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Description of document:	US Department of Justice (DOJ) Office of Justice Programs (OJP) Materials on Addressing Female Genital Mutilation 2018-2020
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U.S. Department of Justice

Office of Justice Programs

Office of the General Counsel

Washington, D.C. 20531

June 24, 2022

VIA EMAIL

Re: OJP FOIA No. 21-FOIA-00014

This letter responds to your October 19, 2021, Freedom of Information Act/Privacy Act (FOIA/PA) request, which was received in the Office of Justice Programs (OJP), Office of the General Counsel (OGC), on the same date. A copy of your request is attached for your convenience.

Please be advised that a search has been conducted in the OJP, and 4 documents, consisting of 154 pages were located which are responsive to your request. After carefully reviewing the attached documents, OGC has determined that these documents are appropriate for release with some excisions made pursuant to Exemption (b)(4) and Exemption (b)(6) of the Freedom of Information Act, 5 U.S.C. § 552 (2018). Exemption (b)(4) protects trade secrets and commercial or financial information obtained from a person that is privileged or confidential. Exemption (b)(6) protects information that if disclosed, "would constitute a clearly unwarranted invasion of personal privacy." Please be advised that we have considered the foreseeable harm standard when reviewing records and applying FOIA exemptions. This completes the processing of your request by OJP.

You may contact a member of our FOIA staff at (202) 307-6235, via e-mail at FOIAOJP@usdoj.gov as well as our FOIA Public Liaison, for any further assistance and to discuss any aspect of your request at:

US DOJ, Office of Justice Programs
Office of the General Counsel
810 7th Street, NW, Room 5400
Washington, D.C. 20531
Attn: FOIA

Additionally, you may contact the Office of Government Information Services (OGIS) at the National Archives and Records Administration to inquire about the FOIA meditation services they offer. The contact information for OGIS is as follows: Office of Government Information

Services, National Archives and Records Administration, 8601 Adelphi Road-OGIS, College Park, Maryland 20740-6001; e-mail at ogis@nara.gov; telephone at 202-741-5770; toll-free at 1-877-684-6448; or facsimile at 202-741-5769.

If you are not satisfied with OJP's determination in response to this request, you may administratively appeal by writing to the Director, Office of Information Policy (OIP), United States Department of Justice, 441 G Street, NW, 6th Floor, Washington, D.C. 20530, or you may submit an appeal through OIP's FOIA STAR portal by creating an account following the instructions on OIP's website: https://www.justice.gov/oip/submit-and-track-request-or-appeal. Your appeal must be postmarked or electronically transmitted within 90 calendar days of the date of my response to your request. If you submit your appeal by mail, both the letter and the envelope should be clearly marked "Freedom of Information Act Appeal."

Sincerely,

Daniel Gaylord

Daniel Gaylord
Government Information Specialist

Attachments

Program Narrative

RTI Proposal No. 0282000.955

Addressing Female Genital Mutilation and Cutting
FY 2020 Competitive Grant Solicitation Solicitation
No.: OVC-2020-17550 CFDA No.: 16.582
April 30, 2020

Addressing Female Genital Mutilation and Cutting Training and Technical Assistance Program (AFTTAP)

Submitted To
U.S. Department of Justice
Office for Victims of Crime
Submitted via Grants.gov

Submitted By
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RTI INTERNATIONAL

RTI International
Proposal No. 0282000.955

This proposal includes data that shall not be disclosed outside the Government and shall not be duplicated, used, or disclosed—in whole or in part—for any purpose other than to evaluate this proposal. If, however, a contract is awarded to this offeror as a result of—or in connection with—the submission of these data, the Government shall have the right to duplicate, use, or disclose the data to the extent provided in the resulting contract. This restriction does not limit the Government's right to use information contained in these data if obtained from another source without restriction. The data subject to this restriction are contained in the entire proposal.

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Appendixes

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List of Exhibits

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1. Description of the Issue

Female genital mutilation and cutting (FGM/C)[a] is a public health, social welfare, and human rights concern in the United States.[3-5] Researchers, practitioners, and survivors[b] have called for culturally informed multisectoral community responses inclusive of law enforcement, social service and healthcare providers, religious and community leaders, and educators to end the practice of FGM/C and improve services for those affected.[3,6,7] The Office for Victims of Crime (OVC) is committed to preventing and serving victims of FGM/C through the *Addressing Female Genital Mutilation and Cutting (FGM/C)* program, which will support up to eight grantees this fiscal year. Grantees are charged with educating multiple sectors on detecting at-risk individuals, providing direct services to victims, and forming community networks positioned to identify and respond to at-risk individuals and victims.

RTI International will support grantees in meeting OVC's goals by using proven strategies for developing and delivering grantee-centric and community-tailored training and technical assistance (TTA), leveraging existing expertise and resources, and creating outreach materials for broad use in FGM/C-affected communities. Our work on the *Addressing FGM/C Training and Technical Assistance Provider (AFTTAP)* project will be guided by a group of eminent researchers, physicians, and community activists in the field; decades of FGM/C research; evidence-based and culturally responsive FGM/C prevention strategies and service approaches; and experience in supporting communities' multisectoral

[a] The term "female genital mutilation" is used to convey the practice as a human rights violation and to advocate strongly toward its end while "female genital cutting" is considered more culturally sensitive because it does not further stigmatize affected communities and individuals. The combined term "female genital mutilation and cutting" (FGM/C) is used to acknowledge the harmfulness of the practice, while simultaneously respecting those affected.[1,2] We use "FGM/C" throughout this proposal.

[b] Throughout this proposal, we use the term "survivors" and "victims" interchangeably and want to acknowledge that individuals who have experienced FGM/C may identify as a "survivor," "victim," or neither.

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responses to complex social problems. Furthermore, our partnership with the End FGM/C US Network will support the project's national reach, scope, and visibility.

1.1 Addressing FGM/C in the U.S.

The World Health Organization (WHO) defines FGM/C as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for nonmedical reasons." FGM/C is practiced primarily in Africa, the Middle East, and Southeast Asia,[8] but individuals affected by FGM/C are living in societies where the practice is not normative, including the U.S.[3] While prevalence in the U.S. is unknown, the Centers for Disease Control and Prevention (CDC) have estimated **513,000 U.S. girls and women have experienced or are at risk of FGM/C**.[4] FGM/C, recognized as a human rights violation and form of gender-based violence and child abuse,[9,10] can cause harmful short- and long-term physical and psychological impacts.[11-13] FGM/C has been illegal in the United States since 1996,[c] and criminalization of "vacation cutting," or intention to transport girls to other countries for FGM/C, has been illegal since 2013.[14] Currently, 38 states have laws against FGM/C.[15] Yet criminalization of FGM/C in the U.S. has been ineffective in halting the practice.[16]

Although defined as an act of violence, the practice is typically motivated by a perceived protection of girls in affected families and communities[17,18] and underpinned by six key factors: cultural tradition, sexual morals, marriageability, religion, health benefits, and male sexual enjoyment.[11] Several studies have shown that communities' beliefs about FGM/C are malleable, rejection of FGM/C has been increasing in some communities,[19] and attitudes are influenced by selective migration or acculturation.[20] Factors that discourage FGM/C include illegality, health consequences, lack of a religious requirement, and community beliefs rejecting the practice.[21]

[c] In October 2018, a federal judge in Michigan ruled that the 1996 federal law banning FGM/C was unconstitutional and dismissed charges against two physicians accused of performing FGM/C. The U.S. House of Representatives has appealed this ruling; thus, the federal law is currently in flux.

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Global and U.S.-based FGM/C prevention efforts have underscored the importance of changing community knowledge and beliefs to reinforce rejection of FGM/C[8] and enacting legislation to help create an "enabling environment" to support changes in FGM/C beliefs and practices.[22]

Communities and experts alike have called for compassionate, culturally sensitive community education and multisector collaboration to prevent FGM/C and identify and help survivors access safe, nonjudgmental, and respectful services.[3,6] OVC's *Addressing FGM/C* program is designed to engender belief and behavior change through its multilevel community-based approach to FGM/C. However, **grantees are likely to encounter several program design and implementation challenges**. FGM/C is a highly complex social issue, shaped by historical, sociocultural, and political forces that impact affected communities; thus, FGM/C programs require careful consideration of these contextual factors and associated challenges.[23] Women who have experienced FGM/C are less likely to seek healthcare or services because of fear, stigma, and lack of resources to access care.[24,25] FGM/C survivors are not likely to come forward to law enforcement because of cultural norms related to FGM/C, a distrust and fear of law enforcement, reluctance to betray community or family, and because the FGM/C may have occurred outside of the U.S.[16] Although those in the field strongly agree the practice should end and girls must be protected, many providers and advocates have cautioned that sensationalized and judgmental language and approaches will only further stigmatize survivors, potentially causing additional harm and shame and ultimately preventing them from seeking services.[18,23,26-29] Inaccurate assumptions about survivors' FGM/C experiences, perceptions, and service needs can cause survivors to feel frustration, distrust, and discomfort.[23] In fact, individuals seeking services may be more affected by other adversities, such as other types of victimization,[30] and feel uncomfortable with an overbearing focus on their FGM/C status.[23]

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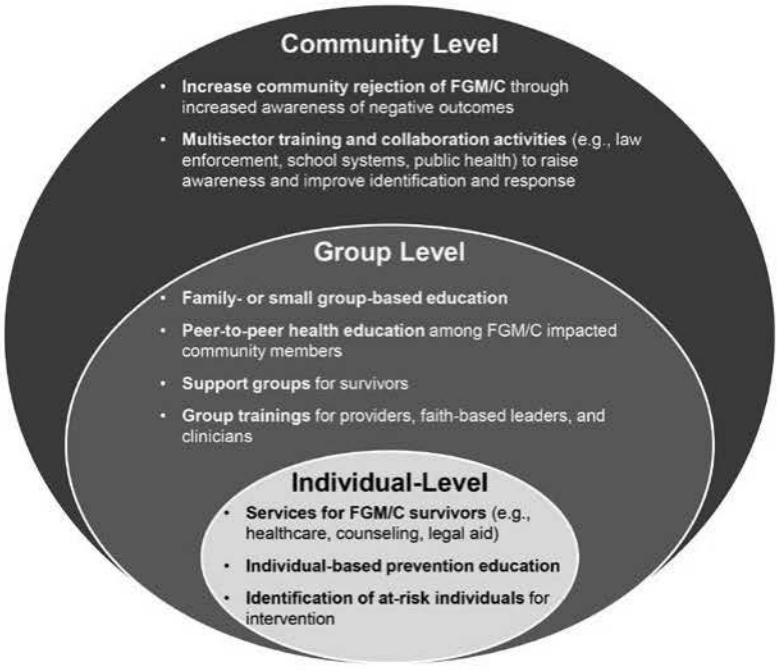
FGM/C prevention and service approaches widely vary.[3,31] FGM/C survivors may require a broad spectrum of services based on their individual needs and wishes, including specialized reproductive and sexual healthcare, counseling, legal aid, advocacy, and other services.[1,32] Moreover, few FGM/C interventions have been evaluated with sufficient methodological rigor to demonstrate effectiveness,[21,33,34] leaving communities without a strong evidence base from which to design their programs. Although multisector approaches offer promise, different sectors (e.g., healthcare, faith-based organizations, law enforcement, and immigrant and refugee service agencies) often have conflicting agendas and perspectives.[35,36] Prevention and eradication of FGM/C in the U.S. is further complicated by the diversity of ethnic groups whose language, culture, and traditions surrounding FGM/C vary.[3]

1.2 Supporting Communities to Address FGM/C

Grantees, communities, and sectors aiming to address and end FGM/C will be diverse, as will their approaches. ***Exhibit 1*** presents examples of programmatic and community efforts to prevent and respond to FGM/C that grantees and communities may employ. Additionally, each grantee will have a unique lead organization, approach, target population, and local context. Involvement of multiple, different sectors (e.g., law enforcement, public health) will require specialized support and considerations.

Exhibit 1. Social Ecological Framework of FGM/C Programmatic Approaches



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Our team of FGM/C experts and experienced TTA professionals is prepared to address the complex problems grantees may face (see *Exhibit 2*) by providing evidence-informed, individualized, and multimodal TTA within and across grantees and communities.

Exhibit 2. TTA Challenges and RTI Team Capabilities

TTA Challenge	RTI Capabilities
Strategies and resources must meet the needs of FGM/C survivors and prevent FGM/C.	The RTI team has worked with FGM/C survivors and conducted studies on their diverse needs. Our work underscores the importance of respectful FGM/C prevention and services. Collectively, we have published dozens of recommendations for sensitive and client-focused services for FGM/C survivors and community-based prevention strategies.
Grantees will be diverse in their needs, resources, and projects	We are grantee centric in our TTA approach. We acknowledge that grantees may have wide variation in their experience working on FGM/C, federally funded grants, and their organizational backgrounds. We use a strengths-based perspective that affirms grantee assets, collaboratively identifies gaps, and partners to build capacity at each site.
Communities are diverse in terms of their target population's culture, needs, and resources	The RTI team brings experience and expertise working with many different communities (e.g., Somali, Egyptian, Indian) affected by FGM/C in the U.S. Our team acknowledges that we are not representative of all FGM/C-affected communities and will thus work closely with communities to ensure messages, resources, trainings, and the outreach campaign are culturally relevant and sensitive. Additionally, we will tap into the End FGM/C U.S. Network's vast member base for cultural-specific input and feedback.
FGM/C survivors have unique needs, perspectives, and desires related to FGM/C services	Our team includes community-based social service and healthcare providers who have cared for FGM/C survivors for decades. We take a client-centered approach to survivor services, which includes creation of safe spaces to discuss FGM/C, health education and options, motivational interviewing, and culturally appropriate care.
Strategies and resources must fit the needs of sectors that encounter and serve at-risk minors and support multisectoral collaboration	Our team has worked in, conducted collaborative research with, and provided TTA to law enforcement, public health, schools, child welfare agencies, juvenile justice agencies, child advocacy centers, healthcare settings, community-based nonprofits, and immigrant-serving organizations. We understand the many worlds in which grantee stakeholders operate and can build bridges between these sectors to enhance collaborative work.
Law enforcement efforts must be sensitive to community needs and cultures and mitigate fear and distrust	Our team's collective TTA experience includes working directly with law enforcement on extremely sensitive issues, such as the Sexual Assault Kit Initiative (SAKI). Our TTA approach to integrating law enforcement will be rooted in being cultural sensitive, building trust, and using law enforcement as a resource for communities seeking to end FGM/C.

We will capitalize on existing FGM/C resources, rather than reinventing the wheel, which will facilitate efficient use of TTA funds and help address gaps in service strategies and resources. Recent efforts of advocates, survivors, practitioners, and researchers have resulted in the compilation of several well-documented recommendations,[3,6,37] evidence-informed practices,[1,23,32,34] resources,[38] and toolkits.[39,40] The U.S. End Violence Against Girls: Summit on FGM/C, held in 2016, resulted in a collection of topline recommendations for

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Engaging Multiple Sectors: Resources for Schools

The Council of the Great City Schools partnered with Angela Peabody from the Global Woman PEACE Foundation to develop *FGM/C Prevention: A Resource for U.S. Schools.* The resource includes guidelines on how educators can form their own FGM/C prevention and identification protocols through examining their school's at-risk population, creating identification and response protocols, and training staff.[2] Ms. Peabody will serve as an expert consultant on this project for expertise on training educators, school systems, and law enforcement.

addressing FGM/C in the U.S., including specific suggestions for healthcare, community and faith, education, and law enforcement.[6] Grantees funded by the Office Our project partner, the End FGM/C US Network, serves as a well-established clearinghouse of resources on advocacy, legal, health, education and training, and research, as well as survivor testimonies.

2. Project Design and Implementation

2.1 Project Goals and Approach

The goals of the *AFTTAP* project are to (1) provide individualized TTA to the grantees *Addressing FGM/C* grantees, (2) develop an outreach campaign to law enforcement, public health professionals, and educators, to be used by grantee and non-grantee communities alike, (3) offer resources and assistance to non-grantee communities affected by FGM/C, and (4) produce ongoing lessons learned and a final report that describes how communities in the U.S. can address FGM/C. The RTI team will support each grantee's capacity to provide direct services to FGM/C survivors, collaborate with multiple sectors in their community, and conduct outreach using the outreach campaign materials. RTI's award-winning communication team will create an outreach campaign toolkit for targeted sectors and disseminate it to grantee and nongrantee communities alike. With OVC approval, RTI will offer electronic resources, including the outreach campaign, recorded webinars, and other project-generated resources through the End FGM/C U.S. Network website, where they will have high visibility and will be housed beyond the project's completion for ongoing impact. Throughout the project, RTI's collaborative and systematic TTA approach will guide our work (***Exhibit 3***).

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Our proposed three-phase approach for *AFTTAP* (***Exhibit 4***) will allow us to strategically plan and deliver tailored TTA responsive to grantee and community needs, while developing an outreach campaign, additional resources, and dissemination materials. For details of our time-task plan, please see ***Appendix B***. ***Section 3*** outlines the team's staffing plan.

Exhibit 3. RTI Team TTA Approach

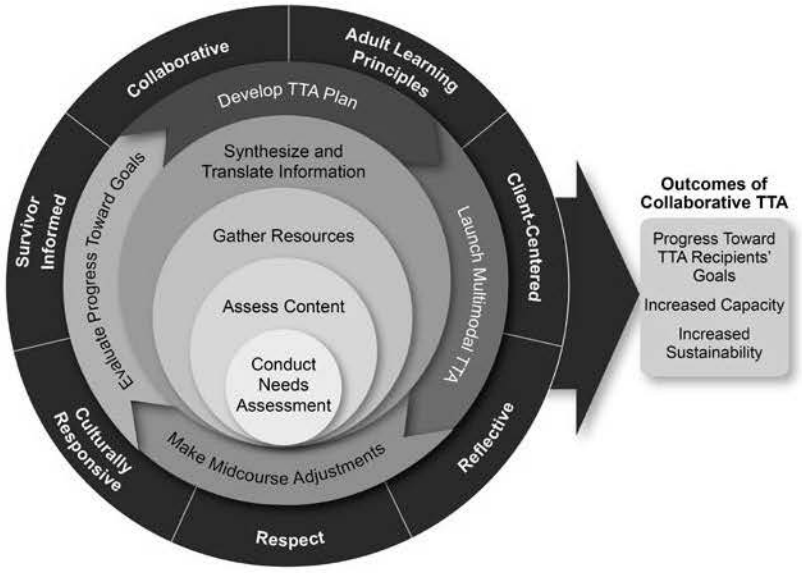
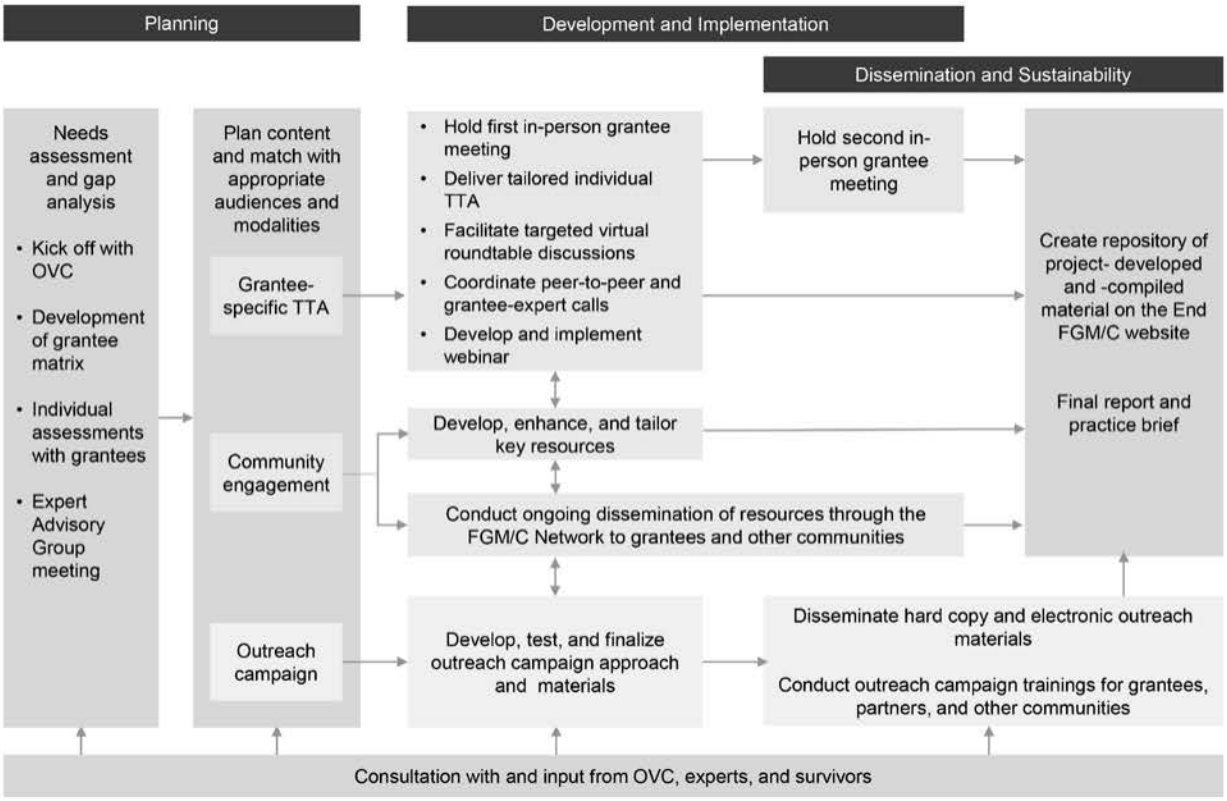


Exhibit 4. Proposed Three-Phase Approach



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Planning Phase. During months 1-6, the RTI team will collaborate with OVC and grantees to conduct project planning and needs assessments. We will first convene a kick-off meeting with OVC to discuss the goals of the *AFTTAP* project, review the awarded grantees, and obtain OVC input and guidance. Next, we will meet with the expert advisory group (EAG) to establish guiding principles for the project, share grantee information, and review research in the field. We will conduct grantee needs assessments and planning activities that will set the foundation for ongoing relationships and inform subsequent activities. The needs assessment will assess each site's services, prevention/outreach efforts, strengths, gaps, and potential areas for support. Using this information, we will develop a grantee matrix, including information about each grantee, such as location, target population, goals and objectives, and project components and approaches. It will serve as a "living document," updated throughout the project.

