IHORERE MUNYARWANDA ORGANISATION (IMRO)

STRATEGY 2022-2026

September 2022

FOREWORD

Both the National Community Health Policy the Rwanda's Fourth Health Sector Strategic Plan (2018-2024) define new approaches for health care service delivery to all citizens without discrimination. These approaches emphasize a more proactive promotion of individual and community health to prevent the occurrence of diseases.

Community health is one of the flagship projects in the 7-year government's Strategy for Transformation (NST1) 2017–2024. In addition, in Rwanda due to high performance in recent years toward the realization of Universal Health Coverage which stands for full population's access to health services they need, when and where they need without financial hardship, we have started recording successes in health promotion that comprises prevention, treatment, and care. However, key and vulnerable populations including sex workers, men who have sex with men, and people living with HIV still face issues preventing them from accessing health services due to poverty, policy barriers, and discrimination.

The ……..**?** edition of the IMRO's strategic plan 2022-2027 intends to build the capacity of individuals and institutions, to increase advocacy interventions and evidence building for IMRO to effectively contribute to the government's program that aims to realize people's rights to the highest attainable health standards, equitable and good quality health care services as provided for in the constitution of Rwanda of 2003 revised in 2015 and many other regional and international human rights treaties that Rwanda has ratified. The development of this new strategic direction has been an all-inclusive process involving all IMRO's staff, board members, and stakeholders.

This strategic plan aims at providing a framework for the IMRO staff team, partners, and stakeholders to join efforts together for a comprehensive and coordinated intervention to promote in a standardized manner health care in Rwanda.

Aimable Mwananawe

National Coordinator

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ACRONYMS

ASRH	: Adolescents' Sexual and Reproductive Health
CSE	: Comprehensive sexuality education
CSOs	: Civil Society Organisations
FSWs	: Female Sex Workers
GBV	: Gender-Based Violence
ICA	: Institute of Cultural Affairs
IIAG	: Ibrahim Index of African Governance
IMF	: International Monetary Fund
IMRO	: Ihorere Munyarwanda organization
LGBTI	: Lesbians, Gay, Bisexual, Transgender, Intersex
MMR	: Maternal Mortality Ratio
MSM	: Men who have Sex with Men
NISR	: National Institute of Statistics of Rwanda
NST1	: National Strategy for Transformation
PESTLE	: Political, Economic, Societal, Technological, and Environmental
PSP	: Participatory Strategic Planning
RDHS	: Rwanda Demographic and Health Survey
SDG	: Sustainable Development Goals
SMART	: Specific Measurable Achievable Realistic and Time-Bound
SRHR	: Sexual Reproductive Health and Rights
STI	: Sexual Transmitted Infections
SWOT	: Strengths, Weaknesses, Opportunities, and Threats
UN	: United Nations
UNDP	: United Nations Development Program
WASH	: Water Sanitation and Hygiene

EXECUTIVE SUMMARY

This strategy builds on the IMRO's previous strategic plan for 2017-2021, the lessons learned over the years, and our track record. It outlines the core values, guiding principles, differentiating factors, and value propositions that IMRO will exhibit and deliver in the next three years. These include a commitment to service, accountability, and integrity as exhibited in our track record in program delivery and financial management; quality and evidence-informed approaches; generation of new knowledge through research; innovations and best practice in programming and service delivery and; leveraging our positioning, technical expertise, and geographic scope.

The new strategic direction gives in detail what we will do within our own programs and the roles that we will play as a non-government organization within the broader health and rights responses in Rwanda with a particular focus on community health and development promotion including sexual and reproductive health and rights, HIV/AIDs and STIs prevention and treatment, GBV prevention, family planning, WASH and nutrition, etc. as we engage at national, regional and international levels through strategic partnerships, or taking on 'collaborative leadership' and roles.

Our theory of change describes why we exist and the changes we aim to create in the short, medium, and long term. We will maintain our focus on service delivery, research, capacity building, technical support, and policy influencing. Under each strategic result area summarized in the table below, the plan identifies thematic areas and key interventions that will be implemented to achieve the objectives and expected results. Based on detailed context analysis, in this plan, we have made some significant strategic shifts that will guide our work in the next five years:

- From being an ordinary civil society organization to a referral center in matters of HIV/TB and malaria prevention and treatment including WASH and nutrition promotion and development in Rwanda.
- From being the usual partner organization to the government to an agent of change in health system strengthening that generates improved health outcomes for vulnerable citizens.
- From being a key player to a champion civil society organization in regard to the promotion of young people and key populations' access to sexual and reproductive health information and services.

- From being a National organization to a regional non-profit organization with great capacity in both human and financial resources, knowledge, and widen partnership.

This strategy will be the basis for the development of annual institutional implementation plans that will contain the key activities, strategies, and outputs across the organization. A board of Directors and the management team led by the national coordinator will provide governance, management, oversight, and leadership for the implementation of the strategy.

