported increases in physical health. One member stated that before the food assistance, they had “problems with [their] legs because [they] did not have enough food, but since the project has been started, [they] have been eating well and ... now that problem has disappeared.” Additionally, members discussed having lower levels of stress in regard to figuring out where and how they will get food. Further discussed was the positive impact of the project on members’ ability to save what money they would have used to purchase food to now use on rent payments or beginning a business to help them earn some income.

Providers

Even though researchers' questions were written to elicit information regarding if and ways in which *Project Rafiki* had benefitted WAMATA members and the project's outcomes, providers' responses were more focused not only on maintenance but improvement of the food assistance program. The following reviews themes that emerged from the provider discussion.

Health improvement. Providers discussed the positive impact that *Project Rafiki* had on WAMATA members' overall health. Subthemes that emerged within this theme include improved physical and mental health, better medication compliance, and improved well-being and social lives. Examples of ways in which providers had witnessed *Project Rafiki*'s positive impact on members' health included providers' testimonies of members' improved diets leading to higher rates of immunity, increased weight gain, lower viral loads, higher CD4 counts, and decreased symptoms due to being able to eat when receiving medicine. One provider spoke to the impact of diet on immunity and treatment compliance as this provider stated that "improved diet leads to improved immunity, so anything that contributes to immunity or enhances immunity in a person living with HIV helps with adherence. Adherence to medication is very key in HIV treatment." Other providers told of WAMATA members gaining healthy weight as a direct result of receiving food assistance. Also discussed was the positive impact regarding members' mental health as providers explained that members were more inclined to attend WAMATA weekly meetings in order to be eligible to receive food from *Project Rafiki*. This led to higher attendance, more participation at meetings, and, in turn, improved mental health as members would share experiences and challenges with one another. A notable statement by a provider touching on this stated that *Project Rafiki* was not only helping in terms of food but that "it is the consistency of coming and staying together" that has really made a positive impact. Members can "share their views, their problems, which even help them improve their health and their mentality." This sense of belonging led to members' higher sense of worth and positively impacted multiple aspects of health.

Community and support. In a second emerging theme, providers discussed an element of community that was brought about over the course of *Project Rafiki*'s implementation. Participants' ability to bond and connect at weekly WAMATA meetings, where food was disbursed, emitted an element of catharsis. This led to WAMATA members feeling close and comfortable sharing experiences, bringing up HIV/AIDS-related challenges, and offering each other potential solutions. One provider discussed this element as they explained how "sitting together...and sharing, you don't feel lonely- you feel like you have some people who are part of a society." This sense of closeness and community initiated elements of education, empowerment, and bonding. Additionally, this community support produced an element of empowerment, sameness, and self-worth as individual members were able to share their experiences of stigmatization with other members also living with the disease.

Need for more services/challenges. Providers that participated in the focus group told about challenges that arose in relation to *Project Rafiki*. Types of need that were expressed were 1) Educational, 2) Financial, and 3) Nutritional. In terms of educational need, providers indicated the desire for counseling and other additional services for the WAMATA members in order to aid in the alleviation of challenges and stresses associated with living with HIV. A

suggestion made by one provider was to add more than food resources to *Project Rafiki's* services, such as “one position to manage the project, ... a counselor,..., a social worker, a psychologist – whoever [could] coordinate volunteerism that go hand in hand with psychosocial issues.” The need for an on-site doctor was also expressed. The need for rethinking *Project Rafiki's* distribution cycle was also indicated by HKMU and WAMATA providers. Suggestions for this included giving food supplies based on the number of members in a recipient's family, instead of giving the same amount of food to every recipient regardless of their family size; or regularly giving to all members as opposed to members waiting to be chosen from the lottery and not knowing when they will receive food. A nutritional need that one provider suggested was *Project Rafiki* potentially providing recipients with nutritional supplements or vitamins. Providers also indicated a need for more funds, as increased attendance had led to an increased allocation of WAMATA funds for bus fare which WAMATA provides to its members for transportation both to and from Saturday meetings. Additionally, members who receive food from *Project Rafiki* are charged double bus fare since their food package takes up a second seat on the bus. These challenges were unforeseen by researchers. Knowing the challenges faced and hearing providers' various needs and suggestions can guide the Advisory Committee as to how to and what elements could improve *Project Rafiki*.