Development and Implementation Phase. During months 6–36, we will deliver universal and targeted group-level TTA (e.g., first annual grantee meeting, virtual roundtable discussions, webinars, and strategic opportunity resources) and tailored individual-level TTA (e.g., monthly meetings with each grantees, coordination of peer-to-peer and grantee-expert calls, provision of resources for specific grantee needs). The End FGM/C US Network will upgrade their website to improve accessibility to their current compendium of resources and conduct outreach to nongrantee communities. With expert input, our communications team will develop, test, and finalize outreach campaign materials. Site Liaisons will collect, summarize, and communicate information about grantees' progress. We will provide this information to OVC on a monthly basis and use it to compile lessons learned for the final report.

Strategic Opportunity Resources

Throughout *AFTTAP*, RTI Site Liaisons will collect cross-grantee challenges to determine potential opportunities to create resources that meet a gap and address a shared need. We will work with grantees and experts to develop resources or guidance on these specific grantee-driven topics.

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Dissemination and Sustainability. During months 18–36, the End FGM/C US Network will post project-generated resources (e.g., webinar recordings, tip sheets, outreach campaign materials) and raise awareness of them. To disseminate the outreach campaign, we will offer several virtual trainings and print materials to grantees and other communities. In year 3, we will hold the second in-person meeting to share individual and cross-cohort lessons learned and discuss project sustainability. Finally, we will draft a user-friendly report and practice brief, describing how communities in the U.S. can address FGM/C based on project findings.

2.2 Expert Engagement

The RTI TTA team is complemented by a group of diverse experts who have committed to serving on the project. **These experts bring a wide variety of knowledge and experience across a range of areas, including public health, education, law enforcement, immigrant and refugee services, survivor engagement and advocacy, and research** (***Exhibit 5***).

Exhibit 5. Proposed List of Experts

Name	Role and Organization	Area of Expertise
(b)(6)		Social services and healthcare for affected populations, community knowledge and awareness of FGM/C, physical and mental health services for survivors
		Collaboration across multiple FGM/C stakeholders in the U.S., dissemination
		Public health sector engagement and training, community-based FGM/C prevention and services
		Education and law enforcement sector engagement and training, FGM/C services and prevention
		Survivor engagement, FGM/C services, dissemination
		Maternal health, nursing engagement in FGC/M prevention, prenatal and antenatal care of survivors
		Pediatric care of minors who have experienced FGM/C, child welfare engagement

*These are proposed experts for the EAG; we may add additional experts to this group in consultation with OVC.

Experts will inform project planning, identify existing resources, review project documents, provide individualized TTA to grantees, participate in strategic opportunity resource

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development, conduct trainings, review the outreach campaign design and approach, and provide input into the final report. (See ***Appendix D*** for letters of support). The End FGM/C Network US may identify additional experts from their expansive list of members, partners, and stakeholders, as emerging issues and expert needs arise. Their diverse members include experts with specific cultural competencies that can assist the diverse communities affected by FGM/C in the U.S. Final selection of experts may shift based on grantee selection and needs and will be made in consultation with OVC.

A subset of experts will serve on the EAG, providing ongoing direction and guidance to the broader TTA project. The EAG will develop guiding principles with an overarching set of common values to guide the TTA project and activities; review grantees' strategies and identify promising practices and areas for support; attend the annual meetings to conduct trainings and share newly published research on FGM/C services and prevention; ensure that project sites have access to relevant information by providing supplemental one-on-one TA; and connect grantees to resources and additional experts in the field.

2.3 Individualized TTA

We anticipate the grantees selected for OVC's *Addressing FGM/C* program will vary greatly in their areas of expertise, community and target population contexts, experience providing prevention and direct services for FGM/C-affected communities, and project approaches. Customized, individual TTA will ensure that **every grantee receives the specific resources and assistance they need to achieve their goals.** We will use a Site Liaison-grantee model that will engender trusting relationships with grantees, allowing Site Liaisons to deeply understand each grantee's strengths, assets, barriers, and complexities and deliver tailored grantee-

Site Liaisons

Proposed Site Liaisons bring a wealth of experience in relationship-building and collaborating with and supporting diverse community-based organizations and projects. Site Liaisons are also internally trained on mentorship; coaching; and applying Strengths, Weaknesses, Opportunities, and Threats (SWOT) implementation analysis.

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focused TTA. Site Liaisons will identify and discuss common needs across grantees to develop strategies to efficiently deliver TTA and resources that address shared challenges. The initial needs assessment activities and kick-off meetings will facilitate relationship building; ongoing monthly meetings will allow Site Liaisons to keep abreast of grantee progress and send monthly summaries to OVC; Site Liaison-facilitated peer-to-peer and grantee-expert meetings will offer site-specific learning; and one-on-one coaching and mentoring meetings will offer grantee leadership staff with safe, nonthreatening opportunities to discuss challenging issues. Site Liaisons will keep notes of program implementation throughout individualized TTA services to integrate into the final report and systematically document TTA in our internally developed TA Request System (TARS). This documentation will be used to monitor ongoing TTA support to grantees, submit performance measures to OVC, and inform our final report.

2.4 Group TTA

Our TTA approach values the importance of peer-to-peer consultation and impactful networking opportunities to the exchange of information, lessons learned, and novel approaches among grantees that encourage problem-solving, innovation, and collaboration. RTI will host **two in-person meetings** for grantees at RTI's offices in Washington, DC: one at the onset of the grant period and one at the closure of the grant period. These 2-day meetings will include 1) formal presentations from experts on shared implementation issues, 2) interactive discussions and group activities that encourage peer-to-peer learning, and 3) multiple opportunities for networking, and 4) strategic planning exercises. Each meeting will have SMART (Specific, Measurable, Achievable, Relevant, Time-bound) learning objectives and activities shaped by adult learning principles. Learning

Example Training Topics

- Partnering and collaborating with local school systems
- Creating safe spaces for individuals and communities affected by FGM/C
- Working with parents to prevent FGM/C
- Engaging FGM/C survivors in program planning and implementation
- Using the outreach campaign materials

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opportunities will be **relevant and useful for both newer and more seasoned grantees**. Between in-person meetings, RTI will facilitate **virtual trainings and roundtables**. Grantees will learn about research-based FGM/C prevention and service approaches both from experts (webinars) and one another (roundtables). Webinars will disseminate complex and particularly nuanced information, and roundtables will highlight new FGM/C resources, encourage peer-to-peer problem solving, and share lessons learned among grantees. To engage nongrantee communities, several trainings will be publicly advertised and open to all.

2.5 Outreach Campaign

The purpose of the outreach campaign is to support grantees, partners, and FGM/C-impacted communities in educating law enforcement, education, and public health professionals on their roles in addressing FGM/C. The campaign will include **sectoral-specific strategies** to foster community-based prevention of FGM/C, identify at-risk individuals, and respond to FGM/C survivors and situations in impactful, safe, and culturally appropriate ways. RTI will leverage our expertise in strategic communication and creative design and our long history of collaborating with federal clients on developing and disseminating outreach campaigns to develop an FGM/C awareness, education, and skills building toolkit for use by law enforcement, health, and education organizations in communities of high need. RTI has successfully developed similar outreach campaign and communication materials; examples are available in ***Appendix E***.

Picking a Toolkit Format

Knowing that public health practitioners in India still largely rely on print materials and experiential learning, our team designed the "Digital Communication Toolkit: Best Practices for Organizations in India" as a printable PDF with worksheets. Alternatively, for U.S. audiences in need of quickly digestible digital content, our team has co-created several toolkit microsites for federal clients, including the "Beyond Labels" Stigma-Reduction Toolkit for March of Dimes and the "Opioid Prevention at Work" Toolkit for SAMHSA.

Depending on OVC desires, and the needs and preferences of a target audience, outreach campaign toolkits can take different forms. One option is designing the FGM/C Toolkit as a microsite that lives on the End FGM/C U.S. Network website.[38] This will allow for quick and

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easy dissemination of print and digital FGM/C materials to members of the target audience. The toolkit will be developed in close collaboration with OVC staff and grantees and will include customizable materials. See ***Exhibit 6*** for potential toolkit components. The outreach campaign will culminate with wide dissemination and publicly available trainings on material use.

Exhibit 6. Potential Toolkit Outline and Components

Toolkit Section	Content Focus	Potential Products	Product Goals
Awareness	FGM/C overview, including facts and misperceptions, FAQs	Posters Infographics FAQs	Raise awareness of FGM/C in the U.S.
Education	Help law enforcement, public health practitioners and educators empathize with victims of FGM/C and understand the practice and the cultural norms related to it in addition to the legal content and health risks the practice poses.	Personal stories FGM/C talking points Community engagement strategies	Teach cultural competency Increase understanding and empathy Reduce stigma Empower to educate others
Action	Provide practical tips for identifying girls at risk and supporting victims. Empower law enforcement, public health practitioners, and educators to take culturally appropriate action and connect to service providers.	'What You Can Do' guides 'Know the Signs' wallet cards Action plan templates	Motivate action Make taking action feel easy and doable
Spreading the word	Share and promote what the organization has been doing with regard to FGM/C.	Sample social media posts How to write an OpEd	Mobilize other organizations Reduce stigma

2.6 Community Engagement

AFTTAP will offer assistance to nongrantee communities by (1) offering trainings, resources, and the outreach campaign to the public; (2) engaging with End FGM/C US Network members to raise awareness of the project; and (3) providing a platform for TTA requests from nongrantee communities on the End FGM/C US Network website. We will assess grantee locations and develop a list of nongrantee communities and a list of key organizations (e.g., community-based health centers, immigrant-serving organizations) to invite to join the *AFTTAP* listserv. The Network will share project-generated resources, advertise publicly available trainings, and reach out to target groups of the outreach campaign. If amenable to OVC, the Network can add an *AFTTAP* assistance request form to their website to offer nongrantee communities an opportunity to access resources and support from the project. To elevate survivor voices, the Network will

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also facilitate three **survivor listening sessions** to obtain survivor input on key emerging topics (e.g., national gaps and barriers in survivor services).

2.7 Final Report

The final report and accompanying practice brief can **fill a critical gap in implementation knowledge**, given the paucity of literature on U.S.-based community approaches to addressing FGM/C. The RTI team brings a wealth of research capabilities that will strengthen the rigor and relevance of ongoing documentation of grantee challenges, facilitators, lessons learned, and the final report. The accompanying brief will be two pages summarizing the project's high-level findings. With OVC approval, both products could be shared on the End FGM/C US Network.

2.8 Plan for Submitting Financial and Progress Reports

As we have done successfully for other OJP projects, RTI is prepared to submit all necessary financial and progress reports through OJP's Grants Management System. RTI uses the government-approved Deltek's Costpoint Accounting and Management System, which can provide project directors with timely reports of their budget and actual costs incurred against specific tasks and against the total project. This system will allow RTI to easily prepare and provide OVC with clear quarterly financial reports for the *AFTTAP* project.

3. Capabilities and Competencies

3.1 Organizational Mission and Capacity

Eradicating FGM/C and improving services for survivors align with RTI's organizational mission of improving the human condition by turning knowledge into practice. With over 60 years of demonstrated success, **RTI has the expertise and corporate capacity to achieve OVC's goals** of a national TTA program to enhance communities' capacity to address FGM/C through enhanced identification, services, and community collaboration. Several relevant projects to *AFTTAP*, carried out by team members, are shown in ***Exhibit 7***.

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Exhibit 7. Examples of Relevant Projects

Project Name	Relevance to Current Program
Improving Outcomes for Child and Youth Victims of Human Trafficking: Children and Youth Technical Assistance Program Funder: OVC (b)(6)	▪ Proactive, tailored TTA with 9 grantees across the U.S. ▪ Facilitation of peer-to-peer and expert-to-peer exchanges ▪ Webinars, roundtables, and in-person trainings ▪ Collaboration with law enforcement, public health, child welfare, and survivors ▪ Compendium of best practices and project lessons learned
Female Genital Cutting (FGC) Community-Centered Health Care and Prevention Project ▪ Funder: OWH (b)(6)	▪ Services for women and girls who have experienced FGM/C ▪ Prevention for women and girls at risk of FGM/C in U.S. or abroad ▪ Development of a toolkit for FGM/C service providers ▪ Support to other FGM/C grantees
The Sexual Assault Kit Initiative: Training and Technical Assistance ▪ Funder: BJA (b)(6)	▪ Proactive, tailored TTA with statewide jurisdictions ▪ Supporting law enforcement in efforts to serve survivors ▪ Facilitation of peer-to-peer exchanges ▪ Development of outreach materials and toolkits
TTA for Addressing the Intersection of HIV and IPV ▪ Funder: OWH (b)(6)	▪ In-person trainings with community-based organizations and healthcare providers ▪ Support in multisector collaboration ▪ Development of a training toolkit for organizations
TTA to Support Implementation of Dating Matters ▪ Funder: CDC (b)(6)	▪ Collaborative, tailored TTA to small group of grantees ▪ Annual meetings with in-person trainings ▪ Grantee needs assessment ▪ Environmental scans of programs/strategies

3.2 Staffing Structure

Led by (b)(6) the RTI team offers OVC over 50 years of combined experience providing TTA to violence prevention and victim service programs. ***Exhibit 8*** shows our proposed organizational project structure. As (b)(6) will oversee all technical and managerial aspects of the project, actively engage with all tasks, and serve as the (b)(6) She will be supported by (b)(6) (b)(6) to facilitate expedient responses to partners. Task leads will oversee the day-to-day activities of their tasks and meet weekly to discuss cross-project coordination. Site Liaisons will serve as the points of contact for each grantee, communicating directly with and supporting grantees throughout the project. (b)(6) (b)(6) will oversee community engagement with nongrantee communities and work closely with the End FGM/C US Network on their community outreach activities and website enhancements. (b)(6) will oversee a communications team to develop the outreach

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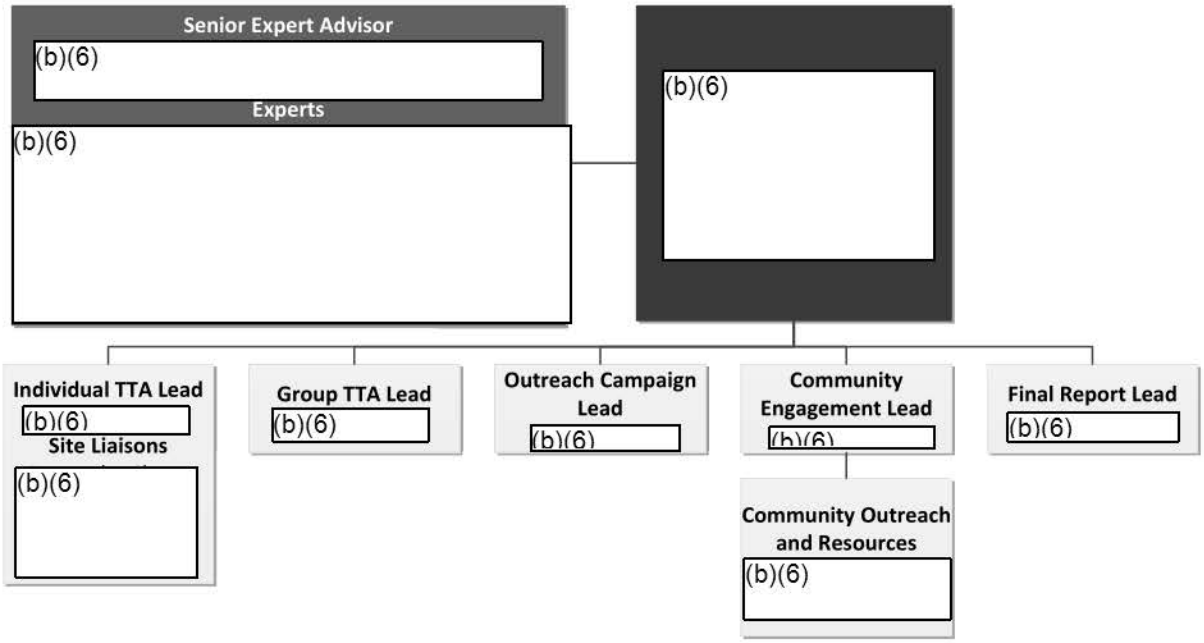
campaign. Complementing our in-house capabilities, the End FGM/C US Network and a cadre of diverse experts on FGM/C will be integrated throughout the project.

Exhibit 8. Organizational Chart



3.3 Qualifications of Proposed Team

(b)(6) brings more than 15 years' experience in public health and criminal justice research and practice. (b)(6) is a proven leader of large national-scale TTA projects; for example, she currently serves as the (b)(6) (b)(6) (b)(6) Likewise, she has held TTA leadership roles on multiple projects related to addressing gender-based violence in vulnerable communities and leads or co-leads several victim services program evaluations. She has published several victim services evaluation reports and briefs for federal partners, such as a (b)(6)

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(b)(6) brings expertise in project management, research, and TTA. On the Improving Outcomes TTA project, she serves as a (b)(6) She has content expertise in reproductive and sexual health and has worked with patients in multiple OBGYN settings and with medical providers, law enforcement, and schools.

(b)(6) has coordinated project operations, managed deliverables, and assisted with research and TTA tasks. She brings experience with multiple vulnerable populations, including foster care youth and resettled refugee populations.

(b)(6), is a renowned FGM/C expert with over 20 years of experience working on FGM/C in the U.S. in direct medical practice, research, and community-based services. She is the (b)(6)

(b)(6)

(b)(6)

(b)(6) (b)(6) has published widely on FGM/C, amassing over 30 journal publications, in addition to numerous other publications. She has served on FGM/C expert panels for the (b)(6).

(b)(6) brings expertise in community and systemic response to victimization and help-seeking behavior in survivors. She has trained law enforcement, nonprofit organizations, and victim service providers on how they can better access, identify, and assist difficult-to-reach populations. (b)(6) leads group trainings on the Improving Outcomes TTA project and has successfully coordinated multiple grantee trainings.

(b)(6) brings experience on a variety of international and domestic projects related to reproductive and sexual

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health, sexual assault, and health services. She has experience providing TTA to multiple types of communities. For example, in (b)(6) skills to provide TA to large-scale longitudinal studies in urban settings.

(b)(6), is a behavior change and communication scientist with experience in crafting strategic, human-centered solutions that improve population health and well-being. She has worked with the CDC, community-based organizations, and others on many issues, and her approach thematically introduces informed decision-making, health behavior communication, and health literacy to each project.

(b)(6), brings expertise in the fields of violence and victimization, including human trafficking, sexual assault, and childhood exposure to violence. With experience in state-level efforts to improve outcomes for child victims in (b)(6) she has provided TTA to child-serving victim service agencies and disseminated program findings.

(b)(6) brings special training in women's reproductive health and FGM/C research, which underpin her role as a FGM/C program analyst and the network coordinator for the U.S. End FGM/C Network, a collaborative group of survivors, advocates, researchers, and others committed to promoting the abandonment of FGM/C in the U.S. and around the world.

(b)(6) is the (b)(6) (b)(6) which supports community-based programs to educate and inform communities about the health and psychological consequences of FGM/C, as well as the criminal penalties. She brings expertise in engaging with public health departments and state-level and local multisectoral approaches to addressing FGM/C.

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(b)(6) is the (b)(6) (b)(6) and brings 10 years of experience working on initiatives to prevent FGM/C and provide services to survivors of FGM/C. She has collaborated across multiple sectors to co-create trainings and resources and has co-presented trainings for educators and law enforcement.

(b)(6) is the (b)(6) (b)(6) to empower Asian communities to end FGM/C and create positive social change through dialogue, education, and collaboration based on community involvement. As a (b)(6) she will bring specific expertise in FGM/C program and services design, survivor engagement, and dissemination.

(b)(6) brings more than 20 years of combined research, clinical practice, and teaching experience in reproductive health, with specific expertise in clinical practice, programs, and approaches to serving individuals affected by FGM/C. She has served on working groups and expert panels on (b)(6) (b)(6), is a (b)(6) with more than 20 years' experience providing healthcare for immigrant and refugee children and expertise in prevention and responses to children affected by FGM/C in the U.S. She has published widely, served on numerous expert panels, and received awards for her work on (b)(6)

4. Plan for Collecting the Data Required for this Solicitation's Performance Measures

The RTI team recognizes the importance of collecting data to assess whether the correct processes are being performed and desired results are being achieved by this program. To ensure quality, we propose RTI capture performance metrics to measure the TTA sections of the Transforming Victim Services (TVS) module in OVC's online Performance Measurement Tool

(PMT) and mechanisms for collecting each performance measure (***Exhibit 9***). We have also suggested potential additional performance measures. We will work in consultation with OVC to refine the metrics as needed to best capture our performance as the TTA provider.