1. ABOUT IMRO

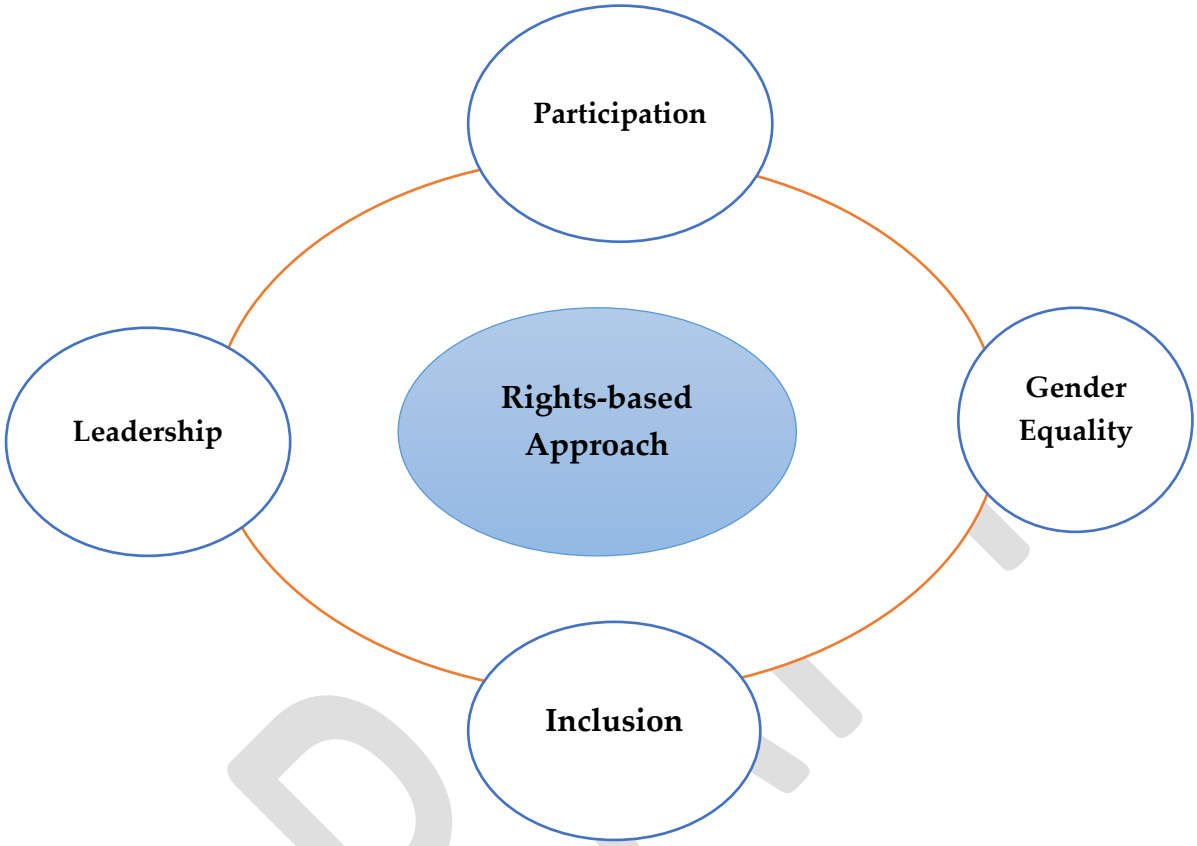
1.1. Mission and Vision

Ihorere Munyarwanda Organisation (IMRO) is a Non-Governmental Organization that was founded in 1999 and legally registered (under legal personality No 03/11) to operate in Rwanda whose mission is to promote sustainable socio-economic development of vulnerable people mainly FSWs and MSM within limited resources in Rwanda and beyond through outreach interventions, Advocacy, and Networking. IMRO envisions a healthy society where every citizen enjoys his/her right to health without discrimination.

IMRO was created following the genocide against the Tutsi of 1994 to address the consequences including the burden on the community to afford the socio-economic life, the overwhelming # of orphans and widows, minors heading households, and trauma, among others. The inception stage of IMRO was largely related to the promotion of the welfare of children, young people, and women with great emphasis on girls and young women engaged in sex work. Major interventions concerned mainly with supporting their income-generating activities, supporting the education of children born to female sex workers; awareness campaigns that aimed at widening sensitization prevention of population about HIV/AIDS, counseling and referral for those affected by HIV.

1.2. Core Values and guiding principles

The following are guiding core values for IMRO interventions Model.



1.3. IMRO's Operating Context

1.3.1. HIV and SGBV among Key populations

Prevention of HIV transmission among the most at-risk population remains to be the main focus of Ihorere Munyarwanda Organisation (IMRO). Sex workers constitute one of the key categories of most at risk and they form an important epidemiological link for HIV transmission to the general population. Available data in Rwanda reveal that HIV prevalence is higher among Female Sex Workers (45.8%) with a high prevalence among Female Sex Workers operating in Kigali at 55.5 %[1]. HIV prevalence among Female Sex Workers is significantly higher compared to the national HIV prevalence which stands at 3%. The National Strategic Plan on HIV and AIDS 2018-2020, suggests reducing Sexual Gender-Based Violence and HIV-related stigma and discrimination, but fails to suggest numeric targets to be achieved. However, IMRO is still concerned with the exclusion of some categories among LGBTI community members in the National Strategic Plan on HIV and AIDS. Violence and the threat of violence hinder the ability of individuals to protect themselves from infection. When sex is violent or forced, women are put at high risk of HIV infection. IMRO's program to key populations has been focusing on:

- Identification and enrollment of MSM and FSWs for screening and follow-up. This is done through hotspots and existing associations/organizations and other key informants.
- Awareness campaigns to address the problem of gender-based violence, stigma, and discrimination to which they are particularly vulnerable.
- Provision of hygienic messages and distribution of condoms and lubricants through hotpot visits and engagement with Anti-AIDS Clubs in Schools and Out of Schools.
- Provision of mutuelle de santé (medical insurance scheme) to most vulnerable key populations to access health care services.
- Advocacy activities to address policy barriers and practices related to health care service for key and vulnerable populations.
- Outreach campaign and sensitization of communities about HIV/AIDS to deliver message and services.

1.3.2. SRHR of women and young people

SRH challenges are among the key problems affecting the well-being of girls and women in developing countries including Rwanda. In most lands with limited resources, women and girls are unable to access the needed Sexual and Reproductive Health services. In

[1] Behaviour and Biological Surveillance Survey (2015).

Rwanda, Sexual and Reproductive Health problems are on the increase, despite school community-based interventions that have sought to reduce them in this population. Currently, more than 25% of girls aged 15-19 in Rwanda have their first sexual experience by the age of 15 and 15% of births occur to teenage mothers. About 15% of births in Rwanda occur to mothers below 20 years of age and is mostly due to unwanted and unplanned pregnancies. STIs are fairly common among women and girls in Rwanda. A recent study revealed that, nearly half of young women who have STIs in Rwanda do not seek treatment mostly because they do not know their rights, did not want other people to know, did not know where to go, or thought it costs too much.