Discussion

This particular article focuses on whether the implementation of the *Project Rafiki* food assistance program made a difference, and if so, how it did. During the process of data collection, there were many benefits of having two student researchers working on the research team. One advantage of having student workers was that students do not tend to hold quite the position of power that professors and professional researchers do. This is an advantage because students can, unknowingly, help participants feel more equal, comfortable, and open (Flynn & McKermott, 2016). The opportunity to have supportive and easily accessible supervisors on the team was key in minimizing student researchers' anxiety and in the building of these graduate assistants' confidence. This was exactly the case in Tanzania, as research professors guided the graduate assistants with both wisdom and constructive criticism.

While in Tanzania, the research team was able to listen to the recipients of the food assistance program *Project Rafiki*. Hearing, first-hand, participants' perceptions about, challenges with, and benefits of the food assistance program, along with shared personal testimonies about life with HIV granted researchers insight into both the HIV/AIDS community and the behind-the-scenes of the food assistance program. Before going to Tanzania, one of the graduate assistants was very involved in the project and spent a lot of time working with it. This member of the research team had even presented at a national conference and was confident while doing so. However, she has claimed that nothing can compare to the actual immersion into the culture and population of whom this program was aiding.

The experience of being able to see, hear from, work with, and share among this underrepresented population proved invaluable. Important information, which would not have otherwise been known from a spreadsheet or email, was shared. One example includes participants not having enough money for bus fare to get their food home once they received food donations. The research team did not realize that taking large amounts of food home often

increases the price of a ride. Another example of what could be found only from building rapport and meeting participants where they are is that oftentimes spouses or family members question how or from where recipients got the food donations, assuming they must have stolen or begged or even performed sexual acts in exchange for the food. This is because the WAMATA members did not always disclose their diagnoses to their family and friends and so their loved ones were not aware that these individuals were members of WAMATA (a clinic specifically for people living with HIV/AIDS). A great deal of valuable and detailed qualitative data was collected in just a short amount of time by students' involvement in service learning, not to mention the life-long insights and impacts taken away from those students' hands-on experience.

Limitations

The findings of this qualitative study should be considered against several challenges and limitations. Provider demographics were not collected as means to maintain anonymity that would protect the identities of coworkers within WAMATA and HKMU. Translators were used to communicate with the participants who were primarily Swahili speaking with very limited use or understanding of English. Also use of a fan at times to cool the room in which focus groups took place often produced external noise to the audio recording of the group sessions. This was also a purposive sample which may not be totally reflective of the entire population of people in East Africa living with HIV/AIDS. The majority of the participants were also female. Further research is required to overcome these identified barriers and limitations.

Conclusion and Implications

The overall impact of *Project Rafiki* and the food assistance given to the members of WAMATA has provided results that were positive. Medication compliance, weight gain, and increased attendance at the agency were all noted. With these positive changes came the added benefits of socialization and education, as well as a sense of community and connectedness. The majority of participants were grateful and indicated such in the focus group meetings.

Social work and public health are both professions that focus on the increased well-being and health of individuals, families and communities. Social Work Education as well as Public Health Education focuses on preparing students to evaluate and provide services and interventions that enhance the quality of life for people. Given the current contemporary practice arena is global, it is critical that students are trained in international venues, making this research even more vital to Social Work and Public Health. Future research can shift to examining the interdisciplinary roles, student engagement, and student service-learning components of this project.

Project Rafiki has the potential for being replicated in other areas both internationally and rurally. Results from this study can provide pilot data needed for securing additional grant funding to further the work of increasing overall health and well-being for people living with HIV/AIDS. The project plans to utilize this pilot data as a means to support the ongoing work of this important initiative.