Exhibit 9. Data Collection for Performance Measures

Activity/ Product	Performance Measures	How Data Will Be Collected
Training	▪ Number of trainings scheduled and conducted ▪ Number and type of participants registered and attending and completing training ▪ % of participants satisfied with the training delivered ▪ % of participants planning to implement training knowledge	▪ Registration and attendance data from online training platform ▪ In-person training registration and attendance ▪ Training evaluation forms ▪ Pre- and post-training assessments
Technical Assistance	▪ Number and type of TTA requests ▪ Number of grantees seeking TA not yet served ▪ Number of recipients who received TA ▪ % of TA recipients implementing changes due to TA ▪ % of participants satisfied with TA delivered	▪ TARS report: - Number of TTA requests received - Number of TTA requests completed - Number of individuals receiving TA ▪ Recipient evaluations of TTA
Peer-to-Peer Consultation	▪ Number of peer-to-peer consultations ▪ % of peers reporting that consultation was useful ▪ % of peers planning to implement new policy/practice	▪ TARS report: - Number of peer consult requests received - Number peer consults completed ▪ Evaluations of peer consults
Resources	▪ Number and types of materials completed and disseminated ▪ Recipient evaluation of resources	▪ Database of materials developed ▪ Evaluation discussion during check-ins with Site Liaisons

At the onset of the *AFTTAP*, the RTI team will develop evaluation and rating forms and use both hardcopy and online tools to collect and report data from grantees and other TA recipients. As referenced in our approach to individual TTA, the metrics collected by TARS can be easily customized to meet the needs of OVC and the *AFTTAP* project and facilitate cost-effective collection of performance measures. TARS data will be accessible to OVC, and we will provide a user manual and training to OVC on how to generate reports of TTA provision and performance. Additionally, the Project Director, with the support of the Project Manager, will aggregate and provide performance data via the PMT. The team has experience using TARS to successfully complete and submit metrics in the TVS module of PMT.

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Appendix A: References

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Appendix B: Time-Task Plan

Activity	Responsible RTI Role	2020–2021 Quarter 1	2020–2021 Quarter 2	2020–2021 Quarter 3	2020–2021 Quarter 4	2021–2022 Quarter 1	2021–2022 Quarter 2	2021–2022 Quarter 3	2021–2022 Quarter 4	2022–2023 Quarter 1	2022–2023 Quarter 2	2022–2023 Quarter 3	2022–2023 Quarter 4
Planning													
Kick-off and planning with OVC	PD, APD	■											
Conduct needs assessment and gap analysis	Site Liaisons		■										
Develop grantee matrix	Individual TTA Lead and Site Liaisons		■										
Convene Expert Advisory Group	PD, APD, and Experts	■		■		■		■		■		■	
Development and Implementation													
Plan 1st in-person grantee meeting (focus: planning/peer learning)	Group TTA Lead				■								
Deliver individual TTA through monthly check-ins and ad hoc calls	Site Liaisons	■	■	■	■	■	■	■	■	■	■	■	■
Collect ongoing project lessons learned for final report/brief	Site Liaisons				■	■	■	■	■	■	■	■	■
Share ongoing grantee project updates, challenges, and solutions with OVC	Site Liaisons and PD				■	■	■	■	■	■	■	■	■
Plan and facilitate virtual roundtables (at least 9 total; 3/year)	Group TTA Lead				■	■	■	■	■	■	■	■	■
Coordinate peer-to-peer and grantee-expert calls	Site Liaisons and Experts		■	■	■	■	■	■	■	■	■	■	■
Develop and deliver webinars (at least 9 total; 3/year)	Group TTA Lead and Experts		■	■	■	■	■	■	■	■	■	■	■
Engage nongrantee communities	Comm. Engagement Lead and End FGM/C Network		■	■	■	■	■	■	■	■	■	■	■
Update FGM/C website to better share resources	Comm. Engagement Lead and End FGM/C Network		■	■			■	■			■	■	
Develop, test, and finalize outreach campaign approach and materials	Outreach Campaign Lead				■	■	■	■	■				
Conduct survivor listening sessions	Comm. Engagement Lead and End FGM/C Network			■				■				■	
Obtain ongoing feedback from experts	Site Liaisons, PD, APD, and Experts		■	■	■	■	■	■	■	■	■	■	■
Dissemination and Sustainability													
Plan 2nd in-person grantee meeting (focus: sustainability/lessons learned)	Group TTA Lead										■		
Create repository of project-developed and compiled materials	Group TTA Lead and End FGM/C Network						■	■	■	■	■	■	■
Develop and submit final report and practice brief	Final Report Lead									■	■	■	■
Conduct ongoing dissemination of resources	Site Liaisons, Comm. Engagement Lead, and End FGM/C Network			■	■	■	■	■	■	■	■	■	■
Disseminate outreach campaign materials	Outreach Campaign Lead									■	■	■	■
Conduct train-the-trainer virtual trainings of outreach campaign	Group TTA Task Lead and Outreach Campaign Lead									■	■	■	■
Project Management													
Hold biweekly RTI team meetings	PD, APD, PM and Task Leads	■	■	■	■	■	■	■	■	■	■	■	■
Convene biweekly RTI / OVC meetings	PD, APD, PM and OVC Project Officer	■	■	■	■	■	■	■	■	■	■	■	■
Biannual progress report	PD, APD, and PM		■		■		■		■		■		■

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Appendix C: Resumes

Resumes are uploaded separately.

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Appendix D: Letters of Cooperation/Support

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VALLEYWISE HEALTH MEDICAL CENTER
DEPARTMENT OF OBSTETRICS, GYNECOLOGY AND WOMEN'S HEALTH

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April 8, 2020

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Founding Director, Refugee Women's Health Clinic
Department Obstetrics & Gynecology
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(b)(6)
Victimization & Resilience Program, Center for Community Safety and Crime Prevention
RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709

Subject: Department of Justice, Office of Justice Programs, Office for Victims of Crime Solicitation Number OVC-2020-17550, Addressing Female Genital Mutilation and Cutting, FY 2020 Competitive Grant Solicitation, Purpose Area #1: Training and Technical Assistance Provider

Dear (b)(6)

The Refugee Women's Health Clinic at Valleywise Health would be pleased to express our commitment to serve as a subawardee to RTI International for the referenced solicitation "Addressing Female Genital Mutilation and Cutting, Purpose Area #1 Training and Technical Assistance (TTA) Provider project".

(b)(6) offers more than 20 years of clinical and research experience in providing direct healthcare to individuals who have experienced FGM/C, conducting research on FGM/C to inform best clinical practices and culturally-informed interventions to optimize health outcomes for FGM/C-affected populations. She has also served as a

(b)(6)

As an (b)(6)
(b)(6)
(b)(6), where she has provided critical culturally-sensitive and linguistically appropriate healthcare services to individuals impacted by FGM/C for nearly twelve years, and has nurtured a clinical learning environment for trainees across medical, public health and social science fields to gain skills in culturally competent care that respects women, builds trust, and creates a safe space for women and adolescents to receive FGM/C-related care. She deeply understands the on-the-ground challenges of optimizing care for women and adolescents affected by FGM/C.

(b)(6)

(b)(6) Engaging community based participatory research (CBPR) principles, over 1,500 community surveys were conducted across two waves assessing the health care needs and experiences with care among Somali women/adolescents affected by FGM/C. In addition she engaged over 200 community members, including religious leaders, men, women, youth and elders, in community forums to understand community-level perspectives on FGM/C, and trained over 1,200 health care providers across multiple specialties on best practices in optimizing high quality care for affected populations and mitigating risk among minors.

Additionally, through CBPR, (b)(6) has worked side-by-side with communities in the U.S. affected by FGM/C and brings an understanding of the cultural nuances and complexities related to FGM/C. (b)(6) brings a breadth of experience having served as a (b)(6) working groups and expert panels on FGM/C for the (b)(6)
(b)(6)

Addressing FGM/C requires strong expertise in working with communities and individuals from a lens of cultural sensitivity, de-stigmatization, and empowerment. As the (b)(6) will provide ongoing guidance and input throughout the TTA project and work closely with the RTI TTA team to ensure grantees and communities affected by FGM/C have access to the most current evidence-based practices and approaches to addressing FGM/C.

As part of the (b)(6) will engage in the RTI TTA project at several points by:

- Reviewing TTA documents and other supporting materials;
- Attending two in-person EAG meetings during the course of the project;

- Providing feedback to the TTA team via quarterly teleconferences for the duration of the project;
- Serving as a consultant TA provider to specific grantees as grantees encounter a challenge that falls within their respective areas of expertise. This will likely involve attending 2-3 phone calls with the grantee and/or reviewing grantee materials and providing feedback;
- Providing input and review of the final report describing how communities in the United States can address FGM/C;
- Conducting up to two web-based or in-person trainings on prevention approaches to FGM/C and/or best practices in service delivery.

The Refugee Women's Health Clinic at Valleywise Health is available to provide support to RTI's effort through a subaward across the 36-month period of performance. We trust that this experience and knowledge base will strengthen RTI International's proposal and look forward to participating and working with RTI International on this important endeavor.

Respectfully,

(b)(6)

(b)(6)

Obstetrics & Gynecology
Valleywise Health Medical Center
http://www.refugeewomensclinic.org/

Research Associate Professor,
School of Social Work,
Watts College of Public Service and Community Solutions,
Director Office of Refugee Health, Southwest Interdisciplinary Research Center
Arizona State University
https://sirc.asu.edu

END
FGM/C
U.S. NETWORK

April 14, 2020

(b)(6)
US End FGM/C Network
45 W 36th St, 6th Floor
New York, NY 10018

Subject: Department of Justice, Office for Victims of Crime (OVC) Solicitation Number OVC-2020-17550, "Addressing Female Genital Mutilation and Cutting Purpose Area #1"

(b)(6)
Victimization and Resilience Program
RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Dear (b)(6)

The End FGM/C Network (the Network) would be pleased to confirm our commitment to serve as a subawardee to RTI in support of the referenced solicitation, for a proposed period of performance anticipated to be up to 36 months from date of award.

With over 90 organizational members and partners, and over 450 individual members and supporters who are FGM/C survivors, advocates, researchers, educators, health care providers, and policy makers, as well as a proven record in community engagement, resource development, and knowledge sharing, the Network is poised to provide support for the potential grant projects in the areas of outreach and recruitment, knowledge dissemination, technical assistance, and collaboration.

Our organization will be supporting this team by providing outreach to our member organizations, partners, and communities on project developed webinars and electronic resources; connecting the project to communities not served by Purpose Area #2 grantees; connecting the project to additional experts, resources, and national efforts to address FGM/C; conducting survivor listening sessions, and updating our website to house a more user-friendly compendium of resources and project-generated materials for grantees and non-grantee communities.

Sincerely,

(b)(6)

April 15, 2020

(b)(6)
Victimization & Resilience Program, Center for Community Safety and Crime Prevention
RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709

Subject: Department of Justice, Office of Justice Programs, Office for Victims of Crime Solicitation Number OVC-2020-17550, Addressing Female Genital Mutilation and Cutting, FY 2020 Competitive Grant Solicitation, Purpose Area #1: Training and Technical Assistance Provider

Dear (b)(6)

I am pleased to express my commitment to collaborate with RTI International as a (b)(6) (b)(6) for the proposed Addressing Female Genital Mutilation and Cutting (FGM/C), Purpose Area #1 Training and Technical Assistance (TTA) Provider project.

I am a (b)(6) with a focus on immigrant and refugee health. Since late 2018 I have served as the (b)(6) (b)(6) Our grant program provided funding to organizations with cultural competence in (b)(6) communities that are impacted by FGC, supporting community-led efforts to educate and inform communities of the health risks and emotional trauma inflicted by FGC practices and the criminal penalties associated with FGC. I also (b)(6) which brought together diverse stakeholders to recommend, inform and coordinate FGC prevention and community engagement efforts in (b)(6) Our Working Group developed recommendations for healthcare professionals, impacted communities, legal and law enforcement professionals, and education and child protection professionals.

I will engage in the RTI TTA project at several points by supporting the development of the outreach campaign materials, specifically related to public health sectors; reviewing other materials developed by the project; and providing TTA to grantees as needs emerge, in particular around the areas of multi-sector collaboration, working with state public health

departments on FGC, engagement and collaboration with community partners, and prevention efforts. I am available to provide support to RTI's effort for fifteen days (120 hours) across the 36-month period of performance. I trust that my experience and knowledge base will strengthen RTI International's proposal, and I look forward to working with RTI International on this important endeavor.

Sincerely,

(b)(6)

April 15, 2020

(b)(6)

(b)(6)
Victimization & Resilience Program, Center for Community Safety and Crime Prevention
RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709

Subject: Department of Justice, Office of Justice Programs, Office for Victims of Crime Solicitation Number OVC-2020-17550, Addressing Female Genital Mutilation and Cutting, FY 2020 Competitive Grant Solicitation, Purpose Area #1: Training and Technical Assistance Provider

Dear (b)(6)

I am pleased to express my commitment to collaborate with RTI International as a (b)(6) (b)(6) for the proposed Addressing Female Genital Mutilation and Cutting (FGM/C), Purpose Area #1 Training and Technical Assistance (TTA) Provider project.

As the (b)(6) I bring 10 years of experience working on initiatives to prevent FGM/C and provide services to survivors of FGM/C. As a nationally recognized leader in the field of FGM/C in the United States, I have collaborated across multiple sectors to co-create culturally sensitive and sector-specific trainings and resources. For example, I co-authored *FGM/C Prevention: A Resource for U.S. Schools* and I have co-presented trainings for educators, such as a training through the American School Health Association; Student National Medical Association; Northern Virginia School Administrators. I have also worked with and trained law enforcement on FGM/C, (b)(6) (b)(6) I trained (b)(6) Police Department. In addition, I trained 45 agents of the Federal Bureau of Investigation on the cultural aspects of FGM/C.

I will engage in the RTI TTA project at several points by supporting the development of the outreach campaign materials, specifically related to outreach to educators and law enforcement, reviewing other materials developed by the project, and providing TTA to grantees as needs emerge, in particular around

the areas of service provision to survivors, engagement and collaboration with community partners, and prevention efforts.

I am available to provide support to RTI's effort for fifteen days (120 hours) across the 36-month period of performance. I trust that this experience and knowledge base will strengthen RTI International's proposal and I look forward to participating and working with RTI International on this important endeavor.

Sincerely,

(b)(6)

April 24, 2020

(b)(6)

(b)(6)
Victimization & Resilience Program, Center for Community Safety and Crime Prevention
RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709

Subject: Department of Justice, Office of Justice Programs, Office for Victims of Crime Solicitation Number OVC-2020-17550, Addressing Female Genital Mutilation and Cutting, FY 2020 Competitive Grant Solicitation, Purpose Area #1: Training and Technical Assistance Provider

Dear (b)(6)

I am pleased to express my commitment to collaborate with RTI International as a (b)(6) (b)(6) for the proposed Addressing Female Genital Mutilation and Cutting (FGM/C), Purpose Area #1 Training and Technical Assistance (TTA) Provider project.

I am the (b)(6) (b)(6) to end female genital cutting (FGC) and create positive social change through dialogue, education and collaboration based on community involvement. For this project, I will bring specific expertise in FGC program and services design, survivor engagement, and dissemination. My experience in these areas include creating global storytelling campaigns, such as the (b)(6) that allow communities to share FGM/C stories that are empowering, cathartic and inspire collective shifts away from this harmful social norms. For its work, my organization, (b)(6) was recognized in (b)(6) I also bring a deep understanding of FGC policy and practice. For example, I work with the (b)(6) (b)(6) on passing state legislation to criminalize FGC and build public awareness campaigns on FGC within the state, and I serve on the (b)(6) (b)(6) I have received multiple awards for my work on FGC and have been interviewed by (b)(6) on the topic.

I will engage in the RTI TTA project at several points by:

- Reviewing TTA documents and other supporting materials;
- Attending two in-person meetings during the course of the project;
- Providing feedback to the TTA team via quarterly teleconferences for the duration of the project;
- Serving as a consultant TA provider to specific grantees as grantees encounter a challenge that falls within their respective areas of expertise. This will likely involve attending 2-3 phone calls with the grantee and/or reviewing grantee materials and providing feedback;
- Providing input and review of the final report describing how communities in the United States can address FGC;
- Conducting up to two web-based or in-person trainings on prevention approaches to FGC and/or

best practices in service delivery.

I am available to provide support to RTI's effort for fifteen days (120 hours) across the 36-month period of performance. I trust that this experience and knowledge base will strengthen RTI International's proposal and I look forward to participating and working with RTI International on this important endeavor.

Sincerely,

(b)(6)

April 6, 2020

(b)(6)

(b)(6)
Victimization & Resilience Program, Center for Community Safety and Crime Prevention
RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709

Subject: Department of Justice, Office of Justice Programs, Office for Victims of Crime Solicitation Number OVC-2020-17550, Addressing Female Genital Mutilation and Cutting, FY 2020 Competitive Grant Solicitation, Purpose Area #1: Training and Technical Assistance Provider

Dear (b)(6)

I am pleased to express my commitment to collaborate with RTI International as a (b)(6) (b)(6) for the proposed Addressing Female Genital Mutilation and Cutting, Purpose Area #1 Training and Technical Assistance (TTA) Provider project.

I bring more than 20 years of combined research, clinical practice, and teaching experience in reproductive health, with specific expertise in clinical practice, programs, and approaches to serving individuals affected by FGM/C. My extensive research and clinical background offer a deep understanding of the issues, challenges, and barriers that will face the OVC-funded grantees of the Addressing FGM/C program. I offer a strong understanding of the national dialogue on FGM/C; I have served on (b)(6) (b)(6) Additionally, I have served as an (b)(6) related to FGM/C. I have an extensive history of disseminating my work related to FGM/C at both conferences and through peer-reviewed journals. My particular expertise pertains to provider training interprofessional teams in providing expert FGM/C-related care. As an (b)(6) I would help elevate this TTA project by bringing expansive knowledge and resources into the hands of communities that are establishing or enhancing approaches to addressing FGM/C in their communities.

I will engage in the RTI TTA project at several points by:

- Reviewing TTA documents and other supporting materials;
- Attending two in-person EAG meetings during the course of the project;
- Providing feedback to the TTA team via quarterly teleconferences for the duration of the project;
- Serving as a consultant TA provider to specific grantees as grantees encounter a challenge that falls within their respective areas of expertise. This will likely involve attending 2-3 phone calls with the grantee and/or reviewing grantee materials and providing feedback;
- Providing input and review of the final report describing how communities in the United States can address FGM/C;
- Conducting up to two web-based or in-person trainings on prevention approaches to FGM/C and/or best practices in service delivery.

I am available to provide support to RTI's effort for fifteen days (120 hours) across the 36-month period of performance. I trust that this experience and knowledge base will strengthen RTI International's proposal and I look forward to participating and working with RTI International on this important endeavor.

Sincerely,

(b)(6)

April 17, 2020

(b)(6)

(b)(6)
Victimization & Resilience Program, Center for Community Safety and Crime Prevention
RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709

Subject: Department of Justice, Office of Justice Programs, Office for Victims of Crime Solicitation Number OVC-2020-17550, Addressing Female Genital Mutilation and Cutting, FY 2020 Competitive Grant Solicitation, Purpose Area #1: Training and Technical Assistance Provider

Dear (b)(6)

The Lowry Family Health Center at Denver Health and Hospitals would be pleased to serve as a subawardee to RTI International for the referenced solicitation "Addressing Female Genital Mutilation and Cutting (FGM/C), Purpose Area #1 Training and Technical Assistance (TTA) Provider project."

(b)(6) is a (b)(6) with more than 20 years' experience providing healthcare for immigrant and refugee children and brings particular expertise in prevention and responses to children impacted by FGM/C in the United States. (b)(6) (b)(6) work has focused on educating patients and families, linking women and children to ongoing care for FGM/C and educating medical providers. Additionally, she has worked with the Department of Justice and given numerous presentations to healthcare providers and others on this topic. (b)(6) has co-

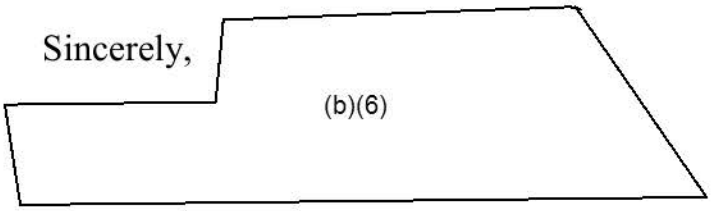
authored numerous FGM/C recommendations for response from the healthcare sector, served as an (b)(6) Department of Justice on FGM/C, and is a current (b)(6)

(b)(6) will engage in the RTI TTA project at several points by:

- Reviewing TTA documents and other supporting materials;
- Attending two in-person meetings during the course of the project;
- Providing feedback to the TTA team via quarterly teleconferences for the duration of the project;
- Serving as a consultant TA provider to specific grantees as grantees encounter a challenge that falls within their respective areas of expertise. This will likely involve attending 2-3 phone calls with the grantee and/or reviewing grantee materials and providing feedback;
- Providing input and review of the final report describing how communities in the United States can address FGM/C;
- Conducting up to two web-based or in-person trainings on prevention approaches to FGM/C and/or best practices in service delivery.

The Lowry Family Health Center at Denver Health and Hospitals is available to provide support to RTI's effort through a subaward across the 36-month period of performance. We trust that this experience and knowledge base will strengthen RTI International's proposal and we look forward to participating and working with RTI International on this important endeavor.