IMRO has been at the forefront of the battle in creating an enabling environment for women, girls, and young people in general through advocacy activities to challenge policy barriers and practices in regard to sexual and reproductive health, but also raising awareness of the citizen about SRHR issues, available services, and related stigma and discrimination. More specifically, IMRO has been involved in the following activities:

- Awareness about emerging issues and causes of unsafe abortion.
- Advocacy to increase their knowledge of SRHR as individuals and how to advocate for women's rights.
- Increase knowledge of Teen Mothers and Female Sex Workers on SRHR issues and available services.

All these interventions have targeted peer educators among teen mothers and Sex Workers, CSOs, and other stakeholders including local law enforcement agents (GBV Police, MAJ, and local authorities), health service providers at the district level as well as policymakers through the engagement of concerned ministries and the parliament.

1.3.3. Social Protection: WASH and Nutrition

Since its establishment in 1999, IMRO, alongside development partners in Rwanda has been conducting programs on nutrition-sensitive social protection in different districts of Rwanda targeting the most vulnerable sex workers.

The nutrition-sensitive social protection Program's focus has been testing and modeling new strategies and approaches of integrated programs for the poorest households managed by female sex workers. The program delivered high-quality results in supporting the most vulnerable sex workers and empowering them to be self-reliant persons and demonstrating evidence of change in child nutrition and poverty reduction among these supported vulnerable groups. This important transformation reached effective service delivery through case management and referral, access to nutrition-rich fruits and vegetables, financial access leading to entrepreneurial activities, and improved household wellness through exposure to community sensitization on social protection.

IMRO's values of working with sex workers and their children under five, pregnant and lactating women engaged in sex work, gender equity, and the inclusion of disadvantaged and marginalized people, are closely aligned with the Government of Rwanda's aspirations for its people. Children under five years in Rwanda experience multiple dimensions of poverty and it becomes worst when it comes to female sex workers children who ended up becoming sex workers.

Malnutrition directly affects one in three people worldwide, making it one of the most prominent issues affecting global health. Despite Rwanda's impressive socio-economic growth in the past several decades, malnutrition remains an issue of major concern. More than one in three Rwandan children under five are chronically malnourished. With malnutrition rates in the poorest households being almost double the rate in the richest households, it is evident that families in extreme poverty require more specific support to address many dimensions of poverty they experience. Among IMRO's interventions included:

- Creating over 400 Kitchen gardens for sex workers' households to increase their nutrition.
- Creating Groups of Saving Loans associations, etc. to reduce socio-economic vulnerability and increase the quality of nutrition among sex workers, people living with HIV, and women with low income.

Retrospection summary of the past strategic period (2017-2021)

Our past strategic period (2017-2021) has mainly focused on raising awareness of key populations especially female sex workers on HIV/AIDS services and the distribution of commodities through their hotspots. The period has also been important to strengthen the capacity of peer educators among key populations on how to form and strengthen community-based advocacy movements but also IMRO has provided financial support to the most vulnerable key populations during the covid-19 pandemic considering the fact that they are the populations most affected due to covid-19 related restrictions including on and off lock-downs. The past strategic period has been the opportunity for IMRO to invest more in the provision of training to sex workers groups of savings and loans associations to enhance the socio-economic and living conditions in numerous districts in the western and southern provinces of Rwanda namely Musanze, Nyamasheke, Kirehe, Rubavu, Ruhango, and Huye. The majority of the reached districts are the border districts with high #s of women engaged in sex work. Furthermore, outreach campaigns have also been conducted to raise the awareness of female sex workers about the legal and policy environment on safe abortion, advocacy activities in close partnership with the Rwanda SRHR coalition through the engagement of duty bearers and policy makers.

Jules Mugisha (Program Manager)

2. STRATEGIC DIRECTION (2022-2026)

2.1. Context Analysis and problem

Rwanda is home to over 12 million people, where 25% live in urban areas and 75% in rural areas (NISR, 2017), with a gross domestic product per capita of USD 776 (IMF, 2017). Although poverty has declined more in rural areas than urban areas, the poverty rate is still at 62% in rural areas, compared to an average of 16% in urban areas (UN Rwanda, 2017). In addition, 53% of the population is under the age of 22 (NISR, 2017) Overall, Rwanda continues to outperform most countries in sub-Saharan Africa in several areas. Life expectancy in Rwanda is fi e years longer than the rest of SSA at 69 years. The maternal mortality ratio, though still unacceptably high, is lower at 248 deaths per 100,000 live births. The adolescent birth rate is considerably lower at 39 pregnancies per 1,000 and relatively low gender inequality at 0.412 (UNDP, 2018). While Rwanda has made considerable strides in overall development, several challenges remain. Education level, measured through the # of years of schooling completed, and a key socio-economic development indicator, is significantly lower in Rwanda, where the average person completes 3.8 years of schooling, compared to 5.4 years in SSA. According to the Ibrahim Index of African Governance (IIAG, 2017), overall governance in Rwanda has slowed in improvement over the last five years. In terms of human development (welfare, health and education), Rwanda's improvement rate, though still on a positive trajectory, has dropped from 1.87% to 0.73%. While progress has also slowed overall on the continent, it has done so at a faster rate in Rwanda. With regards to participation and human rights, Rwanda is showing slower improvement, while the rest of SSA is increasing in improvement: the progress rate declined from 0.87% to 0.55%

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addressed. Most positions from mayor down to village chiefs continue to be dominated by men, raising concerns around effective implementation of all gender equality related programs (UN Rwanda, 2017)

2.1. Gaps in Access to Contraception

According to the latest Demographic and Health Survey (DHS) 2019-2020, 58% of married women reported using a modern method of contraception (predominantly injectable, the pill or implant), with an unmet need at 13.6% (National Institute of Statistics, 2020). However, in some areas of Rwanda, the unmet need for contraception has strongly increased. Kicukiro, Nyaruguru and Muhanga have seen a 50% increase in the unmet need for contraception between 2010 and 2015. Other districts where the unmet need for contraception remains high include Gastibo, Rutsiro, Ruhango, Bugesera, Nyanza, Rusizi and Nyamasheke (National Institute of Statistics, 2020). There is a particularly high unmet need for contraception amongst young unmarried women between the age of 15 and 29 who have sex, at 56% (Figure 8, Basinga et al, 2012). This unmet need is also evident in access to emergency contraception. Women and girls seeking emergency contraception often fear the stigma associated with the morning-after pill and will delay purchasing it, thus decreasing its effectiveness. Adolescents in particular lack access to contraception, especially when seeking contraception without their parents. Parental consent has become a major barrier to adolescent access to sexual and reproductive health in general.