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Appendix A

<p style="text-align: center;">Profile of Questions for the Project Rafiki Participants Focus Group Maelezo ya Maswali kwa Mradi wa Msaada wa Huduma za Rafiki</p> <p style="text-align: center;">Please provide short answers for the following questions. (Tafadhali toa majibu mafupi kwa maswali yafuatayo).</p>
<p>1. How has this project made a difference in your life? (Tafadhali eleza jinsi mradi huu umeleta tofauti katika maisha yako?)</p>
<p>2. What challenges did you experience by participating in this project? (Ni changamoto gani ulipata kwa kushiriki kwa mradi huu?)</p>
<p>3. Do you think this project has impacted your overall health? If so, how? (Je, unafikiri mradi huu umeathiri afya yako kwa ujumla? Kama ni hivyo, kwa nini?)</p>
<p>4. Were there any changes to your symptoms after beginning the food assistance? If so, what were the changes? (Kulikuwa na mabadiliko yoyote kwa dalili yako baada ya kupata msaada wa chakula? Kama ni hivyo, ni nini ilibadilika?)</p>
<p>5. What did the project mean to you as a person living with HIV/AIDS? (Mradi huu umemanisha nini kwako, kama mtu anayeishi na virusi vya UKIMWI?)</p>
<p>6. Has the food assistance impacted your social life? If so, how? (Think about if/ how it impacted your relationships with other patients at WAMATA or people you live with at home). (Msaada wa chakula umeathiri maisha yako ya kijami? Kama ni hivyo, jinsi gani? (Fikiria kama imeathiri uhusiano wako na hapa WAMATA au watu unaoishi nao.))</p>
<p>7. Has the food assistance impacted your personal life? If so, how? (Je, msaada wa chakula umeathiri maisha yako binafsi?)</p>
<p>8. Would you recommend WAMATA to a friend? If so, why? (Je, ungependekeza mradi huu kwa rafiki yako? Kama ni hivyo, kwa nini?)</p>
<p>9. Would you recommend this type of projects in all HIV/AIDS agencies? If so, why? (Je, ungependekeza aina hii ya miradi katika mashirika yote ya UKIMWI? Kama ni hivyo, kwa nini?)</p>
<p>10. What would you have changed about the project or services provided? (Ni nini ungebadilisha kuhusu mradi au huduma zinazotolewa?)</p>
<p>11. Tell us in your own words how you feel about the project. (Tuambie kwa maneno yako mwenyewe, jinsi unavyohisi kuhusu mradi huu?)</p>

Appendix B

<p align="center">Profile of Questions for the Project Rafiki Service Providers Focus Group Maelezo ya Maswali kwa Mradi wa Msaada wa Huduma za Rafiki</p> <p align="center">Please provide short answers for the following questions. Tafadhali toa majibu mafupi kwa maswali yafuatayo.</p>	
1. How has this project made a difference in the lives of the participants? (Eleza jinsi mradi huu umeleta tofauti kwa maisha ya washiriki?)	
2. What types of challenges did the participants seem to experience? (Ni changamoto zipi washiriki walionekana kuwa nazo?)	
3. How do you think this project has impacted participants' overall health and wellbeing as people who are living with HIV/AIDS? (Eleza jinsi unavyofikiria mradi huu umeathiri afya na ustawi ya washiriki kwa jumla kama watu wanaoishi na virusi vya UKIMWI?)	
4. Did the food assistance seem to impact participants' social life? If so, how? (Je, msaada wa chakula umeathiri maisha ya kijamii ya washiriki aje? Kama ni hivyo, kwa nini?)	
5. Did the food assistance seem to impact participants' personal life? If so, how? (Je, msaada wa chakula umeathiri maisha ya kibinafsi ya washiriki aje? Kama ni hivyo, kwa nini?)	
6. Was there any change in members' attendance at WAMATA? (Je, Kulikuwa na mabadiliko yoyote katika mahudhuria ya wanachama katika WAMATA?)	
7. Did you observe or have record of any new clients who were attracted to join WAMATA to benefit from the project? (Je, umeona au una kumbukumbu ya wateja wapya ambao walivutiwa kujiunga na WAMATA kufaidika na mradi huu?)	
8. What would you have changed about the project/services provided to the participants? (Ungebadilisha nini kuhusu mradi/ huduma zinazotolewa kwa washiriki?)	
9. How has the agency (WAMATA) been helped by this project? (Je, shirika hili (WAMATA) limesaidiwa aja na mradi huu?)	
10. What kind of feedback have you received from the clients? (Umepokea maoni gani kutoka kwa washiriki?)	