Sincerely,

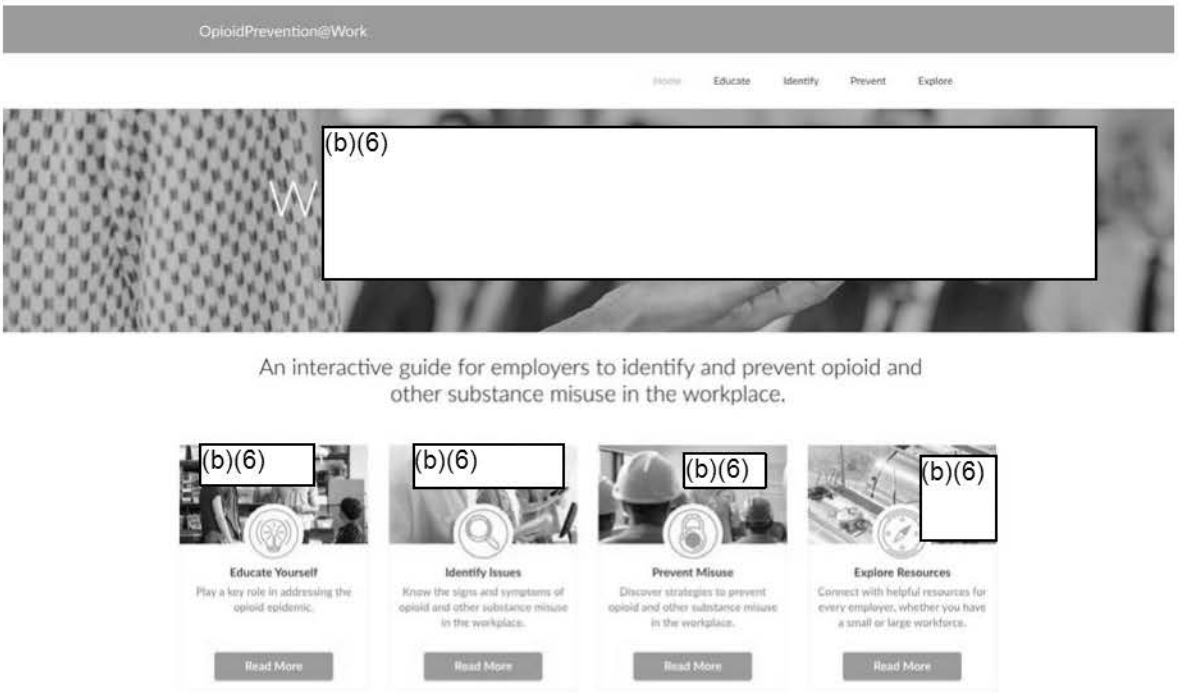


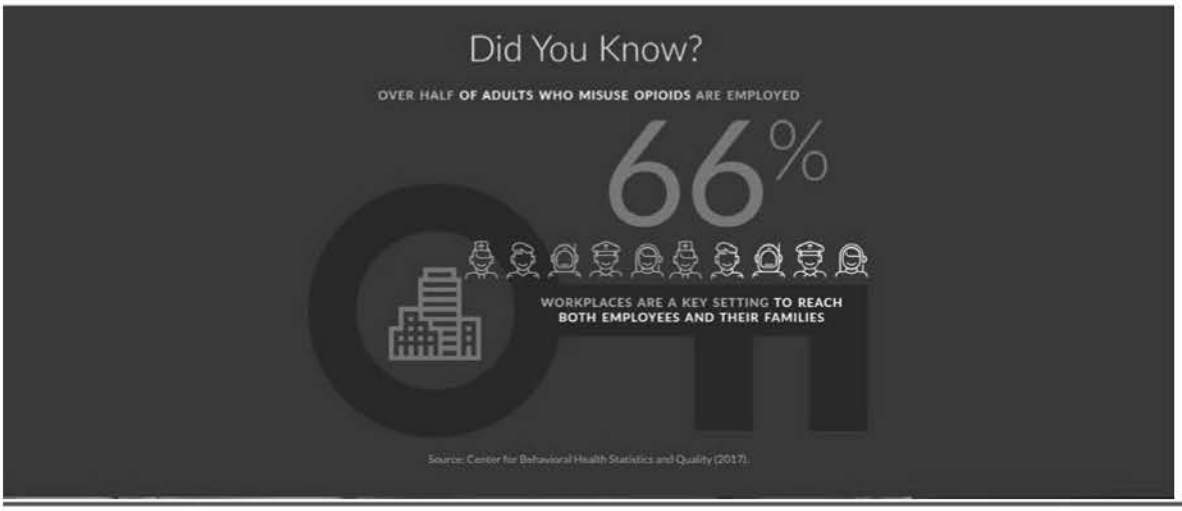
Appendix E: Examples of Previously Developed Award-Winning Toolkits

Opioids Prevention at Work Toolkit

In 2018, RTI's Center for Communication Science developed the award-winning "Opioid Prevention at Work" Toolkit as an interactive guide for employers to identify and prevent opioid and other substance misuse in the workplace. It serves as a clearinghouse for existing SAMHSA opioid education and prevention tools and as a stand-alone tool for stakeholders. To keep pace with web 2.0, the toolkit is a microsite (webpages that complement SAMHSA's main drug-free workplace website), but also can be downloaded and printed as a PDF.

Award: The Toolkit was awarded the top honor and the highest technical honor in the regional 2019 Society for Technical Communication competition.



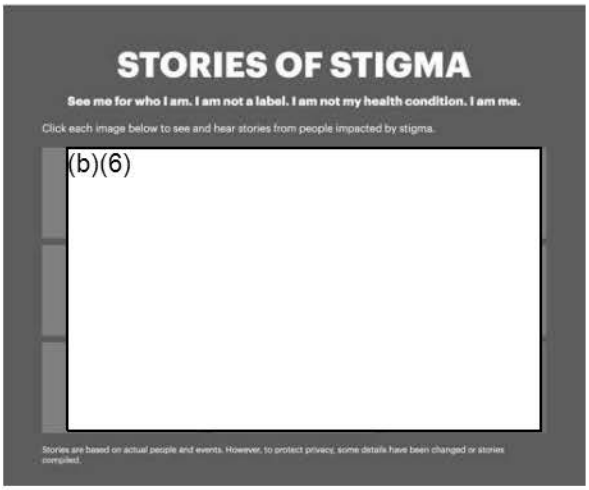


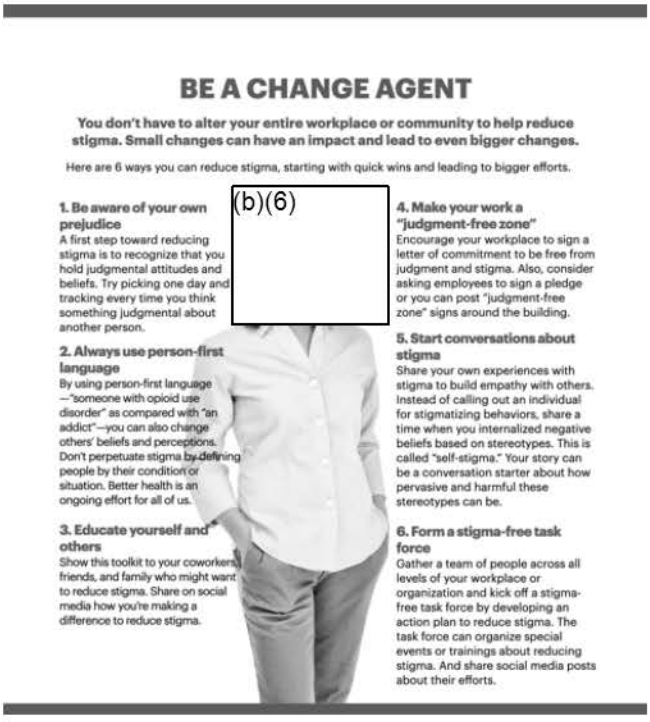
Use or disclosure of any information on this page is subject to the restriction in the proprietary statement of this proposal.

March of Dimes Stigma Reduction Toolkit

Beyond Labels, is an interactive microsite to support March of Dimes staff and partners in helping people receive the best possible health care, free of stigma. The website is designed to increase awareness of what stigma is; identify and acknowledge the fears, myths, and misconceptions that drive stigma; promote action to make institutional environments stigma free; and provide a voice to those who have suffered from stigmatizing attitudes and beliefs. Published in June 2019, the website is in use and is now undergoing enhancements.

Award: In 2019, this toolkit won the HEALTH+WELLNESS Design Award for graphic design in the area of public health communication.

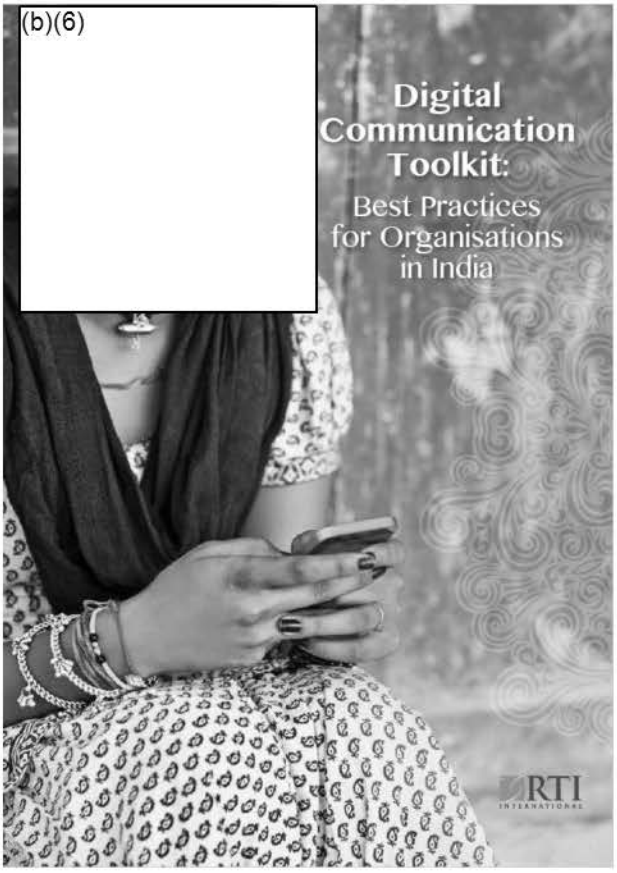


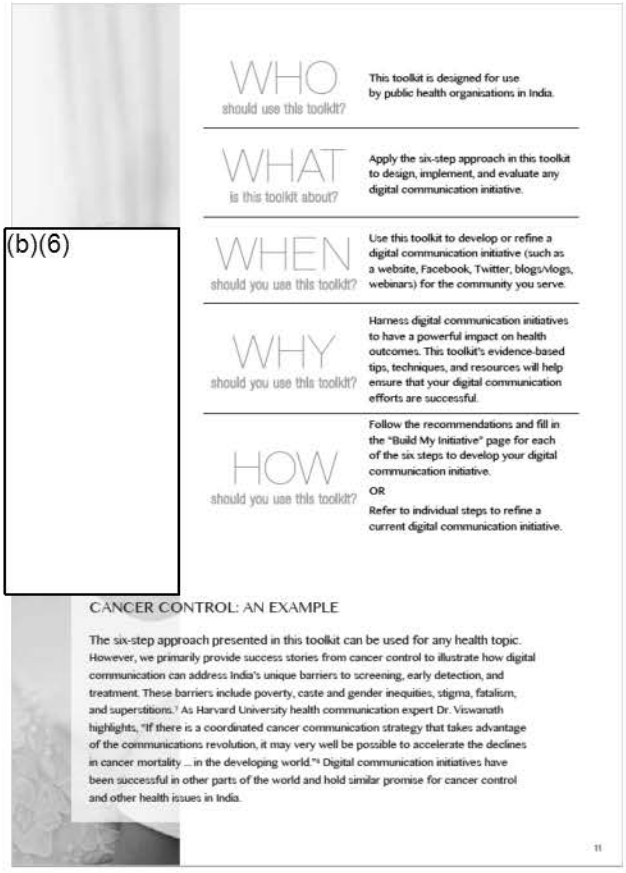


Digital Communication Toolkit: Best Practices for Organizations in India

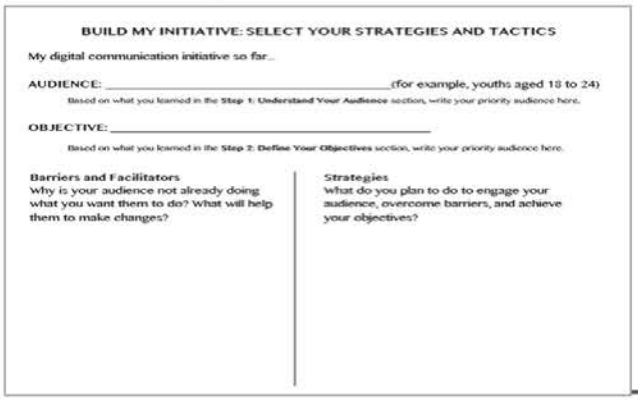
In 2016, RTI's Center for Communication Science and Global India office in New Delhi developed a Digital Health Communication Toolkit to help Indian public health organizations take full advantage of digital communication tools. The toolkit outlines a 6-step approach for impactful public health efforts online, and incorporates best practices, case studies, and expert recommendations.

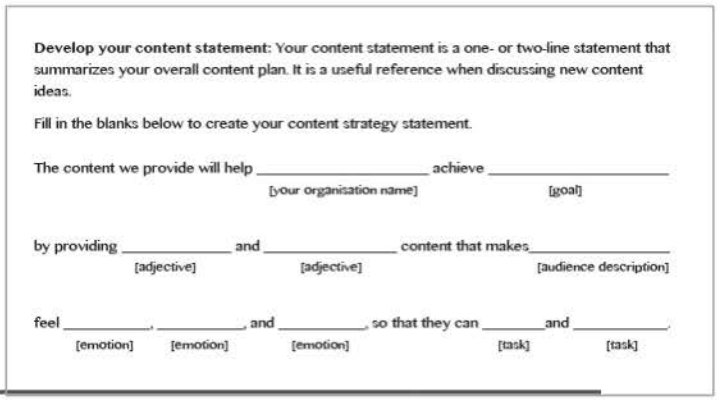
Award: For its effective approach and eye-catching design, the toolkit was awarded "Best Training Material" in the APHA's 2017 PHEHP materials contest.





Example Training Activities:





Use or disclosure of any information on this page is subject to the restriction in the proprietary statement of this proposal.

Project Abstract

Part 1: Please identify the applicant point of contact (POC)

OMB No. 1121-0329
Approval Expires 12/31/2018

Applicant POC	
Organization Name	Research Triangle Institute
POC Name	(b)(6)
Phone Number	(b)(6)
Email Address	(b)(6) @rti.org
Mailing Address	3040 E. Cornwallis Rd. PO Box 12194 Research Triangle Park, NC 27709-2194

Part 2: Please identify the application

Application Information	
Solicitation Name	Addressing Female Genital Mutilation and Cutting FY 2020 Competitive Grant Solicitation
Project Title	Addressing Female Genital Mutilation and Cutting Training and Technical Assistance Program (AFTTAP)
Proposed Start Date	10/01/2020
Proposed End Date	09/30/2023
Funding Amount Requested	$1,199,707

Part 3: Please identify the project location and applicant type

Project Location and Applicant Type	
Project Location (City, State)	Research Triangle Park, NC
Applicant Type (Tribal Nation, State, County, City, Nonprofit, Other)	Nonprofit

Part 4: Please provide a project abstract

Enter additional project abstract information. Unless otherwise specified in the solicitation, this information includes:

- Brief description of the problem to be addressed and target area and population
- Project goals and objectives
- Brief statement of project strategy or overall program
- Description of any significant partnerships
- Anticipated outcomes and major deliverables

Text should be single spaced; do not exceed 400 words.

Project Abstract

Addressing Female Genital Mutilation and Cutting Training and Technical Assistance Program (AFTTAP)

Female genital mutilation and cutting (FGM/C) is a public health, social welfare, and human rights concern in the United States. Researchers, practitioners, and survivors have called for culturally informed multisectoral community responses inclusive of law enforcement, social service and health care providers, religious and community leaders, and educators to end the practice of FGM/C and improve services for those affected. The Office for Victims of Crime (OVC) is committed to preventing and serving victims of FGM/C through the Addressing Female Genital Mutilation and Cutting (FGM/C) program, which will support a training and technical assistance (TTA) provider to educate law enforcement, public health professionals, educators, and others on FGM/C risks and to support grantees funded to provide services to victims and work with community partners to better identify and serve individuals.
RTI International is partnering with the End FGM/C US Network and esteemed and nationally recognized FGM/C experts to develop and execute the Addressing FGM/C Training and Technical Assistance Program (AFTTAP). AFTTAP will develop an outreach campaign toolkit that will include sectoral-specific strategies to foster community-based prevention of FGM/C, identify at-risk individuals, and respond to FGM/C survivors and situations in impactful, safe, and culturally appropriate ways. AFTTAP will support grantees in meeting the goals of this program, using proven strategies for tailored and proactive TTA, including group-level approaches such as grantee meetings, webinars, virtual roundtables, and briefs; individual-level approaches such as phone and video-conferencing; and sustainable materials and resources supporting future initiatives. AFTTAP will share project-created products and offer support to additional communities affected by FGM/C without a grantee. The AFTTAP project will leave a lasting impact after the project's duration through housing project products (e.g., outreach campaign materials, final report) on the End FGM/C US Network website and a final report that summarizes lessons learned through the Addressing FGM/C program.

Part 5: Please indicate whether OJP has permission to share the project abstract

If the applicant is willing for the Office of Justice Programs (OJP), in its discretion, to make the information in the project abstract above publicly available, please complete the consent section below. Please note, the applicant's decision whether to grant OJP permission to publicly release this information will not affect OJP's funding decisions. Also, if the application is not funded, granting permission will not guarantee that information will be shared, nor will it guarantee funding from any other source.

○ **Permission not granted**

◉ **Permission granted (Fill in authorized official consent below.)**

On behalf of the applicant named above, I consent to the information in the project abstract above (including contact information) being made public, at the discretion of OJP consistent with applicable policies. I understand that this consent is only necessary to the extent that my application is unfunded; information submitted in an application that is funded (including this abstract) is always releasable to the public consistent with FOIA rules. I certify that I have the authority to provide this consent.

Authorized Official (AO) Consent	
Signature (b)(6)	Date 04/27/2020
AO Name	(b)(6)
Title	
Organization Name	Research Triangle Institute
Phone Number	(b)(6)
Email Address	(b)(6) @rti.org

Note: *This document is to be submitted as a separate attachment with a file name that contains the words "**Project Abstract.**"*

OMB Approval No. 0348-0043

APPLICATION FOR

	2. DATE SUBMITTED 04/27/2020	APPLICATION IDENTIFIER
1.TYPE OF SUBMISSION	3. DATE RECEIVED BY STATE	STATE APPLICATION IDENTIFIER
	4. DATE RECEIVED BY FEDERAL AGENCY	FEDERAL IDENTIFIER

5. APPLICANT INFORMATION

Legal Name Research Triangle Institute	Organizational Unit
Address (city, state, and zip code) 3040 E Cornwallis Rd. Research Triangle Park, North Carolina 27709-2194	Name and telephone number of the person to be contacted on matters involving this application (b)(6)
6. EMPLOYER IDENTIFICATION NUMBER (EIN) (b)(4)	7. TYPE OF APPLICANT Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education
8. TYPE OF APPLICATION New	9. NAME OF FEDERAL AGENCY Office for Victims of Crime
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE Number: 16.582 CFDA Title: Crime Victim Assistance/Discretionary Grants	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT Addressing Female Genital Mutilation and Cutting Training and Technical Assistance Program (AFTTAP)
12. AREAS AFFECTED BY PROJECT	

13. PROPOSED PROJECT		14. CONGRESSIONAL DISTRICT(S) OF	
Start Date: 10/01/2020	Ending Date: 09/30/2023	a. Applicant	b. Project

15. ESTIMATED FUNDING		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. Federal	$1,199,707	
b. Applicant	$0	Program is not covered by E.O. 12372
c. State	$0	
d. Local	$0	
e. Other	$0	
f. Program Income	$0	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?
g. Total	$1,199,707	N

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS REQUIRED.

a. Typed Name of Authorized Representative	b. Title	c. Telephone number
(b)(6)		
d. Signature of Authorized Representative		e. Date Signed

Previous Editions Not Usable

Standard Form 424 (Rev 4-88)
Prescribed by OMB Circular A-102

Title: Addressing Female Genital Mutilation and Cutting (FGM/C) in the DMV

1.0 Executive Summary

This proposal is presented in response to the US Department of Justice (DOJ), Office of Justice Programs (OJP), Office for Victims of Crime (OVC) FOA entitled "Addressing Female Genital Mutilation and Cutting (FGM/C)" (OVC-2020-17550). The assembled and productive academic-community team from the Milken Institute School of Public Health at the George Washington University (GW/GWSPH) Department of Prevention and Community Health, the Global Woman PEACE Foundation (GWPF), and the US End FGM/C Network (US) has demonstrated extensive experience in the development, implementation, and evaluation of programs and policies of significant public health issues, with a specific emphasis on FGM/C, affecting women and girls in the US and globally. The technical plan that follows is responsive to the Purpose Area 2 (PA2) request in its entirety and presents a 36- month community collaborative approach with a total budget of $300,000 to the systematic and efficient evaluation of the multimethod approach towards the secondary and primary prevention of FGM/C. Our project will build upon our previously successful pilot efforts with FGM/C in the Washington DC Metropolitan Area (DMV) to direct services to survivors of FGM/C, provide outreach to at-risk individuals and communities about FGM/C to increase identification of potential victims (young girls), and disseminate our results and evaluation to a multitude of audiences. We are uniquely poised to leverage our virtual living online toolkit 'FGMToolkit.gwu.edu' we developed, tested, and evaluated as part of our funded successful collaborative efforts with the Office on Women's Health [ASTWH160035]. The living toolkit will be used in tandem with survivor-centric activities including survivor led support groups and responsive law enforcement, health, and educational systems trainings to create a complete package to assist in the secondary prevention of FGM/C and to be conversant with primary

prevention efforts of FGM/C for girls living in the US who because of their birth may be at risk for having FGM/C (or related procedure) in the US or being at risk for being sent to another country ("grandmother trips") for FGM/C. In the following sections, we describe: 1) description of FGM/C in the DMV; 2) project design and implementation; 3) capabilities and competencies and 4) plan for collecting performance measures.

2.0 Description of the Issue in the DMV

Our academic-community collaborative has a unique opportunity to efficiently utilize the resources available in the FOA to bridge the existing gaps that exist in the prevention of FGM/C in the DMV. Below we outline our respective efforts to address FGM/C, the challenges that have been present, and how the current proposal will leverage our resources to address these challenges and work towards meeting the needs of communities of care to prevent FGM/C in the DMV by creating an Integrated Community of Care (ICC) model.