2.2. Lack of knowledge about CSE among young people

Comprehensive sexuality education (CSE) is a well-evaluated intervention that has proven, significant, positive results on adolescents' sexual and reproductive health, including knowledge of sexual and gender-based violence. Rwanda signed onto the Eastern and Southern African Ministerial Commitment on CSE and SRH services for adolescents and young people. The rate of teenage pregnancy has been on the rise since 2018. The most recent Rwanda Demographic Health Survey indicates that by age 19, 15.4% of young women have begun childbearing. Given this increase in teenage pregnancy, adolescents' sexual and reproductive health (ASRH) has come to the forefront of the Rwandan government's efforts (Adolescents and contraception, 2019). The Rwandan government is investing heavily in several programs and policies aimed at improving ASRH, including championing the introduction of CSE as a competence-based, cross-cutting subject within both primary and secondary schools. Implementation of CSE has been slow and challenging. Although no evaluations of CSE delivery in the Rwandan school system have been conducted yet, studies from other countries in east and southern Africa show that the curricula lacked precision, provided incomplete information, and did not empower young people to advocate for their sexual and reproductive health and

rights. In addition, teachers were often ill-equipped to deliver the curricula as intended and therefore were not likely to have the desired impact (Chandra-Mouli et al, 2015). These findings suggest that similar constraints are to be found in Rwanda. Indeed, UN Rwanda (2017) lists social barriers and particularly cultural and religious barriers as key obstacles to the delivery of the CSE program.

2.3. High prevalence of unsafe abortions

Abortion in Rwanda remains highly restricted and hence the prevalence of safe, legal abortion in the country is virtually non-existent. The current legal framework only permits abortion in the case of rape, incest of the second degree, forced marriage, in the case of child defilement, or when the pregnancy jeopardizes the child's or woman's health. Furthermore, abortion is only permitted to be performed by a medical doctor, which limits the # of healthcare providers who may perform the procedure (Ministerial Order N°002/MoH/2019). Though the ministerial order does not require a woman to produce evidence when seeking safe abortion services, oftentimes women are subjected to burdensome administrative conditions whereby they are required to explain the circumstances surrounding stories of their sexual violence and are forced to first report the cases to the police. This procedure continues to be a barrier for illiterate, poor, and vulnerable women including adolescents, and domestic and sex workers to access abortion services. Furthermore, hospitals with religious affiliations which make up around 60% of hospitals country-wide can deny safe abortion services to women and girls due to conscientious objection. This forces some women and girls to travel long distances and spend extra money to seek abortions. According to insurance regulations, users of Mutuelle de Santé (community-based health care) must start at the health center level in order to use it to cover their medical procedures. This has been a barrier for women seeking safe abortion, as the first level of care for abortion is the hospital level. Mutuelle de Santé users are often denied coverage due to a lack of harmonization between the insurance regulations and the Ministerial Order. This raises concern, as it may lead to an increase in unsafe abortion cases. Research shows that annually 26,000 women are treated for complications resulting from spontaneous as well as induced abortions, and 65% of complications are a result of induced abortion (Basinga et al, 2012). Post-abortion care is estimated to cost the Rwandan public health system USD 1.7 million every year, and if all demand was fulfilled, this figure would rise to USD 2.5 million annually (Vlassoff et al, 2015). Consequently, Rwanda has a high maternal mortality ratio that could be decreased by 22% if access to safe, legal abortion is facilitated

HIV/AIDS The national HIV prevalence rate is 3%, with a higher HIV prevalence rate amongst women (3.6%) than men (2.2%). The prevalence rate is far higher in Kigali: 8% amongst women and 4.4% amongst men (Figure 9). HIV prevalence is highest amongst

female sex workers at 51% (PEPFAR, 2017). In Rwanda, FSW and men who have sex with men (MSM) represent the key population (KP) groups in the National Strategic Plan. Although 90% of FSWs test for HIV, only 78% of those who are HIV positive are on treatment. Importantly, only 47% reported using condoms consistently with clients and other sex partners. MSM, while not having a significantly higher HIV prevalence rate than men in urban areas in the general population (at 4%), face greater risk of contracting and spreading HIV as 42% reported selling sex (PEPFAR, 2017). Along with males aged 45-49 and females aged 40-44, young people aged 15-24, and especially adolescent girls and young women, represent priority populations (PPs) in decreasing the spread of HIV in Rwanda. Adolescent girls and young women are particularly vulnerable to HIV, due to compounding factors such as sexual gender-based violence, significantly older male sex partners and vulnerability to sexually transmitted infections (PEPFAR, 2017). Antiretroviral therapy (ART) coverage is near universal in Rwanda at 92%, and 91% have achieved viral suppression. While treatment retention in the general population is high at 93%, it is lower amongst pregnant women and adolescents at 86% and 87% respectively, indicating that these groups require more support (PEPFAR, 2017).

2.4. Teenage pregnancies and issues of maternal health

Fertility rates in Rwanda are relatively high, with an average of 4.2 births per woman (UN Rwanda, 2017). Pregnancy in the teenage years is not uncommon (45 births per 1,000) and, on average, Rwandan women continue childbearing until their late 30s. Most pregnancies occur between the ages of 30 and 34, at 186 births per 1,000 women. Challenges remain in decreasing the maternal mortality ratio (MMR). Rwanda's current MMR stands at 290 deaths per 100,000 live births and the SDG 3 target is less than 70 deaths per 100,000 live births. As shown earlier, the retention of pregnant women in ART programs is a challenge that needs to be addressed. While 99% of women attended at least one antenatal care visit and 91% of live births were attended by a skilled health provider, only 43% of women attended the recommended fi s or more antenatal care visits (Assaf, Staveteig & Birungi, 2018).