FGM/C in the DMV. According to the Centers for Disease Control and Prevention, FGM/C refers to procedures involving partial or total removal of female genitalia or other injury to female genital organs for any cultural, religious, or nontherapeutic purpose. It is illegal in the United States under federal law to perform this procedure on people under 18 years of age (see 18 U.S.C. § 116). Our team has been recognized in our instrumental efforts in working with the House Judiciary Committee US House of Representatives to formulate HR6100 The STOP FGM Act[1]. The GWPF was recognized by the Commonwealth of Virginia for their efforts in helping to draft Virginia Senate Bill No. 1060 in 2017 and SB No. 47 in 2018, relating to FGM/C criminal penalty (SB 47 was an amendment to SB 1060). In 2019, GWPF assisted in drafting and getting SB No. 1159 passed, to include FGM/C in all middle and secondary schools in Virginia. The

GWU investigators (b)(6)) are working with DC to formalize District law to stop FGM/C.

In the past decade, while research on the health effects of FGM/C continued to receive attention, the global mobilization against FGM/C shifted from a health to a human rights approach; FGM/C is therefore a public health concern as well, as it is most often carried out on children and youth[2]. Further, the practice violates the rights to health, security and physical integrity of the person, and the right to be free from torture and cruel, inhuman or degrading treatment[2]. Available UNICEF data show that FGM/C is mainly concentrated in a path of countries from the Atlantic coast to the horn of Africa, and in areas of the Middle East and Asia, such as Iraq, Yemen, and Indonesia, where more than 200 million girls and women alive today have undergone some form of FGM/C[3]. Evidence also suggests that FGM/C exists in some places in Colombia, India, Malaysia, Oman, Saudi Arabia, and the United Arab Emirates, with variations in terms of the type performed, circumstances surrounding the practice and size of affected population groups[3]. With increased international migration, the practice of FGM/C is not restricted to the practicing origin countries. The CDC and PRB reported that an estimated 513,000 girls and women in the U.S. have undergone or are at risk of being subjected to FGM/C, "wholly a result of rapid growth in the number of immigrants from [FGM/C]-practicing countries living in the United States," and noting that the risk for FGM/C for girls under age 18 was four times that of previous estimates[4,5].

According to the PRB's data, the number of women and girls at risk of FGM/C varies widely, with about three-fifths living in eight U.S. States and the majority concentrated in in cities or suburbs of large metropolitan area[5]. The Washington, D.C., metropolitan area, comprised of Virginia, Maryland, West Virginia, and the District of Columbia, has the second highest concentration of women and girls at risk for FGM/C in the country, estimated at

approximately 51,411[5]. With only an estimated 22% difference in numbers, this is second to the New York, New Jersey, Pennsylvania metropolitan area, which is estimated at approximately 65,893 women and girls at risk for FGM/C[5].

Few regions of the world are tied as closely in a transnational sense to the greater Washington area as is the horn of Africa. Ethiopians and Eritreans represent the largest African immigrant populations in the area, and Nigerians represent the second largest group, according to recent U.S. Census Bureau data[6,7]. With approximately 170,000 African-origin residents, the DMV accounts for one half of the top ten sending countries that have high FGM/C prevalence rates and large numbers of immigrants to the U.S.[5,7]. These data highlight the significance of the DMV as a site for identifying clusters of FGM/C practice, understanding determinants of FGM/C, introducing intervention strategies, and as solicited by this funding opportunity, addressing prevention gaps of FGM/C in the U.S.

Previous efforts and noted challenges. The GWU team and GWPF are the leading academic-community partners who serve as sources of information, education, and support to women living with FGM/C in the DMV. Our efforts in the prevention of FGM/C are many and we highlight those below that have expressly informed our proposal for OVC funding. We began our collaboration through the systematic needs assessment of women living with FGM/C in the DMV (n=26) and their FGM/C health and social service providers (n=25). As noted above, women with FGM/C in our project represented the broad swath of the globalization of FGM/C. We found that challenges towards the prevention of FGM/C were reflected in the words of these women. **The challenges include the stigma, taboo, and cultural identity social norms that unjustly silence women from bringing awareness of their experiences of FGM/C to light**. A pervasive theme in our work was the need for a safe space to talk with other women who have

experienced FGM/C without repercussions from their community. GWPF has been **the only** community-based organization to provide this safe space in the DMV for over 10 years.

FGMToolkit.GWU.EDU. Four years ago, we set out with funding from the Office on Women's Health, to meet the needs of survivors of FGM/C and the providers who serve them. What we found is a profound lack of awareness about FGM/C from the providers and a corresponding need for information from both women and providers. These were constructs we could change. Months were spent interviewing, drafting, and developing an online virtual living toolkit to meet these needs and build upon these stakeholders' strengths. The result was 'FGMToolkit.gwu.edu'. The stakeholders worked with us to develop an evidence based professionally curated online virtual living toolkit. The toolkit is an audience tailored multi-media resource that includes interactive and static material to engage the stakeholder including screening forms, quizzes, videos, peer reviewed literature and studies, and we partnered with SAHIYO, a leader in FGM/C prevention to create captivating stories (https://sahiyo.com/voices-to-end-fgm-c/) to relate to stakeholders in the prevention of FGM/C. The toolkit materials are downloadable and available for audiences without internet access and available in multiple languages with a simple click on any screen.

The toolkit has undergone pilot testing (alpha and beta) and evaluated by competency-based education modules[8]. Our pilot testing with survivors, community members, health/social providers, and clinical trainees (n=250) found the toolkit to have high ratings of usability and engagement and pre-post test differences demonstrated statistically significant increases in FGM/C awareness, knowledge of FGM/C, and self-efficacy to screen for FGM/C in practice. Always looking to improve, our team was cognizant that the toolkit stakeholder audience went beyond our initially funded aims and in collaboration with our community partner, we sought

and were awarded funding from Islamic Relief to utilize the same methods and techniques to develop a tailored toolkit for faith-based leaders and male community members.

We recognize the social practice of FGM/C does have deep historical roots and often misplaced connotations with religious faith and practice. While there is debate as to its origins and social foundations[9,10], many development organizations (UNICEF/WHO) view FGM/C as a social norm or beliefs about how individuals in a community should behave (injunctive norms, beliefs about what should be) and what most people in the community actually do (descriptive norms, empirical beliefs)[11]. Thus, when a social norm such as FGM/C is in place, families and individuals engage in the practice because they believe that it is expected of them and is prevalent in their community. However, could it be that without these perceptions, alternative views of FGM/C would emerge, the social norm would be weakened, and the practice would be abandoned. Changing social norms has been hypothesized as a key step in behavior change[12,13]and the current proposal will address these challenges.

Challenges to be addressed. The DMV is unique in the diversity of stakeholders and audiences that are essential to participate in our Integrated Community of Care model (ICC). Currently, the attempts to address FGM/C have posed challenges to prevention coordination; this will be a hallmark of our proposed work. To change social norms it is imperative that a coordinated collaborative approach be developed that creates not only an awareness of FGM/C in our community, but that we all have ownership in the prevention of FGM/C. The team of GW, GWPF and the US Network to End FGM/C has the background, the resources, and the vision to be this agent of change. As a trusted educational institution, we are an opportune organization to serve as a liaison to convene multisectoral partners to work together, to foster communication, and collaboration to achieving our key prevention goals. Specifically, under this PA2, GW/GWPF has

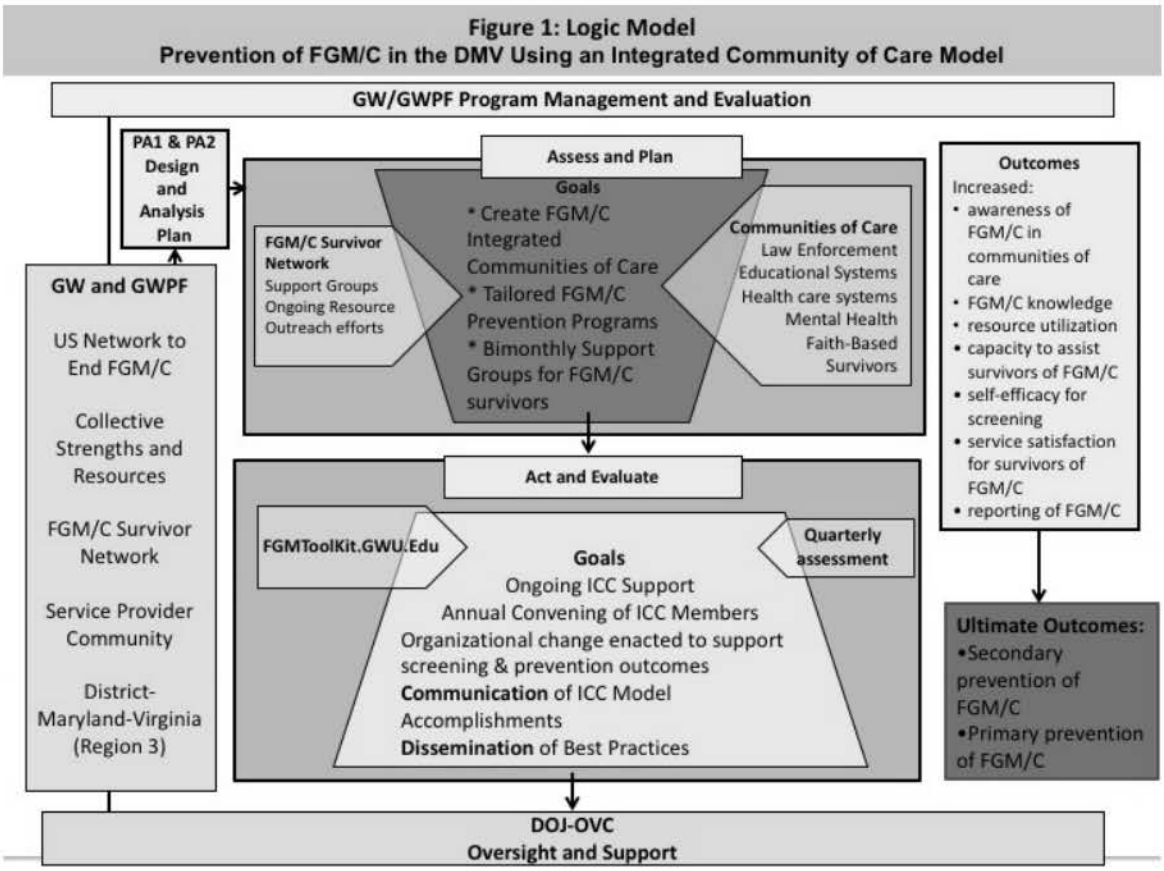
outlined services to deliver to victims of FGM/C and work to increase education, detection, and local partner engagement to address and help stop FGM/C victimization at the community level.

3.0 Program Description/Project Design and Implementation

The GW/GWPF team presents an overall description of the proposed program to address the articulated challenges and barriers noted above. We present the goals and objectives, a description of the major activities, project phases, staff responsibilities, and deliverables that fit within the 36-month time task plan. We have built in time in the first quarter of project funding to work with the selected PA1 site and other PA2 sites to utilize and integrate their valuable knowledge and resources to assist with enhancement of our proposed services.

Overall scope: The Logic Model (see Figure 1 below) depicts the underlying the structure and organization of the proposed efforts. The guiding framework is designed to harness the strengths of the community of care to ensure the health of women who have experienced FGM/C in the DMV, and youth who are risk of FGM/C in the U.S., consistent with the goals and mission of the DOJ/OVC. This logic model provides a guide for assessing the following **goals and proposed outcomes** towards the prevention of FGM/C in the DMV.

Goal statement. The overarching goal of this program is to deliver programming to address and be a partner to help stop the practice of FGM/C by: (1) Educating law enforcement, public health professionals, and educators on detecting at-risk girls in the DMV; (2) responding to victims (survivors) by providing appropriate services; and (3) forming a community network of agencies and organizations that are positioned to identify girls and families at risk. We will meet the needs of communities of care to prevent FGM/C in the DMV by creating an integrated community of care (ICC) model.



Integrative Community of Care (ICC): We use it to describe our collaborative approach towards fostering and enabling an encouraging and supportive atmosphere where all parties are empowered to engage in the prevention of FGM/C, to support others in doing the same and to develop reciprocal relationships that foster partnerships towards a mutual goal. The collective responsibility fosters a strong, sustainable, and connected community.

Communities of Care Include: Stakeholders including law enforcement agencies, educational systems, social and health services, community members, public health, faith-based/religious leaders, and survivors of FGM/C. (see Appendix for a list of our participating ICC members).

Prevention: Prevention for this proposal is two-fold: (1) the prevention of FGM/C incidence (primary prevention) and (2) the prevention of negative outcomes among those who have experienced FGM/C (screening for prevalence of FGM/C, meeting the needs of survivors).

Objectives: Using a Public Health Model we have developed a three phased project:

Phase 1 Assess and Plan:

- To create an integrated community of care (ICC) model to provide prevention and intervention services for FGM/C. To assess the readiness to engage in the prevention of FGM/C for each of our communities of care during the first phase of the project.
- To tailor a prevention program for each community of care based on their readiness to engage in the prevention of FGM/C.

Phase 2 Act and Evaluate:

- To implement, monitor, and evaluate an FGM/C prevention program for the ICC. A competency-based assessment tool will assess changes in awareness and screening of FGM/C, organizational capacity, and utilization of available resources in the DMV.

Phase 3 Communicate and Sustain:

- To communicate and disseminate the ICC model to prevent FGM/C to all stakeholders. To reconvene representatives from our integrated community of care to develop a collaborative plan for sustainability for the program.

Proposed Strategy and Work Plan. Our proposed strategy is composed of those efforts we have found to be effective in program development with sensitive content areas in the DMV. Given the current COVID19 pandemic we are structured to provide all content virtually and/or in person as the situation necessitates. We have outlined the phased rollout of the ICC model in Table 1 below.

Phase 1: During the first two quarters we set the framework for the successful implementation of

the project. We will convene with the PA1/PA2 sites and incorporate suggested programmatic efforts into our ICC model. We will individually assess each ICC member's readiness to engage

Table 1: Time Task Gantt Chart for *Addressing FGM/C in the DMV*

	Year 1				Year 2				Year 3			
Task	**Q1**	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**	**Q7**	**Q8**	**Q9**	**Q10**	**Q11**	**Q12**
Phase I: Assess and Plan												
Award set up												
Convene PA1/PA2 sites												
Invite ICC members												
Assess ICC readiness engage												
Tailor training modules												
Convene ICC												
Phase II: Act and Evaluate												
Quarterly ICC Follow-Up												
ICC training												
Hold FGM/C Support Groups												
Convene ICC members												
Analysis (quarterly metrics)												
Phase III: Communicate and Sustain												
Quarterly reports to OVC												
Convene ICC members												
Convene PA1 & PA2 sites												
Prepare final report												
Prepare final deliverables												

in the efforts to address FGM/C in the DMV and training modules will be tailored for each ICC member. Once initial assessments have been completed, the ICC members will be convened to engage in planning and strategy meetings to determine how and in what ways GW/GWPF will serve as a centralized care coordination for FGM/C. This care coordination will be facilitated by the interactive **FGMToolkit.gwu.edu** toolkit (see above) that will house materials necessary for responsive prevention efforts (screening tools, organization specific assessment, quizzes, DMV specific resources). Based on the initial assessment, tailored trainings for each ICC representative and their members will be developed and tested with a pre-post assessment of indicators to round out the efforts in the first phase of the project (see Table 2).

Phase 2: This phase will be the active implementation of the project. As part of the training developed in Phase 1, each ICC will designate a point of contact that will be complete a quarterly update to coincide with OVC reporting requirements. The FGMToolkit.gwu.edu will serve as a

mechanism that service providers can use to access other ICC resources, to complete quarterly metrics using a secured REDCap (project-redcap.org) site, and as a repository of curated materials. A second convening of the ICC members will be held at the mid-point to conduct a process evaluation and determine the usability and utility of the resources and garner suggested modifications. Throughout the entirety of the project, GWPF will implement **survivor-centric activities** including psychological counseling, physical therapy, outreach to families, and advocacy efforts. Most importantly GWPF will conduct and evaluate **survivor led support groups**. In addition to the emotional support provided in this safe space, the support groups will empower survivors to provide a vital voice to the ICC efforts. The FGMToolkit.gwu.edu has a devoted section of the toolkit for FGM/C survivors. This website will be modified to include a survivor information and service portal for FGM/C survivors to find service providers in the DMV and submit inquiries for personal follow up by GW/GWPF.

Table 2. Example of Proposed Indicators Integrated Communities of Care (ICC)

Indicator	Operational Definition	Source of Data
Readiness to Engage	Stage of Readiness to engage in FGM/C prevention	Pre survey
Knowledge of FGM/C	Knowledge about the basics of FGM/C	Pre and post survey
Awareness of FGM/C	Awareness of FGM/C in communities of care	Pre and post survey
Participant Satisfaction	Level of satisfaction with ICC activities.	Pre and post survey
Self-efficacy to communicate with FGM/C survivors	Belief in the ability to communicate effectively with survivors of FGM/C	Pre and post survey
Toolkit Utilization	How often was toolkit used: by topic and duration	Google Analytics
	Toolkit Pattern of Traffic on the website materials	Google Analytics
Organizational Capacity	How and in what ways have the activities of the ICC/toolkit influenced the service provider to connect with resources provided/recommended?	Survey of service providers and Google Analytics

Phase 3. A fundamental necessity for the project is the continued and sustained communication and dissemination of the project activities and results. In the third phase of the project multiple forms of communication will be used to ensure primary, secondary, and tertiary stakeholders are kept apprised. Throughout the project, plans will be drafted for sustainability of effective activities and prompt attention to enhancement of activities needing improvement. The project will convene the ICC to develop a manual of 'best practices' to be shared with the PA1

and P2 sites. We are fortunate to partner with the US End FGM/C Network to ensure communications are disseminated to interested audiences.

Deliverables. As a PA2 site our deliverables will include:

- care coordination of direct services to victims of FGM/C, for example, physical and mental health care, advocacy, legal intervention, and other services the project sites determine will advance the goal of addressing FGM/C in their community.
- outreach to at-risk individuals and communities about FGM/C to increase identification of victims and persons at risk of victimization.
- a final report describing project activities, promising practices, challenges encountered, and solutions to address those challenges.

Financial Reports. As the primary site, GW has the ability and demonstrated experience to submit financial reports in a timely fashion. See page 14 for a detailed explanation.

4.0 Capabilities and Competencies

We are fortunate to have assembled an academic community partnership that brings together the best of what is needed for a successful project in terms of rigor and utilization by all invested communities. As the organizing body, GW is home to some of the nation's top experts on healthcare, policy, and public health programs and has successfully completed millions of dollars in contracts with federal, state, and local governments. Researchers work hand-in-hand with a diverse group of community, private, and government partners to identify unmet public health needs, to test innovative prevention models and strategies, and to evaluate public health initiatives to ensure that they are effective and sustained in the communities that will benefit the most.

The GWSPH's overall research portfolio totals approximately $64 million. The School has received funding from most federal health agencies (DHHS, OWH, CMS, AHRQ, NIH, HRSA,

CMS, CDC), key foundations (Robert Wood Johnson Foundation, Commonwealth Fund, Kaiser Family Foundation), state government agencies, and numerous other sources. Faculty and staff are recognized for their expertise in public-health research, including policy analysis and assessment; program assessment; evaluation design studies, data collection; and production and dissemination of research findings via tailored methods, including briefings, publications, and websites. University students are a great asset, and frequently work as research assistants on projects.

The Department of Prevention and Community Health at GWSPH focuses on interventions to change behavior and promote healthy communities. Research and community projects address violence, alcohol use, HIV, tobacco, obesity, and other public health threats. The Department maintains an entire floor of offices in the new Platinum LEED building on the Washington Circle, a metro ride away from our partners at GWPF. Facilities are ample to carry out the functions of the proposal and include links to the university's computer network, email and digital phone systems, 14 fully-equipped PC/MAC stations for students, and individual laptops tied to the University server or secure Wi-Fi for all faculty/staff. PCs have a full complement of word processing and graphics software, as well as SAS/STATA/SPSS/MPLUS (quantitative) and QSR NVIVO (qualitative) software for analysis. The Department also has several laptops and LCD projection equipment, and one fully integrated conference room (Video Conferencing enabled seating for 30) and one team meeting rooms (Wi-Fi and seating for 10). The Department is located at 950 New Hampshire Avenue, Suite 300, Washington, DC 20052.

Within the Department we have two centers that will an asset to our project efforts: 1) Center for Health and Health Care in Schools is a nonpartisan policy, resource, and technical assistance center with a continued history of developing school-connected strategies for better health and education outcomes for children. CHHCS partners with foundations, government health and

education agencies, school districts, and providers across the country to support their school-connected initiatives and 2) Redstone Center/Bridging Community Resilience strives to implement and evaluate strategies to improve health and to measure outcomes globally, nationally and in the Washington, DC community.

University collaborations: As part of a unified unit within the university, the Department staff currently collaborates with faculty and research efforts with other GWSPH Departments and at schools throughout the university, including the School of Medicine and Health Sciences, School of Nursing, Children's National Health Center, GW Law School, and the Graduate School of Education and Human Development. These resources have allowed us to expand our web of expertise far beyond the skills among core faculty.

Other resources: Within the Department, an executive associate manages financial issues and a research services coordinator and a graduate research assistant work with faculty who are developing grant proposals, providing pre- and post-award coordination with funders and other GW offices. The GW Office of Research provides grant oversight and financial management services and the Office of Human Research Services in the Office of Health Research, Compliance and Technology Transfer oversees the protection of human subjects and institutional review of research for the University.

Global Woman PEACE Foundation: GWPF is a 501c3 nonprofit organization located in Fairfax County, Virginia. It was founded in 2010, based on the principles of ending violence and injustices against women and girls. The mission of the organization is to empower women and girls through education to help eradicate gender-based violence, especially FGM/C. Since its inception, GWPF has offered services to both women living with the consequences of FGM/C and girls at risk of it. GWPF runs the only support group for FGM/C victims in the DMV, where

they provide free counseling and therapy. In addition, the support offers assistance in the assimilation to an American lifestyle as a victim of FGM/C. GWPF has also engaged in training of local law enforcement, school nurses and teachers in the DMV. They provide these frontline personnel with resources to support FGM/C victims through the stages of prevention, protection, and prosecution all key partners in our ICC efforts.

US End FGM/C Network: The US End FGM/C Network's (endfgmnetwork.org) mission is to eliminate FGM/C by connecting, supporting, elevating, and advocating on behalf of and with diverse US stakeholders engaged in prevention, education, and care. The Network is a collaborative group of survivors, civil society organizations, activities, policymakers, researchers, healthcare providers, and others committed to promoting the abandonment of FGM/C in the US and worldwide (GW and GWPF are members). The values of The Network center on deep collaboration, respect, diversity/inclusion, tolerance, gender equity framing, action engagement, and being survivor-centered. The Network will partner throughout the project to develop and convene the ICC members, to review the training materials, and participate in the dissemination of the results of the project to our global stakeholders.

Project Management. All CV's can be found in the Appendix.

(b)(6) proposed PI and an (b)(6) in the (b)(6) is a public health program evaluation and implementation specialist with over 20 years' experience working with community groups, public health agencies, and health care systems both locally and globally. (b)(6) (b)(6) expertise lies in using mixed methods to look at complex public health issues and programs. (b)(6) was awarded (b)(6) federal grant awards to develop and test community-based approaches to prevent FGM/C (ASTWH160035).

(b)(6) and her team, including the GW investigators below, (b)(6) (b)(6) worked in tandem with survivors of FGM/C, community activists, health care organizations, and governmental agencies to develop a virtual living toolkit to inform, educate, and be a partner to increase awareness and change the social norms around FGM/C. (b)(6) has also published on the role of social norms and GBV and has extensive expertise in GBV in immigrant communities (CDC funded) and evaluating national programs to provide services to address GBV including the National Domestic Violence Hotline/loveisrespect Helpline (HHSP23320095635WC). (b)(6) served as the PI on a (b)(6) (b)(6) to conduct a similar examination to the current focused on FGM/C within the topic area of human trafficking in the DMV. (b)(6) has traveled with (b)(6) through funding from the Department of State to assist in the training, development and evaluation of community-based programs for maternal and child health in (b)(6) including areas affected by FGM/C (b)(6). (b)(6) has worked in the areas of service provision to vulnerable populations within the full program cycle. She has worked with a number of populations including low-income urban women, women living with HIV, women of religious faith, immigrants/refugees and survivors of human trafficking. (b)(6) (b)(6) has implemented services including health care provider training, Advocate based counseling, and trainings with clinical/social/medical groups, legal advocates, university students, and advocacy groups. With over 50 peer-reviewed publications and over 100 conference presentations in the field of women's health, program development, evaluation and health promotion and was inducted into the American Academy of Health Behavior. The current

application builds logically on prior work, and the chosen team members provide additional expertise in community driven programs, methodologies, policy, and communications.

(b)(6) (b)(6)

(b)(6) She holds a Bachelor's Degree in Broadcast Journalism from (b)(6)

(b)(6) (b)(6)

(b)(6)

(b)(6)

(b)(6) She is the recipient of several awards (b)(6)

(b)(6)

(b)(6) In her advocacy work against FGM/C, she and her organization were instrumental in getting legislation passed in Virginia to criminalize FGM/C and to have it included in the Family Life Education Curriculum for all middle and high school students.

(b)(6) currently serves as the (b)(6)

(b)(6) has demonstrated expertise, leadership, training and track record to assist the project in connecting to and working closely with key stakeholders in the Washington DC metropolitan area. Since joining GW in (b)(6) has been instrumental in establishing formal agreements with area Health Departments including District of Columbia; Prince George's, Montgomery, Frederick and Somerset Counties in Maryland; and Arlington, Alexandria and Fairfax Counties in Virginia. In addition, (b)(6) continues to be a conduit of communication and collaboration with local hospitals and service organizations and is instrumental in the GW's successful (b)(6) (b)(6) is committed to sustaining our collaborative teams in addressing FGM/C prevention and maintaining a successful record of working within local communities to improve the health of underserved populations.

Research Assistants (b)(6) will be responsible for providing outreach, service provision, research, clerical, and administrative support to the project team. The Research Assistants will work directly with (b)(6) and with GWPF and will respond in a timely fashion to all support administrative and analytic requests from the team. (b)(6)

(b)(6) , (b)(6) has served as a (b)(6)

(b)(6)

(b)(6) is a certified (b)(6)

(b)(6) will serve as a (b)(6) expert for the project. Each (b)(6) will devote 20 hours per week to this project and will be equally distributed between project tasks.

A **Project Team** will be established as the organizational unit to tie together all the project components and key personnel. The Project Team will be composed of the Principal Investigator, our community liaison, our community partner, ICC members, and research assistants to work with the team to complete the outlined tasks and achieve the proposed goals and outcomes. The project team's primary tasks are to design, plan, implement and evaluate the project activities, foster communication and coordination of project activities, to track progress toward project timetables and outcomes, and to focus attention on emerging issues.

5.0 Plan for Collecting Performance Measures

We recognize and appreciate the need for the use of evidence-based programming, and we will support the monitoring and evaluation of our funded program, activities and outcomes. We will provide the relevant data by submitting quarterly performance data through the Transforming Victim Services module in OVC's online Performance Measurement Tool (PMT).

(b)(6) will serve as the (b)(6) to gather and report performance data. As the PI, (b)(6) will work with other staff as needed to gather the required information when it is due (baseline, quarterly, annual). Within PA2, our project team has experience collecting the required performance measures as well as those from other FOA relevant sections (e.g. Training, data gathering, collaborative partnerships, and strategic planning) and any relevant shared measures. Within the required section, VII. Victim Services, we are poised to answer questions about the provision of direct services to 'victims'. The project will monitor and report all victims served through the funded program and will include percent of victims served who are new, percent of victims served who were the victim of a violent crime (FGM/C), and the average number of services provided per victim. These performance measures will be calculated by tracking the individual level characteristics of the service(s) provided including

demographics, type of victimization, special qualifications, type of services provided (information/referral, personal advocacy/accompaniment, emotional support/safety services, criminal/civil justice system assistance).

Previous experience with quarterly reporting requirements. Our team has extensive experience with quarterly reporting requirements. Similar to what is requested for the current FOA, our OWH project (ASTWH160035) required quarterly and annual reporting through an online reporting system. We met every reporting requirement without incident.

6.0 Conclusion

Our proposed project team, in light of our demonstrated expertise in community developed programs, implementation and evaluation and in the issues of sensitive women's public health issues provides OVC the opportunity to engage leading organizations who can quickly and efficiently carry out all of the rigorous activities required of this proposal with little or no learning curve. Our proposed technical approach, grounded in a unique conceptual framework and described in innovative detail, is informed by meticulous attention to the special requirements of sophisticated community developed program development and evaluation methods. In addition, our focus on conducting applied service and research represents our commitment to providing survivors of FGM/C, service providers, program managers, policy makers, and the general public with high quality feasible information needed to best serve women living in vulnerable contexts. We believe that ultimately improving the lives of these women is the goal of this research; to that end, we look forward to assisting OVC in furthering its already significant contributions to that goal.

Legal Name of Applicant: **The George Washington University**
Project Title: **Addressing FGM/C in the DMV (District of Colombia, Maryland, and Virginia)**
Geographic Area to be served: **Washington D.C. Metropolitan Area (DMV)**

Abstract
Addressing FGM/C in the DMV

Female Genital Mutilation/Cutting (FGM/C) is a serious threat to women's health globally and within the United States. The Washington, D.C., Metropolitan area (DMV), has the second highest concentration of women and girls at risk for FGM/C in the country, estimated at over 50,000. Certain populations bear a disproportionate burden of FGM/C and yet have not benefited from the development and evaluation of appropriate secondary and primary prevention efforts. The proposed collaborative team at the George Washington University School of Public Health (GW), The Global Woman PEACE Foundation (GWPF), and the US End FGM/C Network are in an opportune position to take advantage of new and existing frameworks to undertake a rigorous planning, implementation, and testing of a prevention program designed to address the gaps in FGM/C-related identification and service provision. This application to the Office of Victim Services (OVC-2020-17550) is responsive to Purpose Area 2 in its entirety and utilizes a 36- month community collaborative approach with a total budget of $300,000 to the systematic and efficient evaluation of the multimethod approach towards the secondary and primary prevention of FGM/C. The overarching goal of this program is to deliver programming to address and be a partner to help stop the practice of FGM/C by: (1) Educating law enforcement, public health professionals, and educators on detecting at-risk girls in the DMV; (2) responding to victims (survivors) by providing appropriate services; and (3) forming an **integrated community of care** (ICC) network that is positioned to identify girls and families at risk. Our project takes a three-phased approach. Phase 1 Assess and Plan: To create an ICC network to provide prevention and intervention services for FGM/C. To tailor a prevention program for each community of care based on their readiness to engage in the prevention of FGM/C. Phase 2 Act and Evaluate: To implement, monitor, and evaluate an FGM/C prevention program for the ICC. A competency-based assessment tool will assess changes in awareness and screening of FGM/C, organizational capacity, and utilization of available resources in the DMV. Phase 3 Communicate and Sustain: To communicate and disseminate the ICC model to prevent FGM/C to all stakeholders. This study has the potential to impact the field by providing needed data on a community driven intervention that would be feasible to replicate in many settings. Our findings will provide a clear understanding of the prevention intervention to provide opportunities for leadership to address gaps and challenges in service provision to survivors of FGM/C in the short term and decrease FGM/C incidence in the longer term.

OMB Approval No. 0348-0043

APPLICATION FOR

2. DATE SUBMITTED	APPLICATION IDENTIFIER
04/30/2020	

1.TYPE OF SUBMISSION	3. DATE RECEIVED BY STATE	STATE APPLICATION IDENTIFIER
	4. DATE RECEIVED BY FEDERAL AGENCY	FEDERAL IDENTIFIER

5. APPLICANT INFORMATION

Legal Name	Organizational Unit
The George Washington University	PREVENTION & COMMUNITY HEALTH
Address (city, state, and zip code) 1922 F Street, NW - 4th Floor Washington, District of Columbia 20052-0042	Name and telephone number of the person to be contacted on matters involving this application (b)(6)
6. EMPLOYER IDENTIFICATION NUMBER (EIN) (b)(6)	7. TYPE OF APPLICANT Private Institution of Higher Education
8. TYPE OF APPLICATION New	9. NAME OF FEDERAL AGENCY Office for Victims of Crime
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE Number: 16.582 CFDA Title: Crime Victim Assistance/Discretionary Grants	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT Addressing FGM/C in the DMV (District of Columbia, Maryland, and Virginia) Purpose Area 2
12. AREAS AFFECTED BY PROJECT	

13. PROPOSED PROJECT		14. CONGRESSIONAL DISTRICT(S) OF	
Start Date: 10/01/2020	Ending Date: 09/23/2023	a. Applicant	b. Project

15. ESTIMATED FUNDING		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. Federal	$300,000	
b. Applicant	$0	Program is not covered by E.O. 12372
c. State	$0	
d. Local	$0	
e. Other	$0	
f. Program Income	$0	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?
g. Total	$300,000	N

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS REQUIRED.

a. Typed Name of Authorized Representative	b. Title	c. Telephone number
(b)(6)		
d. Signature of Authorized Representative		e. Date Signed

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Standard Form 424 (Rev 4-88)
Prescribed by OMB Circular A-102

CO - Time Task Plan

The time-task plan is organized to correspond to the three project objectives, and lists the required final deliverable. Refer to **b. Project Design and Implementation section of the Program Narrative (pages 12-13).**

When more than one Colorado project team member is included as staff responsible for an outcome, the lead is listed first.

Objective 1: Educating providers, law enforcement, public health professionals, and educators on detecting at risk girls in localities where FGM/C is a risk Objective 2: Respond to victims by providing appropriate services				
Final Deliverable: Direct services to victims of FGM/C, for example, **physical and mental health care**, advocacy, legal intervention and other services the project sites determine will advance the goal of addressing and helping to stop FGM/C in their community				
Strategy	Activity/Task	Staff Responsible	Project Phase (Year)	Interim Deliverable
Standardized FGM/C training	Develop educational content on FGM/C topics and clinician skills (e.g., how to ask patient about FGM/C, obstetric management, gynecological, urologic and other complications and management, preventing FGM/C in girls: talking to mothers and fathers, medical legal implications of FGM/C in girls, and immigration relief for undocumented girls and women)	(b)(6)	2	Recorded short video lectures

	Research curriculum gaps and/or hold discussions with local higher education entities to ensure that educational content meets educational needs of local higher education entities	(b)(6)	2	Educational content matches educational or certification gaps
	Incorporate provider-focused educational topics to address community member knowledge, attitudes, and beliefs into educational content		2	Educational content geared to culturally informed FGM/C care and treatment
	Create educational content on narrated and timed slideshow platform		2	Educational content (digitized video lectures) ready for distribution
	Create plan for dissemination of educational content		2	Multi-cadre local and national audience identified Dissemination plan
	Disseminate educational content		3	Local and national audience receives FGM/C training
Standardized FGM/C training	Deliver in-person FGM/C clinical education to select cadre (chosen for highest impact or correlation to FGM/C care needs)		1, 2, 3	Prioritized cadre receives FGM/C training 2 lectures each year delivered
	Train Pediatricians, child abuse pediatricians family medicine, adolescent medicine, emergency		2, 3	Larger cadre of child abuse-aware Pediatricians with expertise in FGM/C formed

	medicine and pediatric urology in medical and mental health and legal considerations in the management of girls and adolescents with FGM/C			1 training session completed yearly
Standardized FGM/C training	Develop curriculum for Pediatric training module	(b)(6)	1	Curriculum created
	Create clinical protocol for screening women and girls for FGM/C		1	Protocol for screening girls and women for FGM/C
Standardized FGM/C training	Create clinical protocol and process for consistent and accurate documentation of FGM/C by type and characteristic		1	Protocol for determining type and characteristics of FGM/C Tool for charting type and characteristics of FGM/C
	Create (clinical; community) protocol for assessing girls' risk of FGM/C victimization		1	Tool for measuring risk of FGM/C (provider use) Tool for measuring risk of FGM/C (community stakeholder use)
Complex defibulation and clitoral reconstruction training	Assess community need and demand for surgery Attend surgical trainings in complex defibulation and clitoral reconstruction		1	Community inquiry as to need and demand for surgery Up to 4 providers have advanced clinical ability to carry out procedures for victims of FGM/C (trainer: (b)(6) 2 training sessions completed

Objective 2: Respond to victims by providing appropriate services				
Final Deliverable: Direct services to victims of FGM/C, for example, physical and mental health care, **advocacy**, legal intervention and other services the project sites determine will advance the goal of addressing and helping to stop FGM/C in their community				
Strategy	Activity/Task	Staff Responsible	Project Phase (Year)	Interim Deliverable
Increase covered services available for specialized care of affected women/girls	Coordinate with Colorado Health Care Policy and Financing (HCPF) to increase covered services available to girls and women affected by FGM/C	(b)(6)	1,2, 3	Increase in necessary medications, services and treatment to care for girls and women affected by FGM/C covered services under Health First Colorado (state Medicaid program) Meetings between Colorado project and HCPF held

Objective 2: Respond to victims by providing appropriate services				
Final Deliverable: Direct services to victims FGM/C, for example, physical and mental health care, advocacy, legal intervention and **other services** the project sites determine will advance the goal of addressing and helping to prevent FGM/C in their community				
Strategy	Activity/Task	Staff Responsible	Project Phase (Year)	Interim Deliverable
Enhanced referral to care processes and resource	Educate patients and providers on how to refer to FGM/C specialty care and what services and resources are available	(b)(6)	1, 2, 3	Information campaign content developed Outreach and communication complete Patient navigation carried out

acquisition				
Increase covered services available for specialized care of affected women/girls	Develop criteria and process for needs-based funds use for FGM/C care and treatment	(b)(6)	1	Written funds utilization protocol
	Maintain portfolio of services that can be covered with funding (e.g., childcare, travel to/from clinic visits, and copays or costs for visits and medical/surgical management and ancillary care)		1	Allowable funds use documented
	Administer payments for childcare, travel to/from clinic visits, and copays or costs for visits or medical/surgical and ancillary care		1, 2, 3	Up to 20 women and girls able to access services not covered by Medicaid or insurance

Objective 3: Form community networks of agencies and organizations that are positioned to identify girls and women affected as well as persons at risk (e.g., law enforcement agencies, schools, community health and mental health organizations)				
Final Deliverable: Outreach to at-risk individuals and communities about FGM/C to increase identification of victims and persons at risk of victimization				
Strategy	Activity/Task	Staff Responsible	Project Phase (Year)	Interim Deliverable
Community	Develop an outreach plan to assure reach to women, girls,	(b)(6)	1	Outreach plan complete

outreach, engagement and education	and men			
	Conduct outreach to schools, mosques, churches, community centers, ESL classes, apartment complexes, adolescent girls' women's gatherings	(b)(6)	1	List of community leaders, locations for outreach, contacts compiled
	Develop a guided inquiry tool/discussion guide (to capture specific details on knowledge, attitudes and beliefs held around FGM/C)		1	Tool/guide complete
	Research existing tools for development of guided inquiry/discussion guide tool		1	Tool/guide is best practice based
	Create modular curriculum or discussion guides that covers distinct components of FGM/C education		1	FGM/C education is accurate and consistently delivered
	Hold one:one and small group sessions with representatives of affected and at-risk communities (primarily Somali, Eritrean, Ethiopian, Djibouti, Egyptian, Sudanese, Yemeni, and Iraqi) to provide support and education and resource		1, 2, 3	6 small group sessions annually held (3 of 6 with 2 hours of interpretation) 12 one:one sessions held annually (6 of 12 with 30 minutes of interpretation) Increased community knowledge of resources available

	sharing			Increased community knowledge of FGM/C risks Increased community connectivity and social bonding Increased community knowledge of illegalities related to FGM/C (18 U.S.C. § 116)
	Medical providers attend, alongside community navigators, select small group and/or one:one sessions with community members	(b)(6)	1, 2, 3	Increase in community members' ability and opportunity to connect in non-medical setting with doctors to address questions, fears, or concerns Accurate information available to community members Decrease in apprehension to seek medical care or ancillary services for FGM/C
Documentation of community knowledge, beliefs and practices around FGM/C	Create summary of knowledge, attitudes and beliefs and best practices in survivor-to-survivor connectivity work documented		3	Increased project team stakeholder knowledge of FGM/C practices Best practices for education and support of populations suffering from FGM/C documented Program improvement
	Share summary with community members and advisory group		3	Increased victim knowledge of FGM/C Increasingly empowered women

Objective 3: Form community networks of agencies and organizations that are positioned to identify girls and women affected as well as persons at risk (e.g., law enforcement agencies, schools, community health and mental health organizations)				
Final Deliverable: A final report describing project activities, promising practices, challenges encountered, and solutions to address those challenges.				
Strategy	Activity/Task	Staff Responsible	Project Phase (Year)	Interim Deliverable
Documentation of community knowledge, beliefs and practices around FGM/C	Pull select content from summary of knowledge, attitudes and beliefs and best practices documents by (b)(6) for inclusion in final report	(b)(6)	3	Increased project team and grant administrator knowledge of FGM/C practices
	Meet as Colorado project team to delineate and finalize final report content		3	Final report submitted on time
	Disseminate documentation to FGM/C affected communities, stakeholders		3	Increased affected community and stakeholder knowledge of FGM/C practices
Increase covered services available for specialized care of affected women/girls	Document state's progress towards meeting SB 99-096 goals		1	Connection to original drafters and supporters made SB 99-096 parameters upheld under the Colorado project

Overall Grant Administration and Project Management			
Objective: A plan is in place for timely and accurate submission of financial and progress reports and efficient project execution			
Final Deliverable: Semiannual progress reports and quarterly financial reports			
Activity/Task	Staff Responsible	Project Phase (Year)	Interim Deliverable
Complete OJP Grants Management System Computer Based Training	(b)(6)	1	Informed project management requirements and requisites for operating an U.S. Department of Justice grant (https://www.ojp.gov/gmscbt/external-overview)
Issue contractual agreements to Colorado project team		1	Statements of work developed Contracts comply with OJP subaward and compliance and reporting requirements as per https://ojp.gov/training/training.htm. Contracts signed
Hold Colorado project start up meetings (virtual, in-person and through electronic correspondence) to outline implementation and data collection plans		First 30 days	Project deliverables developed Plan for data collection developed
Hold monthly Colorado project team meetings		1, 2, 3	Informed and coordinated activities

Hold quarterly advisory group meetings	(b)(6)	1, 2, 3	State, federal, and project priorities align
Submit quarterly performance data		1, 2, 3	Performance measures tracked and reported through OVC online Performance Measurement Tool
Submit quarterly reports recording grant activities completed		1, 2, 3	Progress towards goal, objective, and deliverable achievement tracked
Submit quarterly financial reports/invoicing		1, 2, 3	Accurate expense and project funding accounting
Write semiannual progress reports		1, 2, 3	Timely report submission to Office for Victims of Crime
Complete quarterly financial reports		1, 2, 3	Timely report submission to Office for Victims of Crime
Complete final report		3	Project activities, promising practices, challenges encountered, and solutions to address those challenges described and documented

The Colorado project will activate a community and organizational response to address the needs of victims of Female Genital Mutilation/Cutting (FGM/C). Our project will educate health professions students and specialty medical providers in FGM/C care and treatment. Colorado's mental health providers, law enforcement, public health professionals, educators and other stakeholders will receive orientation on the detection of at-risk women and girls and basics of FGM/C. We will respond to victims of FGM/C by providing appropriate services. Agencies, organizations and other stakeholders positioned to identify and support victims of FGM/C, or those at risk of FGM/C, will be engaged. As such, Colorado will meet the stated Office for Victims of Crime solicitation goals, objectives and deliverables. The programming planned addresses the current needs of victims of FGM/C, and helps stop the future practice of FGM/C.