2.5. Gender discrepancies

Gender inequality, particularly gender-based violence continues to undermine the health and well-being of women and children in Rwanda. More than 20% of women have experienced violence from a partner in the past year (RDHS 2019). Acceptance of intimate partner violence remains high and according to the Survey Report on Violence against Children and Youth (MoH, 2017), half of all girls and six out of ten boys experience violence. Rwanda has committed to promoting gender equality and fighting all discrimination as evidenced by the different policy and legal frameworks in place. Despite the existence of government gender and GBV policies and programs, gender inequalities

and GBV remain serious challenges, which require more effort to ensure a comprehensive remedy. In Rwanda, gender equality is central to the government's agenda and priority; however, there is still a challenge at the household the level in redistribution of care work due to patriarchal tendencies. This limits women's opportunities to participate in leadership, and opportunities to create income-generating activities claim their rights, and participate in decision-making. Furthermore, gender and cultural norms have instilled internalized misogyny in some women, such that the women have difficulty seeing the problem with traditional gender roles.

2.5.1. LGBTI community members

In Rwanda, there is no law prohibiting same-sex acts, and the Rwandan government has signed the UN Human Rights Council statement towards "Ending Acts of Violence and Related Human Rights Violations Based on Sexual Orientation and Gender Identity". Rwanda has made progress in the area of LGBTI rights by prohibiting discrimination of any kind in the Rwandan Constitution and criminalizing discrimination in the law determining offenses and penalties in general (article 163). Even so, there are no current laws protecting the rights of LGBT persons (Luft, 2016). LGBT persons face harassment, such as verbal and physical abuse by state officials and arbitrary arrests by the police (Iradukunda & Odoyo, 2016). LGBT persons' access to education, healthcare and employment is also severely limited (Iradukunda & Odoyo, 2016). Additionally, although the law prohibits discrimination, the legal framework does not recognize gender identity for intersex persons, nor does it allow for sex reassignment in birth records. The law also does not provide adequate protection for transgender, intersex, and other non-conforming people against gender-based violence. LGBTI persons are also not mentioned in health policies. For example, the Fifth Health Sector Strategic Plan sets out the national direction for the health sector, but makes no mention of LGBTI persons or their health needs.

Although Rwanda has signed in 2011 a Joint UN statement on Ending violence and discrimination against LGBTI people, stigma and discrimination, inadequate legal protection against gender-based violence, as well as the inadequate enforcement of the law criminalizing hate speech which targets transgender persons, arbitrary arrest and detention are still observed.

2.5.2. Female sex workers and their children

According to the Rwandan Biomedical Center, there are between 8,500 and 22,000 female sex workers (FSWs) in Rwanda, the majority of whom live and work in Kigali (Rwanda Biomedical Center, 2018). Although there is a male sex worker (MSW) community in Rwanda, they identify primarily as LGBT, and therefore there is no research specifically on MSW (Iradukunda & Odoyo, 2016). Prior to 2018, sex work was illegal, however sex workers' rights were protected under the Rwandan Constitution. The Government of Rwanda has since decriminalized sex work due in part to IMRO's advocacy and, although sex work is no longer a crime, sex workers still face high levels of stigma and discrimination, including from health care providers, leading to undesirable social, psychological and health outcomes for FSWs and arbitrary arrest (Ingabire et al, 2012). In addition, the Ministerial Order determining the mission, organization, and functioning of transit centers cites prostitution among deviant acts or behaviors despite the fact that sex work has been decriminalized. Furthermore, approximately 80% of FSWs have children, which means that poor social and health outcomes will impact their families as well. Stigma and discrimination are key barriers in health-seeking behavior amongst sex workers, which is costly to public health.

3. Strategic Planning Process and Methodology

The process for developing this Strategic Plan for IMRO took place over a 3-month period from July – September 2022. The methodology used was largely based on one of the Technology of Participation methods[2] known as Participatory Strategic Planning (PSP), developed by the Institute of Cultural Affairs (ICA)[3]. The process involved several stages, which are described below:

1. **Initial planning and preparation.** A series of meetings and discussions between the lead facilitator and key members of the Organisation's management to agree and organise the process for developing the Strategic Plan.
2. **Consultation sessions.** A series of sessions to ensure that the voices of different stakeholders were heard and documented in order to contribute meaningfully to the process. These took place with a total of 12 people (approx. 55% female, 45% male). These included staff, board members, and other partner organizations.

[2] For more information about ToP methods, please see https://top-facilitation.com/
[3] For more information about ICA, please see https://www.ica-international.org/

3. **Analysis of the internal and external environments.** This involved two sessions with key members of IMRO's team in order to develop a SWOT analysis[4] and PESTLE analysis[5].

4. **Practical Vision.** This was one of the questions in the Consultation sessions and enabled participants to develop a practical and meaningful Vision together, drawing in all ideas and suggestions. This stage allows a team to be creative, dynamic and visionary, whilst remaining practical and realistic in developing its collective ideas.

5. **Contradictions.** During this stage, participants were asked to identify the possible blocks, challenges and barriers to achieving the desired vision that had been developed. The session helped the team members to identify and name underlying causes, and issues that may block the practical vision.

6. **Strategic Directions.** This stage revisited the contradictions listed whereby participants were asked to identify creative and innovative solutions to the blocks identified, which will enable them to move towards the desired vision. The stage then develops key strategic pillars which will guide organisational activities and plans for the next 5 years. The stage enabled participants to think creatively beyond the contradictions in a focused and strategic manner.

7. **Implementation.** During this stage, participants were asked to identify key targets and then develop action plans to be achieved in first year of the strategic direction. Participants were encouraged to develop indicators and quantitative targets and activities that can be considered SMART (Specific Measurable Achievable Realistic and Time-Bound).