Potential for FGM/C victimization in Colorado is high. A significant number of an at-risk population lives in Colorado. Statistics demonstrate the prevalence of FGM/C. According to the World Health Organization (WHO), FGM/C is practiced in 30 countries, primarily in Africa, the Middle East, and Asia (less so in other regions, like South America). FGM/C is documented in Europe, Australia, and North America when at risk women and girls are living outside of their birth country. Estimates highlight that more than 200 million girls are victims of FGM/C and the WHO calculates that nearly three million girls are at risk of falling victim to FGM/C each year. Colorado Refugee Services Program (CRSP) data from 1980-2017 identified arrivals from 27 countries where FGM/C is practiced (10,805 people) from these countries. Colorado welcomes up to three percent of the national total of refugee arrivals each year, translating to an increasing population of women and girls at risk of FGM/C. The foreign-born population totals almost 10%, and in 2018, individuals born in Africa represented almost 38,500

residents of Colorado. This state-specific data signifies that the population at risk of past or future FGM/C, and corresponding marked physical and mental health impacts, is significant.

Colorado's General Assembly declared it to be in the interest of public health, safety, and welfare to protect female children from harmful aspects associated with FGM/C through Senate Bill 99-096. The bill declares that persons should be made aware of the nature and extent of possible long-term physical, psychological, emotional trauma FGM/C can inflict. This bill enacts space for outreach to educate affected communities concerning the health risks associated with FGM/C and promotes the education of the medical community regarding recommended standards of practice for recognizing and treating FGM/C. SB 99-096 moves to inform the medical and stakeholder community of the criminal penalties for child abuse involving FGM/C. Activities under this legislative backing, dormant in recent years, provide a project catalyst.

US Department of Homeland Security hosted a 2019 seminar in Denver on "FGM/C: strategies for identification and response" that was attended by nearly 20 people representing various sectors and actors (law enforcement, health care, public health, survivors). The event shared health and legal consequences plus details on "Limelight" (prevention campaign that targets airports during times of high volume of travel to prevalent FGM/C areas and provides education to travelers). A dialogue between our team, key State and federal partners, and community members that followed cemented broad stakeholder interest in outreach and education. The ability to build on this momentum, and contribute to federal efforts is critical.

a. Description of the Issue

This section first describes the **need for the Colorado project, given identified complex and multi-faceted challenges.** The need centers on four main areas:

1. insufficient provider clinical training (both locally and across the United States; primary care, mental health care, public health, and specialty-level);
2. patient-level access barriers (economic, transportation, clinic/health care system)
3. unknown or limited community member knowledge and beliefs related to the risks of FGM/C (physical, mental, and legal) and resources available to them; and
4. low refugee and immigrant-serving stakeholder awareness and engagement on the topic of FGM/C and its evaluation and treatment.

Below is detailed information about existing resource, policy and systems barriers and training gaps or challenges. By addressing them through our project focus, outcomes for victims of FGM/C will be improved.

CLINICAL TRAINING

No standard training on FGM/C for medical or mental health care providers in Colorado: Providers in fields of obstetrics and gynecology, family medicine, pediatrics, adolescent medicine, emergency medicine, urology, internal medicine, midwifery, mental health, school nursing, education, social work, refugee medical screening do not have the necessary knowledge and skills to ask, address and manage FGM/C and its complications. Providers at the largest Federally Qualified Health Centers (FQHC) systems in the state (Clinica; Peak Vista; Salud; STRIDE; Sunrise) and the 78 Title X Family Planning clinics lack access to FGM/C clinical training (conceptual and applied skills). The American Academy of Family Physicians (AAFP) "encourages family physicians to educate themselves about the practice, the health consequences of FGM and how to manage them in clinical practice, particularly during pregnancy and childbirth. Family physicians are encouraged to provide culturally sensitive counseling and education to the patient and her family members about the negative physical and

emotional consequences of the procedure and discourage them from having the procedure performed". However, standard training that addresses aspects of FGM/C like: best approach to diagnosis, management, treatment, prevention or counseling in girls and women in FGM/C is not available. Until 2011, Colorado African Organization educated providers on the topic of FGM/C in women (but not in girls) and its management.

Scarce and unstructured access to FGM/C obstetrics and gynecology (OB/GYN) and FGM/C pediatric expertise: (b)(6) is the only (b)(6) in Colorado. (b)(6) is the only (b)(6) in Colorado. A mechanism to uniformly obtain clinical guidance from these experts is not in place in Colorado.

Limited FGM/C expertise outside of the Denver Health system: a geographic and institutional barrier to technical/clinical FGM/C expertise exists. In counties with high potential for FGM/C victim concentration (Adams, Arapahoe, Boulder, El Paso and Weld), providers lack knowledge of the Denver Health FGM/C specialty care clinical services.

Gaps in systematic identification of at-risk girls and women: Girls and women who had FGM/C in their home country prior to migration are at risk for significant medical and psychosocial complications of FGM/C. Since medical provider knowledge is limited, few are identified as having FGM/C, unless they present with significant medical complications from the procedure or for management of pregnancy and childbirth. Training on and knowledge of national and international guidelines for FGM/C classification, as well as culturally appropriate interview techniques, are insufficient to adequately identify at-risk individuals.

PATIENT-LEVEL ACCESS BARRIERS

Prohibitive surgical and ancillary clinical care and treatment costs: The cost of surgical treatment to alleviate clinical problems associated with FGM/C may be unattainable for

victims. Insurance and out-of-pocket expense barriers can exist limiting access to services and care that are critical to physical and mental well-being. The inability to access coverage and provision of ancillary clinical services for treatment is common (e.g., sexual health therapy, pelvic floor physical therapy, and mental health services to support counseling and treatment of body dysphoria and post-traumatic stress disorder, sexual side effects and pelvic pain/dysfunction associated with FGM/C).

Appointment access barriers: FGM/C patients who require specialty care are faced with transportation, time and cost-benefit barriers to attend appointments. Transportation to appointments can be a logistics challenge and cost. Metro area bus routes are time-consuming, but especially so for patients living at up to 100 miles away. Many victims of FGM/C work in the service sector, where time off or paid time off is limited or not available. Challenging appointment-making systems and treatment and follow up protocols are complex. Women with children face child-care needs when needing to attend appointments. Interpretation needs are also lacking insofar as specialty appointments. Female interpreters are preferred, especially among the Somali population, and are not always available. Medicaid in Colorado does not specifically cover interpretation costs, which is a barrier for clinicians caring for victims.

COMMUNITY MEMBER KNOWLEDGE AND BELIEFS

Insufficient community member knowledge of risks of FGM/C - medical and legal consequences: Myths and taboos around FGM/C translate to low immigrant and refugee knowledge of the health and psychosocial effects of FGM/C, including urinary, menstrual, sexual and birth complications. Additionally, there is concern that community members do not know or fully understand the legal consequences of FGM/C. Issues such as “vacation cutting” (travel to countries outside of the U.S. to perform FGM/C) must be addressed.

Gaps in documented information about local community member knowledge, attitudes, practices, and beliefs around FGM/C: General information about immigrant and refugee's interpretation of and insight into FGM/C is available. However, Colorado lacks state resident-specific details of what girls, women and male family members know, how they perceive elements of FGM/C, what practices are common, and what beliefs exist.

Risk of FGM/C for children if mom is an FGM/C victim: A focus on maternal and paternal education, as a means to decrease the risk of FGM/C to female offspring is not in place within the majority of community based organizations. The provision of pre-emptive preventive engagement and orientation is not typically undertaken.

Victims lack knowledge of the Colorado healthcare system: Many immigrants and refugees struggle to master awareness of the breadth of services available to them. A majority have low health literacy, especially as it pertains to female anatomy and sexual health. To compound this issue, a certain degree of distrust of non-African physicians/clinicians, in addition to distrust of institutions due to stigma, racial profiling, and/or legal concerns is evident.

Cultural norms and beliefs promote gender violence: Beliefs surrounding FGM/C practice vary. Some see the procedure as a religious requirement, rite of passion to womanhood, and/or a way to ensure fidelity. Cultural norms requiring FGM/C as a requisite for marriage exist among certain communities. The practice is not viewed as gender violence with significant risk of medical (urologic, OB/GYN, mental health) complications.

STAKEHOLDER AWARENESS AND ENGAGEMENT

Uninformed mainstream stakeholders: The Colorado project team has strong connections to entities within community health, public health, law enforcement, low-income housing projects, and non-profit organizations whose services benefit the State's immigrant and

refugee population. Little or no knowledge is held of: who is at risk of FGM/C; how to identify girls and women at risk; how to respond to those affected with service referrals; what resources are available; and the process for obtaining care and treatment for victims. Insufficient progress towards achieving goals outlined in SB 99-096 has been made. The focus, important upon bill enactment, is imperative, and needs to be revisited and progress documented.

Uncoordinated efforts: (b)(6) have given local, national and international grand rounds, lectures, workshops and panel discussions on FGM/C diagnosis, management, treatment and prevention to multiple cadres of medical professionals. Given clinical and organizational demands, information needs to be standardized, digitized and routinely disseminated. (b)(6) co-developed clinical tools for talking to patients about FGM/C and culturally appropriate ways to discuss the topic with patients. These resources must be more readily available, accessible and geared to medical professionals in an organized and orchestrated way to reach a wider subset of stakeholders. No established mechanism is in place to share best practices and resources related to FGM/C to Colorado's service providers (not on a clinical, psychosocial, program management or community level).

In light of the aforementioned limitations and described needs pertinent to FGM/C in the State, we next outline numerically our strategies; they are the mechanism through which **the Office for Victims of Crime funding will support the project's value to victims and allows us to address these unique challenges.** Both from details provided above, as well as those to follow, it is clear that the proposed Colorado project aptly addresses gaps in existing (or non-existent) efforts and does not duplicate resources. **Strategies:**

(1) Community outreach, engagement and education: This funding will allow for survivors and girls at risk of FGM/C to connect through one:one and small group gatherings with

Colorado project team members, both clinicians and those with lived experience. Women and girls will unite for education and support to learn about FGM/C and learn from each other to better cope with the consequences of FGM/C. This clinician-survivor-community interaction allows for a formalized yet important interpersonal connection. Families benefit from clarification on treatment options for FGM/C (with clinical accuracy), myths about FGM/C, and affected communities are given education about appropriate health care management of FGMC complications. This builds a strong rapport and contributes to better outcomes for patients and providers. This project funds expert community navigators' time and effort to strengthen the existing network of community leaders, and identify groups within affected communities. Educational content will be delivered through both formal (e.g., classes, workshops) and informal (e.g., tea with women's groups; family gatherings) modes. Topic include: biology and physiology of FGM/C; cultural norms and issues; religion and its connection to FGM/C; family dynamics and support systems; women's empowerment, and legal parameters of FGM/C in the U.S. A modular curriculum and guided inquiry/discussion guide will be created to uniformly approach outreach, engagement and education. To avoid duplication of efforts, we will link to established forums (e.g., mental health or psychosocial groups; ESL classes; women's, men's or youth group gatherings; refugee cultural orientation sessions; religious or community celebrations and groups, etc.) and existing U.S. FGM/C curricular documents to carry out our work.

(2) Documentation of community knowledge, beliefs and practices around FGM/C: This funding will incorporate information learned from survivors on what they commonly believe about FGM/C into a compendium to share with stakeholders and inform programming. Exploratory discussions with FGM/C victims, both formal and informal, will validate

assumptions and add to the knowledge base our State's stakeholders hold on FGM/C. Some research exists related to the Somali community (primarily by the Southwest Interdisciplinary Research Center), though our work will expand understanding of how FGM/C is understood and is approached within other ethnic communities. The type of information gathered will serve to guide program implementation, and does not constitute research.

(3) Enhanced referral to care processes and resource acquisition: This funding allows for an information campaign to patients and providers throughout the target areas in Colorado on how to refer to FGM/C specialty care and what services and resources are available. A formalized mechanism with expert patient navigation will assist girl, adolescent, and adult patients seeking Pediatric and OBGYN consults to access Denver Health's dedicated semi-monthly clinic (or access through via telemedicine consult), to address their health concerns. (b)(6)

(b)(6)

(4) Stakeholder education and coordination: This funding will allow local actors (individuals, organizations, institutions) to increase their knowledge of FGM/C through educational sessions and exchanges. The Colorado project will, for the most part, link to existing meeting forums in order to streamline these endeavors to provide education. Key to success is Colorado project's FGM/C-focused connection to an array of stakeholders (law enforcement, education, employment, social services, medical/clinical, religious, etc.). More than 15 refugee-serving contractors, plus a network of 1000+ immigrant and refugee-serving/supporting individuals and organizations to systematically share pertinent training and information will occur. A project advisory group will also be formed. Advisory members will meet quarterly to exchange lessons learned, and identify gaps in programming. Advisory members may include: 1. federal agency partners with a focus that overlaps with FGM/C

activities (Region XIII Departments of Homeland Security, Justice, and Health and Human Services); 2. health department partners working in women's health; 3. clinical providers from local clinics with high refugee and immigrant confluence; 4. immigrant and refugee community members; 5. representative(s) from immigrant and refugee-serving organizations; and 6. Colorado project team members. No FGM/C advisory group exists in the State currently.

(5) Standardized FGM/C training: This funding will support the creation of standard but customizable educational course content for clinical, organizational, and community-based training and education on FGM/C. We will provide in person lectures or series, and strive to make digital educational content available to health professions students and established medical specialty groups and providers. Staff of 78 Title X clinics (serve 43,774 females and 9840 men in 2019) will be targeted as recipients of FGM/C training. The content may include: FGM/C diagnosis, management, treatment, and prevention and management of OB/GYN, urologic, psychosocial complications in girls and women, medical-legal aspects of FGM/C specific to the pediatric population, and child abuse legal parameters in pediatric care. Content will also include an evaluation tool. Given clinical and logistical demands, education needs to be standardized and made virtual in order to reach wider audiences. Due to attrition and organizational staffing shifts, training must be repeated at least once per year. The educational course content can also be incorporated into national Maintenance of Certification (MOC) or Continuing Medical Education (CME). We will link to professional societies and educational entities with the goal of exploring the inclusion of FGM/C content into formal training and certification systems to consistently address provider and health care team knowledge gaps. Funding will provide support for production of this content, as well as time for this funded

team to explore avenues within national CME/MOC requirements to allow the courses to become a training offering for medical providers who will see affected girls and women. No known CME or MOC, nor created educational content on this topic exists formally for Colorado health professions students or providers. Local, national, and international connectivity to medical education networks is exclusive to this project's team members. In addition, funding will support the development of a FGM/C screening protocol for all refugees arriving to the state to utilize during its Refugee Domestic Medical Examination by five Colorado FQHCs. Building on the prior research of (b)(6) on FGM/C questionnaires, a standard protocol for documentation of clinical findings plus a protocol for preemptive counseling for FGM/C prevention and identifying girls' risk of FGM/C will be rolled out. CRSP is the sole entity in the State that oversees the refugee medical screening program and active coordination with and education of screening entities can assure uptake.

(6) Complex defibulation and clitoral reconstruction training: Through community engagement, education, and clinical provision named above, we will evaluate the need by community members for increased consultation and access to clitoral reconstruction and complex defibulation procedures. If the need exists, this funding will provide training for (b)(6) (b)(6) and additional Gynecology providers in surgical techniques involved in complex defibulation procedures and clitoral reconstruction (repair of damage due to FGM/C) by (b)(6) (b)(6) to expand the provision of this procedure in Colorado and the United States.

(7) Increase covered services available for specialized care of affected women/girls: This funding will allow project team members to document gaps in healthcare coverage of services related to FGM/C. Identification of gaps will support a coordinated communication effort with Colorado Health Care Policy and Financing (HCPF) to assure that an increased number of

medications, care and treatment vital to the well-being of victims of FGM/C are covered services under the Medicaid program. No current or previous efforts in this arena have been undertaken. A limited amount of needs-based funding to cover FGM/C-related clinical services and ancillary care for a select number of the most psychosocially or medically complex care patients (where financial or insurance barriers preclude receipt of services) will be available. Funds may be allocated to patients for childcare, travel to/from clinic visits, and copays or costs for visits and medical/surgical management and ancillary care.

b. Project Design and Implementation

The project design and implementation plan outlines how the Colorado project will carry out our seven principle strategies. The execution of time-bound activities will lead to solving the problems, gaps and challenges described above. Specificities of each of the project strategies and how they support the Office for Victims of Crime delineated goal and objectives are contained in the time-task plan. The overarching ***goal*** governing the Colorado project teams' work is to deliver programming to address and help stop the practice of FGM/C. The three project ***objectives*** are: *Objective 1:* Educating providers, law enforcement, public health professionals, and educators on detecting at risk girls in localities where FGM/C is a risk; *Objective 2:* Responding to victims by providing appropriate services; and *Objective 3:* Forming community networks of agencies and organizations that are positioned to identify persons at risk.

The final ***deliverables*** included on the time-task plan correlate with one of the three final deliverables required under Purpose Area 2: *Final deliverable 1*: Direct services to victims of FGM/C, for example, physical and mental health care, advocacy, legal intervention and other services the project sites determine will advance the goal of addressing and helping to stop FGM/C in their community; *Final deliverable 2:* Outreach to at-risk individuals and

communities about FGM/C to increase identification of victims and persons at risk of victimization; and *Final deliverable 3:* A final report describing project activities, promising practices, challenges encountered, and solutions to address those challenges. **The Time Task Plan, covering three years of planned work, is contained as attachment 10.**

c. Capabilities and Competencies

Our team possesses the **institutional experience and expertise** to effectively implement the requirements of Solicitation Number OVC-2020-17550 and the project as planned. We have the necessary credentials, skills, abilities, and training needed to **address FGM/C and stop the practice of FGM/C**, and educate stakeholders and residents of Colorado; we are uniquely primed to do so. Our capabilities and competencies, as well as a strong management structure and financial capacity, are demonstrated in this section of the narrative.

Management Structure and Plan

As applicant, CRSP holds the overall project management role, directing project activities and assuring project outcomes. CRSP is within the Employment and Benefits Division (EBD) of the Colorado Department of Human Services (CDHS). CDHS is the State agency designated by the governor to implement effective refugee resettlement. CRSP does not provide direct services though provides State leadership, coordination, networking, monitoring and systems navigation on behalf of refugees and agencies that assist them, through contracts with public or private partners, faith-based, community-based and other nonprofit organizations.

CRSP convenes its contractors and stakeholders for specific purposes, such as Employment Consortium, Case Management Supervisor Consortium, Medical Screening Workgroup, Family Stabilization Specialist Workgroup and Mental Health Consortium. None of our consortia are required by statute, and many include non-contracted agencies that through

their own organizational priorities and funding also serve refugees. The consortia are all components of ensuring efficient, effective, and elegant contract management.

CRSP contractor performance is based upon the key values of CRSP which are: deliver services that are elegant, effective and efficient; hold ourselves accountable for being client centered; be outcome focused; and leverage costs. These tenants parlay to the proposed procurement contracts (issued by CRSP under CDHS purview; follow established State procurement procedures) that will be put into place to form the Colorado project team.

Each team member holds a specific skill set that is an integral part of the project structure. The six team members, their project title and very brief description of their role (specific responsibilities are laid out in the Time Task Plan; attachment 10) follows. (b)(6)

(b)(6)

Manage community education and outreach efforts. Develop outreach plan. Create modular curriculum to help frame and consistently and accurately deliver the educational efforts. Provide patient navigation to connect women and girls to medical care, treatment and available resources. Carry out community outreach, engagement and education. Participate in FGM/C advocacy work related to the Medicaid program. (b)(6) ***clinical expert (adult) -*** Develop FGM/C educational content. Deliver provider education. Participate in select community education sessions. Establish and coordinate state referral network for FGM/C clinical care of adolescents/adults. Participate in FGM/C advocacy work the state Medicaid program. (b)(6) Carry out community outreach, engagement and education. Provide patient navigation to connect women and girls to medical care, treatment and available resources. Participate in FGM/C advocacy work related to the Medicaid program. (b)(6)

(b)(6) Facilitate advisory group meetings. Lead FGM/C coordination work with the state Medicaid program. Make connections to relevant refugee and immigrant serving network (context and contact information) for Colorado team members. (b)(6) – Develop FGM/C educational content. Deliver provider education. Establish and coordinate state referral network for FGM/C clinical care of girls/adolescents. Participate in select community education sessions. (b)(6) – Design educational content platform.

The detailed biographies presented next document the professional team members' **unique qualifications that enable them to fulfill the grant responsibilities** under this project.