8. **Review Process.** At several stages, small groups of people from IMRO management and staff were engaged to check through either the work of the lead facilitator or to discuss a particular aspect of the plan.

In some ways, this strategic planning was a lengthy process but certainly, an enjoyable one, and the critical importance of engaging such a large # of stakeholders cannot be

[4] SWOT analysis refers to the process of analysing the Strengths, Weaknesses, Opportunities & Threats of the organisation, both internally and externally

[5] PESTLE analysis refers to a process to analyse the external (and, at times, internal) Political, Economic, Social-Cultural, Technological, Legal & Environmental factors affecting the organisation

overstated. The aim was to develop a plan that everyone associated with the organization can feel part of and energized to work towards its effective implementation.

3.1. SWOT ANALYSIS

STRENGTHS	WEAKNESSES
• Changing the life of key populations, youth, and adolescents. • The engagement and participation of our community • The flexibility of the management and team • Readiness to learn new things • Attractive location to serve key populations and young people. • A regionally recognized organization, and member of different platforms. • Key populations, youth, and adolescents committed to their own development and change • Proven success stories of key populations who have come through the programme • IMRO is a family (more than just an organization) • Engagement with professional SRHR service providers across the country. • IMRO is well known in the community and CSO workplace in Rwanda. • Great reputation in Kigali city and countrywide. • Powerful mission (transforming key populations and young peoples' lives).	▪ Limited financial and human resource capacity. ▪ Organisational structures are not efficient enough. ▪ Offices are rented and costly. ▪ Limited working facilities. ▪ Few local donors support our areas of intervention. ▪ Ineffective Networking due to limited financial capacity. ▪ Lack of qualified staff in monitoring and evaluation systems. ▪ Lack of backup system for generated data.
OPPORTUNITIES	**THREATS**
• People can donate more if fundraising strategies are effectively implemented. • Improved visibility and reformed structure can lead to more support. • Many youth volunteers committed to support the organisation.	• The instability of the team slows down IMRO's progress and affects our mission • High costs of renting affects # of beneficiaries and programs supported.

• Government recognition and support in key populations and young people's development programs. • Availability of international donors in our areas of interest. • Programmes that can create income-generating opportunities for key populations. • Developing new partnerships with different CSOs, Academia, and other research institutions.	• Political instability can affect the programmes, esp. at the international level. • Possible new variants of Covid-19.

3.2. PESTLE ANALYSIS

The External factors affecting the work of IMRO are presented in the table below.

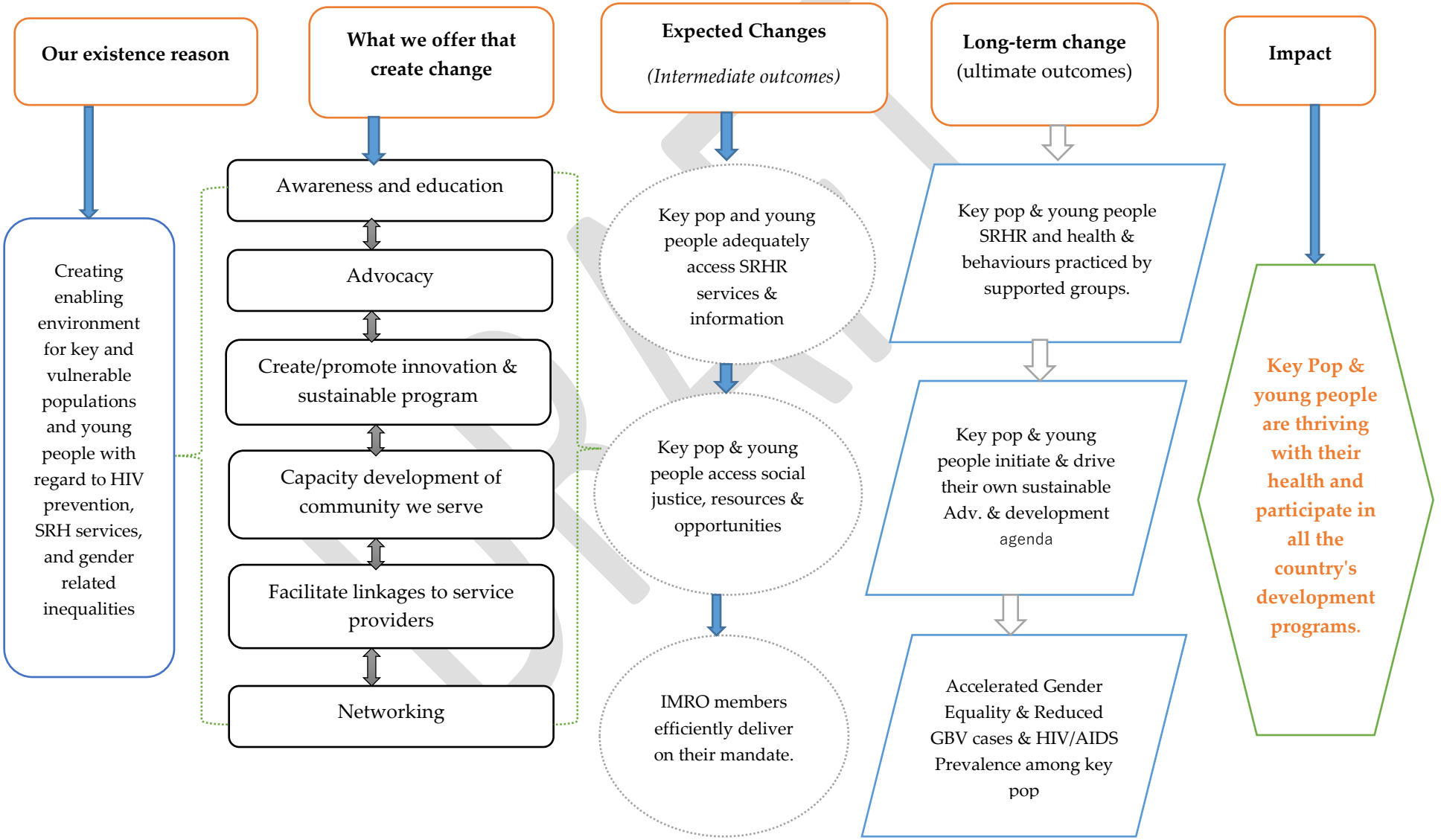
POLITICAL	**ECONOMIC**
• International relationships can affect engagement with international partners. • Perception and relationship with local government can affect organisation	• High inflation affecting supply costs • Unstable donors affect key population support programs. • Cost of living affects our potential in getting volunteers
SOCIAL	**TECHNOLOGICAL**
• Instability of beneficiaries' moving due to community stigma and discrimination. • A good reputation can easily be destroyed	• Online threats towards our program beneficiaries. • Our present data can be hacked, and easily interfered with. • Poor access to internet facilities for most of our staff team.
LEGAL	**ENVIRONMENTAL**
• Safeguarding issues (policies and laws) affecting our work. • High tax rates. • Accreditation of programs.	• A large # of vulnerable key populations, youth, and adolescents are affected by environmental health issues

	• Growth of the city impacts the relevance of the Organisation's location • Poor infrastructure affects the local community (e.g. water, electricity).

3.3. IMRO's Theory of Change

IMRO has set for itself a response to the huge social and developmental burden of meaningful participation of key populations, and young people in the fight against issues related to their sexual reproductive health, HIV/AIDS, gender related inequalities and inequities and violence mainly gender based violence. We equally recognise that while access to healthcare, safety and security are rights guaranteed under the Constitution of Rwanda of 2003 revised in 2015, a significant section of the population including sex workers and MSM do not yet enjoy these rights. We understand that these concerns and their disproportionate impact on specific groups is a function of behaviour patterns, capacity challenges, social injustices, and unsupportive policy frameworks. We commit therefore to invest in culture reflection (i.e. change or preservation), as well as promotion of the rights and dignity of key populations and young people in general. Further, we believe that creating sustainable long-term solutions around these concerns requires an integrated approach that addresses underlying systemic factors that promote or sustain violence, abuse/addiction, and the HIV/AIDS scourge among key populations. We, therefore, invest in SRHR, HIV prevention, abuse & addiction prevention/treatment; violence & trauma prevention/ treatment through behavior change education, advocacy, and resilience building for vulnerable program's beneficiaries. These would be in addition to the continued institutional development of IMRO. We will work especially with marginalized groups of key populations and young people to assure social justice while leveraging other actors' resources to guarantee sustainable and scaled impact.

NOTE: A schematic representation of this theory of change is presented in figure 2 below.


Our existence reason
What we offer that create change
Expected Changes
(Intermediate outcomes)
Long-term change
(ultimate outcomes)
Impact
Creating enabling environment for key and vulnerable populations and young people with regard to HIV prevention, SRH services, and gender related inequalities
Awareness and education
Advocacy
Create/promote innovation & sustainable program
Capacity development of community we serve
Facilitate linkages to service providers
Networking
Key pop and young people adequately access SRHR services & information
Key pop & young people access social justice, resources & opportunities
IMRO members efficiently deliver on their mandate.
Key pop & young people SRHR and health & behaviours practiced by supported groups.
Key pop & young people initiate & drive their own sustainable Adv. & development agenda
Accelerated Gender Equality & Reduced GBV cases & HIV/AIDS Prevalence among key pop
Key Pop & young people are thriving with their health and participate in all the country's development programs.

4. Implementation Strategies and Interventions

4.1. Strategic pillars and priority activities

This section presents the strategic objectives and broad priority interventions for the four strategic pillars that IMRO will focus on. The section does not go into the detailed activities as these will be elaborated in the detailed result framework with clear targets and timelines.

Strategic pillar 1: Becoming a landmark CSO in Rwanda as far as HIV, TB, and malaria prevention and treatment are concerned including WASH and nutrition for community health development.

Priority activities:

1) *Advocacy to influence policy and practices to create an enabling environment for key and vulnerable populations.*
2) *Outreach campaigns to awareness-raising communities about HIV, TB, and malaria prevention and treatment including WASH and nutrition.*
3) *Training of health care providers on stigma-free service delivery of STIs, HIV and AIDS screening, pregnancy testing, family planning counseling, pre and post-abortion counseling, and referral of women seeking a safe abortion.*
4) *Training for law enforcement authorities about the legal and policy environment of abortion in Rwanda as well as the fundamental human rights of key populations to reduce violence and arbitrary arrest cases of sex workers and LGBT persons.*
5) *Continue mentorship programs to facilitate key populations to form saving groups and loan associations.*
6) *Accompanying women engaged in sex work from vulnerable households to build kitchen gardens to prevent malnutrition among their children.*

Strategic pillar 2: Contribute to Rwanda's health systems strengthening that generates improved health outcomes.

Priority activities:

1) *Support to expand the geographic and population coverage with health services and thus contributing not only to disease control but other packages of health services and consequently realizing universal health access.*
2) *Training to support the integration of skilled health cadres in the health workforce including capacity building of community health workers within both public and private health facilities.*

3) *Provide accurate health information including disease surveillance.*
4) *Advocacy to strengthen health products and commodities supply chain and delivery by expanding laboratory capacity.*

Strategic pillar 3: Enhancing young people's access to sexual and reproductive health accurate information and services.

Priority activities:

1) *Provide pieces of training for peer educators of youth to connect with the community for effective engagement and development.*
2) *Provide support to students and other young people in schools and out-of-schools through health clubs to effectively play a vital role in SRHR service and information provision.*
3) *Conduct advocacy activities to challenge policy barriers and practices hindering girls to achieve their full potential in SRHR.*
4) *Apply a gender-transformative approach to engage men and boys to support women and girls in meeting their SHRH needs.*

Strategic pillar 4: Increasing organizational resilience and capacity in both human and financial resources for improved knowledge, relationships, and performance.

Priority activities:

1) *Improve communication and visibility and related tools.*
2) *Train staff on human rights, gender, and inclusion.*
3) *Develop a strategy for sustainable staff learning and retention.*
4) *Organize in-house resource mobilization, grant proposal writing, and monitoring and evaluation for the professional development of staff.*
5) *Improve organizational compensation, benefits, and staff incentives for sustainable staff retention.*
6) *Improve organizational management systems and policies, operating structure, and leadership.*

4.2. Result Framework and implementation Plan

Vision:								
Strategic pillar 1: *Becoming a landmark CSO in Rwanda as far as HIV, TB, and malaria prevention and treatment are concerned including WASH and nutrition for community health development.*								
Outputs	**Output Indicators**	**Baseline (2021)**	**Target by 2023**	**Target by 2024**	**Target by 2025**	**Target by 2026**	**Target by 2027**	**Total**
Raised awareness in the communities about HIV, TB, and malaria prevention and treatment, WASH, and nutrition.	*# of general population reached through outreach activities*		5,200	6,300	7,400	8,500	9,500	27,000
	# of condoms and lubricants served to MSM		2,900	3,190	3,509	3,859	4,500	17,958
	# of condoms and lubricants served to sex workers		20,500	25,000	30,000	35,000	40,000	150,500
	# of PWUDs/PWIDs reached		2,500	3000	3500	4000	4500	17,500
	# of secured partnerships		4	7	9	11	13	43
	# of PLHIV reached by our program		2000	2500	3000	3500	4000	17,000
Strengthened capacity of health care providers on HIV, family planning, and abortion stigma-free service delivery.	*# of healthcare providers trained and engaged*		2500	3500	4000	4500	5000	18,000
	# of events organized		30	45	55	65	75	270
	# of law enforcement agents trained.		200	300	400	500	600	2000

Established and mentored key population-centered saving groups, and loan associations.	*# of saving groups and loan associations mentored*		5	10	20	30	40	105
	# of mentorship sessions conducted.		24	48	96	192	384	744
	# of training provided		4	8	16	32	64	124
	# of program graduates among key populations		20	30	40	50	60	200
Strategic pillar 2: *Contribute to Rwanda's health systems strengthening that generates improved health outcomes.*								
Expanded IMRO's interventions in the geographic and population coverage with health service, and education.	*# of focal point offices established in the district*		0	1	0	1	0	3
	# and type of services delivered at a local level		2	4	6	8	10	30
Improved health products and commodities supply chain and delivery.	*# of duty bearers engaged*		250	300	350	400	450	1,750
	# of policymakers engaged		30	40	50	60	70	250
	# of policy briefs/position papers developed.		2	4	4	4	4	20
Strategic pillar 3: *Enhancing young people's access to sexual and reproductive health accurate information and services.*								
Strengthened capacity of youth peer educators for effective engagement and development.	*# of youth engaged*		300	500	600	700	800	2,900
	# of young people's program tools designed		5	8	10	12	14	59
	# youth-centered advocacy initiatives supported		3	3	4	5	6	21
	# of students engaged		2,500	3000	3500	4000	5000	

Supported students and young people in schools and out-of-schools through health clubs.	*# of out-of-school adolescents engaged*		2,500	3000	3500	4000	5000	18,000
	# of school and club visits held		4	4	4	4	4	20
Influenced policies and laws hindering girls to achieve their full potential in SRHR.	*# of policies and laws influenced*		TBD	TBD	TBD	TBD	TBD	
	# of service providers engaged		200	300	400	500	600	2000
Engaged men and boys to support women and girls in meeting their SHRH needs.	*# of men and boys reached with program*		2500	3000	3500	4000	4500	17,500
	# of training on positive masculinities held		4	4	4	4	4	20
	Organized monthly gender coffee		12	12	12	12	12	60
Strategic pillar 4: *Increasing organizational resilience and capacity in both human and financial resources for improved knowledge, relationships, and performance.*								
Improve communication and visibility and related tools.	*# of programs held at community Radio stations and TV.*		12	12	12	12	12	60
	# of leaflets, posters developed and disseminated		TBD	TBD	TBD	TBD	TBD	TBD
	IMRO's website updated		Weekly	Weekly	Weekly	Weekly	Weekly	Weekly
	# of media articles developed		Quarterly	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly
	# of social media platforms created		TBD	TBD	TBD	TBD	TBD	TBD

	# of contents created to increase young people's knowledge		TBD	TBD	TBD	TBD	TBD	TBD
Strengthened staff capacity on human rights, gender, and inclusion, resource mobilization, grant proposal writing, & ME	*# of in-house training held*		12	12	12	12	12	60
	# of human rights issues identified							
	Develop a strategy for sustainable staff learning and retention.		1	0	1	0	1	0
Improved organizational management systems and leadership	*# of developed policies*		1	0	1	0	1	0
	Operating structure revised		1	0	1	0	0	1
	Established mid-level managers		TBD	TBD	TBD	TBD	TBD	TBD

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ANNEXES: Tools used for SP data collection

1. Organization Profile

Question	Answer
Mission	
Vision	
Programs	
Stakeholders	
Human capacity (What capacity do your staff have?)	
Financial (What capacity do you have now?)	
Values (What are the IMRO's guiding principles?)	

S.W.O.T ANALYSIS

Strengths (*What are the strengths/efforts does IMRO have?)*	**Weaknesses (***In which field/capacity does IMRO feels weak?)*
Opportunities *(what opportunities does IMRO have to operate?)*	**Threats** *(what are the major threats IMRO faces?)*

PERFORMANCE MEASURES

Strategic Objective 1 *(think about your interventions in the advocacy for key and priority populations):*		
Activities	**Output (s)**	Indicators
Strategic objective 2: (*think about your interventions in the capacity building …*		
STRATEGIC OBJECTIVE 3: *think about your intervention in inclusive economic growth for key populations*		
STRATEGIC OBJECTIVE 4: *think about your intervention for young people*		

STRATEGIC OBJECTIVE 4: *think about your organization's capacity development*		

RISK ASSESSMENT

Risk factor:	Probability level	Impact level	Mitigation strategy
INTERNAL			
EXTERNAL			