(b)(6) has thirteen years of experience working with refugees and immigrants. She is employed with (b)(6) (b)(6) She is a skilled Community Navigator who supports (b)(6) populations as they strive for self -sufficiency and local integration and at presenting information through home-based meetings and ethnic association gatherings, and encouraging community participation in leadership opportunities. (b)(6)

(b)(6)

(b)(6)

(b)(6) is an Associate Professor of OB/GYN at the (b)(6) and attending physician at (b)(6) (b)(6) She completed her undergraduate training in Biochemistry and German at (b)(6) and medical training and residency in OB/GYN at the (b)(6) She completed a Diploma in Tropical Medicine and Hygiene via the (b)(6) and has her CTropMed® certification. Since 2018, she provides specialized clinical care to women affected by FGM/C, is an active member of the (b)(6) and presented research on FGM/C at the (b)(6) She served as the (b)(6) (b)(6) She has collaborated with the (b)(6) (b)(6) as the OB/GYN lead on HIV, Hepatitis B, and Maternal Mortality guideline implementation initiatives. Her clinical and scholarly interests include (b)(6)

(b)(6)

(b)(6) - For more than five years, (b)(6) has worked in the health care field from senior care living to the (b)(6) (b)(6) is a Care Manager at (b)(6) where she provides patients with the best quality of care regardless of socio-economical background. She creates an open line of communication between patients, healthcare providers, and community resource agencies to address patients' social determinants of health. As an (b)(6) has dedicated years of volunteer work and education to the women's health arena. She is an active member of various (b)(6) groups, and she focuses on improving the lives of immigrants and (b)(6) as a priority. She believes creating awareness about women's health among healthcare providers is the key to stop the practice of FGM/C for the next generation of women. (b)(6) volunteer and professional skills and experience promote the empowerment and well-being of women of all nationalities, regardless of cultural group or social status.

(b)(6) – As a skilled program manager with more than 30 years of program management experience, (b)(6) has been awarded, designed, implemented, monitored, and overseen grants from Health Resources and Services Administration, Pan American Health Organization, Centers for Disease Control and Prevention, United States Agency for International Development, and Office of Refugee Resettlement. She has a Master of Public Health from (b)(6) She has extensively worked on cross-sector collaborative health improvement efforts, and holds strong leadership and coordination capabilities. Since 2015, (b)(6) and represents (b)(6) serves on the (b)(6)

(b)(6)

(b)(6) is a general pediatrician at (b)(6) (b)(6) and an Associate Professor at the (b)(6) (b)(6) She was an undergraduate at (b)(6) received her medical training at (b)(6) and pediatric residency training at the (b)(6) She is the Medical Director of the (b)(6) (b)(6) She is Co-Medical Director of the (b)(6). Her career focus has been in providing care for new immigrants and refugees and has presented talks nationally on the development of standard of care medical screening guidelines for these populations, including the diagnosis and management of FGM/C in children. She is the lead author of the (b)(6) (b)(6) (b)(6) She serves on the Executive Committee of the (b)(6) (b)(6). She is a certified Spanish medical interpreter and is fluent in French.

(b)(6) has worked with refugee youth and families as a teacher and social service worker since 2005 including youth programming and services for vulnerable and unique populations. In 2016 she began working with the (b)(6) (b)(6) n a role that links CRSP to the Division of Child Welfare in the coordination of the Unaccompanied Refugee Minor program. (b)(6) has extensive experience in adult training, educational platforms, (b)(6)

(b)(6)

Financial Capability

CRSP currently manages over 30 contracts tied to federal funding. As federal funding recipients since its inception in the1980s, CRSP has strong systems of fiscal and programmatic monitoring in place that support the Office of Victims of Crime requirements and expectations around sound project management. The CRSP annual federal funding portfolio exceeds $17,000,000. CDHS has offices and staff dedicated entirely to accounting, budget and policy, procurement, grants management, audit, performance management, human resources, communication and information technology. Colorado has an upgraded financial system (Colorado Operations Resource Engine), which comports with federal financial reporting requirements and allows the monitoring of contractual budgets accordingly.

d. Plan for Collecting the Data Required for this Solicitation's Performance Measures

We recognize that Office of Justice Programs will require the submission of regular performance data to demonstrate project results. The Time Task Plan (attachment 10) lays out goals, objectives, and deliverables; a plan to collect progress data against those will be created upon award notification. At a high level, samples of what data may be collected are: Number of community meetings/educational sessions in community with attendance; Change in attitudes, beliefs and knowledge (community members); Change in attitudes, beliefs and knowledge (stakeholders); Number of medical providers and trainees completing training; Change in knowledge (medical providers and trainees); Number of providers reached and engaged in referral network structure; Number of stakeholder education sessions held; Cadres of stakeholders reached through education.

More specifically, our data collection will be geared towards accurate tracking of the performance measures/data that is outlined in the Office for Victims of Crime/Transforming

Victim Services/Performance Measures/Victims Services section (VII). We will be primed to collect encounter-level information (e.g., race/ethnicity, gender identify, age) and types of victimization of those served. Types of services provided by us will also be collected (e.g., information and referral; personal advocacy/accompaniment; emotional support/safety services; shelter/housing services; criminal/civil justice system assistance). As specified in section VII, number of individuals receiving those services, as well as the number of times the service was provided in the reporting period will be tracked. We plan to provide relevant data by submitting quarterly performance data through the Transforming Victim Services module in OVC's online Performance Measurement Tool (located at: https://ovcpmt.ojp.gov/).

CRSP is registered with the Grants Management System (GMS) and is prepared to submit regular performance data through it, as requested or required.

Our team will meet after award notification to develop a written plan for collecting the performance measures data. Key data collection and reporting responsibilities of each team member will be documented in the plan.

Project evaluation work (broadly, to assess community member knowledge, attitudes, beliefs as they pertain to our specific education focus; assess provider knowledge) is intended to generate internal program improvements and frame service delivery. Evaluation efforts will not be designed to contribute to or develop generalizable knowledge and is not human subjects research.

Endnote 1: 1. **Young J** - Presenter, Global Alliance for Nursing and Midwifery, Johns Hopkins School of Nursing, Center for Global Initiatives, Blog post on female genital cutting in children. 2018. Available at: https://ganm.nursing.jhu.edu/optimizing-care-of-women-girls-affected-by-female-genital-cutting-part-3-janine-young-md/; 2. Atkinson H, Carlough M, Curtis M, Fitzgerald K, **Heinrichs G**, Johnson-Agbakwu C, Mishori R, Nour N, Ottenheimer D, Shell-Duncan B, Smart N, Warren N, **Young J.** *Healthcare Sector's Recommendations for Strategies to Respond to FGM/C in the US.* End Violence against Girls, Summit on FGM/C, 12/2016 Washington, DC. Available at: https://www.equalitynow.org/sites/default/files/Summit%20-FGM_Recommendations_HEALTHCARE_sector.pdf; 3. **Young J.** Female genital cutting in immigrant children—Considerations in Treatment and Prevention in the US. *Current Sexual Health Reports*. May 2019, DOI: 10.1007/s11930-019-00200-3. https://rdcu.be/bz9TR; 4. **Young J**, Iman B, Rodrigues K, Johnson-Abakwu C. Female Genital Mutilation/Cutting –Pediatric Physician Knowledge, Training, and General Practice Approach. *Journal of Immigrant and Minority Health* 2019; https://doi.org/10.1007/s10903-019-00938-x; 5. **Young J**. Somali-American teenage girls and women—A hidden refugee population with barriers to health. *American Journal of Public Health*. 110, 18_19, https://doi.org/10.2105/AJPH.2019.305455 2019; 6. In press: **Young J.**, Nour N, Macauley R, Narang S, Johnson-Abakwu C. American Academy of Pediatrics Clinical Report: Diagnosis, Management and Treatment of Female Genital Mutilation/Cutting in Girls. *Pediatrics* 5/2020.

Legal Name of Applicant: Colorado Department of Human Services (Colorado Refugee Services Program) (CRSP)

Purpose Area: Purpose Area 2; Project Site

Title of Project: Colorado Combats Female Genital Mutilation and Cutting (FGM/C) through Community and Clinical Partnership and Education

Geographic Areas to be Served: Highest number of refugees and immigrants: Denver/Aurora, Colorado Springs, Greeley/Ft. Morgan (Adams, Arapahoe, Denver, El Paso, and Weld counties).

Description of Population to be Served: Immigrants and refugees. Victims and girls at risk of FGM/C, family members, community leaders and other stakeholders. Domestic Medical Exam and specialty medical providers and health professions students. Mental health providers, law enforcement, public health professionals, educators and other stakeholders.

List of Project Partners Who Will Assist with the Goals, Objectives, and Deliverables:
Contractors: (b)(6)
(b)(6)

High-level overview of project activities:

1. Conduct community outreach, engagement and education to reduce the risk of FGM/C and improve community member knowledge of: biology and physiology of FGM/C; cultural norms and issues; religion and its connection to FGM/C; family dynamics and support systems; women's empowerment, and legal parameters of FGM/C in the U.S.
2. Document community knowledge, beliefs and practices around FGM/C to share with stakeholders and inform programming in a written compendium that results from formal and informal inquiry and interactions with affected community members.
3. Enhance the referral to FGM/C-related care and resources. An information campaign to patients and providers on how to refer to specialty care and what services and resources are available will be carried out. The project provides patient navigation and access to funding to improve access to FGM/C care, treatment, and ancillary services.
4. Educate and coordinate with stakeholders. We will provide education to individuals, organizations, and institutions to improve knowledge of FGM/C. An advisory group to exchange lessons learned and identify gaps in programming will be formed.
5. Create and deliver standardized FGM/C training to health professions students, medical specialty groups and other providers. Topics may include: FGM/C diagnosis, management, treatment, and prevention and management of OB/GYN, urologic, psychosocial complications in girls and women, medical-legal aspects of FGM/C specific to the pediatric population, and child abuse legal parameters in pediatric care.
6. Training in complex defibulation and clitoral reconstruction will be provided to up to four OB/GYN providers.
7. Increase covered services available for specialized FGM/C-related care of affected women/girls through coordination with State Medicaid entity and provision of needs-based funds to cover clinical and ancillary services needs of victims.

Federal funding requested for the 36-month project period: (b)(4)
(b)(4) for a total of $310,398.

OMB Approval No. 0348-0043

APPLICATION FOR	2. DATE SUBMITTED 04/29/2020	APPLICATION IDENTIFIER
1.TYPE OF SUBMISSION	3. DATE RECEIVED BY STATE	STATE APPLICATION IDENTIFIER
	4. DATE RECEIVED BY FEDERAL AGENCY	FEDERAL IDENTIFIER

5. APPLICANT INFORMATION

Legal Name	Organizational Unit
Colorado Department of Human Services	Office of Economic Security
Address (city, state, and zip code) 1120 Lincoln Street Suite 1007 Denver, Colorado 80203-2138	**Name and telephone number of the person to be contacted on matters involving this application** (b)(6)
6. EMPLOYER IDENTIFICATION NUMBER (EIN) (b)(4)	**7. TYPE OF APPLICANT** State
8. TYPE OF APPLICATION New	**9. NAME OF FEDERAL AGENCY** Office for Victims of Crime
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE Number: 16.582 CFDA Title: Crime Victim Assistance/Discretionary Grants	**11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT** Colorado Combats Female Genital Mutilation and Cutting (FGM/C) through Community and Clinical Partnership and Education
12. AREAS AFFECTED BY PROJECT	

13. PROPOSED PROJECT		14. CONGRESSIONAL DISTRICT(S) OF	
Start Date: 10/01/2020	Ending Date: 09/30/2023	a. Applicant	b. Project

15. ESTIMATED FUNDING		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. Federal	(b)(4)	Program is not covered by E.O. 12372
b. Applicant		
c. State		
d. Local		
e. Other		
f. Program Income		17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT? N
g. Total	$310,398	

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS REQUIRED.

a. Typed Name of Authorized Representative	b. Title	c. Telephone number
(b)(6)		
d. Signature of Authorized Representative		e. Date Signed

Cultural Modernity: Addressing FGM

in Greater Los Angeles and San Diego Counties

Program Narrative

Description of the Issue

Female genital mutilation (FGM), also known as Female Genital Cutting (FGC) is an injurious cultural practice employed in as many as 29 countries of origin in Africa, Asia, the Middle East, Eastern Europe, and South America. The term encompasses the ritual partial or total cutting or removal of the external female genitalia or the sealing or stitching closed of the labia. The practice has no medical application and is harmful to the short- and long-term health of FCM victims on numerous levels.

FGM is a direct cause of severe immediate and long-term physical and mental health consequences. It causes urination problems, chronic infections, the formation of cysts, and in most extreme cases, death. FGM-affected women are at greater risk of experiencing complications during childbirth such as prolonged labor, post-partum hemorrhage and obstetric fistula. Due to complications caused by FGM and lack of culturally sensitive education amongst medical practitioners, women affected by FGM are more likely to undergo more expensive procedures such as caesarean deliveries (C-section) resulting in a longer recovery process and an increased financial burden. FGM also increases a woman's likelihood of having a low birth weight infant or still birth. Mental health consequences include shock upon experiencing the painful and frightening procedure, and in the long-term, post-traumatic stress disorder (PTSD), anxiety, depression, memory loss, sleeping disorders, reduced social functioning, feelings of worthlessness, guilt, emotional distancing, inability to trust others, social isolation, flashbacks and suicidal ideation.

The World Health Organization classifies female genital cutting into four types of procedures: 1) Clitoridectomy partial or total removal of the clitoris; 2) Excision partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora; 3) Sealing cutting and stitching together of the labia minora or labia majora to form a seal and infibulation (the closing off of the vulva), the additional removal of the clitoris after sealing: and 4) Any other harmful procedure to female genitalia tissue for non-medical reasons, including burning, piercing, or scraping.

The practice of FGM has migrated to the United States with refugees fleeing from terrible violent conflicts. Nile Sisters Development Initiative's (NSDI) service areas, Greater Los Angeles and San Diego Counties are hot spots in the nation for FGM. An analysis of the American Community Survey from 2013 by the Population Reference Bureau (PRB), listed Los Angeles and San Diego as the most impacted regions with 23,216, and 7,777 women and girls potentially at risk of FGM, respectively. Currently, it is estimated that approximately, 37,500 women and girls in Southern California are at potential risk of experiencing FGM. We believe that many more refugees have relocated in the last seven years to these two cities in the warm climate of southern California and that the numbers of women and girls at risk of FGM has grown exponentially. San Diego County is estimated to have at least 150,000 refugees that have settled in the area over the last twelve or so years. The refugee population in Greater Los Angeles area is more difficult to enumerate because it extends over a much longer period. However, we do know that between 1995-2016 close to 90,000 refugees from Africa, Asia and the Middle East settled in the Los Angeles area.

In Greater Los Angeles efforts to address FGM have been limited to promoting awareness of this inhumane practice by the nonprofit and CBO communities. Additionally, we

have heard that intermittently the U.S. Immigration and Customs Enforcement (ICE) arm of Homeland Security has questioned young girls returning to U.S. from countries which practice FGM about their experiences and treatment abroad. ICE has also posted warnings at airports about the illegality of FGM and vacation cutting (the practice of taking a girl to another country to have circumcision performed). Gaps exist in the areas of outreach to families with young children at risk for cutting and current FGM sufferers, FGM education and prevention, and the provision of culturally competent healthcare and behavioral wellness services.

Since July of 2019, San Diego County has been without organized efforts to address FGM by providing outreach, education, or medical services to victims and girls at-risk. From 2016-2019, as a partner and collaborator, NDSI provided FGM outreach and education to hundreds of women and families underwritten by a three-year grant to Family Health Centers of San Diego from the U.S. Department of Health and Human Services, Office on Womens' Health to provide culturally competent medical care for FGM victims and FGM prevention education.

NSDI knows that there are numerous challenges to improving outcomes for FGM victims and girls at risk. Most of these challenges can be addressed through our persistence; because of our reputation in our service communities, the trust we have gained over the years, and our knowledge of FGM and how to reach our communities. Our awareness and experience lend us the perspective to take into consideration the following barriers.

1) U.S. laws regarding FGM do not currently support effective prosecution. A federal ban that had been in place for more than two decades was found unconstitutional in 2018. This means that FGM crimes must be prosecuted at the state level. As of March 27, 2020, 13 states have no laws on their books banning the practice. Crimes like FGM typically do not receive a high priority because they mainly affect a certain demographic in the US: immigrant women.

The will to prosecute does not seem to be strong or widespread. Current laws are not being adhered to in regard to protecting the most vulnerable and at risk population, which is girls between the ages of 0 and 5, especially in cases of vacation cutting. Thus, perpetrators may be encouraged to continue to practice without consideration for any legal consequences. Mainstream law enforcement personnel are disconnected from the communities in which FGM is practiced and are unable to detect the crime and enforce the law.

2) Discussing FGM in the refugee communities has been largely taboo but seems to be changing as peers discuss the issue. However, looking for medical services or guidance is discouraged by the community and the shame felt by many FGM victims often prevents them from seeking help.

3) In communities which still hold traditional cultural values and beliefs, girls are unmarriageable unless they are circumcised. There is a stigma for women who advocate against the practice openly; therefore, it is up to the men to embrace modernity and choose health for the women in their lives who bear their children.

4) The size and prevalence of the FGM problem is unknown because it is well hidden in the community.

5) There is a shortage of culturally competent healthcare providers and counselors serving refugee and immigrant communities. Many mainstream providers are unaware of this practice and are often caught off guard when they witness their first case. This creates a feeling of discomfort for women and girls and an added layer of why they don't seek help. They don't like feeling like a case study during a routine visit.

6) Cultural, lingual, and trust barriers exist for women who seek help. Additionally, most FGM victims have a very limited knowledge of what is available medically to support the issues

they may be facing including cyst removal and deinfibulation (the cutting of a female's vulva that has been stitched together), etc. Some women feel they have no choice but to suffer in silence or they are afraid of the stigma of reconstruction procedures to mitigate any further damage caused by FGM.

7) Privacy regulations designed to protect clients prevent medical care providers and CBO's like NSDI from tracking or communicating with FGM victims about procedures that could benefit them and contacting the families of girls at-risk of cutting. The inability to maintain databases with the names and contact information of those affected by FGM is a barrier to networking to identify those at risk and organizing the community of victims to stand up against FGM preventing it in the future.

With our vast experience aiding refugee and immigrant communities and the support of the OVC, NSDI proposes to embark on a new and vital three-year program providing outreach, education, behavioral wellness counseling, medical and legal referrals, and job training and placement to women who suffer FGM and the families of girls at risk of being cut.

Our program titled "Cultural Modernity: Addressing FGM in Greater Los Angeles and San Diego Counties" has the following goals: 1) Serve 100 women affected by, and girls at risk of FGM and their families. 2) On an ongoing basis make contact with target audiences from refugee and immigrant communities from Africa, Asia, and the Middle East consisting of FGM victims of all ages and families with young children. 3) Provide two educational workshops on family and women's health and behavioral wellness. 4) Make workshop videos or podcasts available online at several different sites, make educational materials available online in conjunction with digital interpreters such as Google Translate which supports 103 languages. 5) Enroll women and families in our counseling sessions lead by culturally competent mental health

professionals. 6) Provide referrals to culturally competent medical care providers who can address the health complications of FGM and suggest preventative health measures, as well as deinfibulation or reconstruction procedures. 7) Provide referrals for legal services, if needed. 8) Provide job training and placement. 9) Perform advocacy for the prevention of FGM.

Unfortunately, other CBO leaders in our service areas believe that FGM is a phenomenon of the past and are making no effort to provide services for its victims who continue to suffer from its deleterious physical and mental health effects. These CBOs represent cultures in which FGM is prevalent and they do not necessarily pass judgement on the practice but accept it as part of the culture. They are taking no actions to prevent the future and ongoing illegal and inhumane occurrence of FGM in regard to young girls. They are conveniently closing their eyes to a hidden yet pernicious phenomenon locally and foregoing the international goal of the United Nations to eliminate FGM by 2030 globally. After our three years' experience reaching out to FGM victims and providing education on culturally competent medical services offered for FGM victims and the prevention of FGM in the next generation, we know there are too many women suffering in silence, shame, and ignorance. We also know that it is our responsibility to plant the seed of cultural modernity and the cessation of FGM forced upon our girls forever changing their lives and destroying their health. Furthermore, the United Nations confirms the practice of FGM has devasting economic effects globally, with countries spending as much 10 – 30% of their annual expenditures treating FGM-related complications, which amounts to 1.4 billion globally per year. The medical and economic toll of treating FGM is felt locally in Southern California as documented by KPBS (NPR affiliate station) in 2016.

Project Design

The project design for "Cultural Modernity: Addressing FGM in Greater Los Angeles and San Diego Counties" includes several approaches or dimensions to achieve its goals. The crime of FGM is traumatic to the victims and our activities take this into consideration. Our program goals include: 1) Serving 100 women affected by, and girls at risk of FGM and their families. 2) On an ongoing basis, make contact with target audiences from refugee and immigrant communities from Africa, Asia, and the Middle East consisting of FGM victims of all ages and families with young children. 3) Provide two educational workshops on family and women's health and behavioral wellness. 4) Make educational workshop videos, podcasts, and materials available online for low-literacy learners in conjunction with digital interpreters such as Google Translate. Create and make available an interactive and culturally relevant free mobile app for access to FGM resources and education. 5) Enroll women and families in our counseling sessions lead by culturally competent mental health professionals. 6) Provide referrals to culturally competent medical care providers who can address the health complications of FGM, preventative measures, as well as reconstruction procedures. 7) Provide referrals for legal services. 8) Provide job training and placement. 9) Perform advocacy for the prevention of FGM.

Counseling services will be provided one day a week, as will career development, training, and job placement. Medical and legal referrals will be provided as needed any day of the week. Case management for other wrap-around services will be provided as needed any day of the week. Our two educational workshops will each occur once a year. Outreach staff will attend six to ten outside events as they occur. Outreach activities will be ongoing. Advocacy will occur on an ongoing basis. Online materials including educational videos and our FGM app will be available 24/7. As long as COVID-19 and social distancing continue to be an issue, the full complement of our programming will be delivered via technological solutions.

OUTREACH -- NSDI will go to the community and recruit volunteer **Peer Navigators** who themselves are FGM survivors or cultural peers who have embraced FGM prevention and will spread the word about and promote involvement in the program at gatherings, partner community events, and through social media, email and telephone. Our Peer Navigators will receive incentives to make contact with their communities like our successful Behavioral Health Navigators have over the past three years for a program that raises awareness of behavioral and mental health and wellness. The Peer Navigators will provide emotional and community support to other FGM victims and young girls who are at risk of cutting. NSDI staff including our Community Engagement Specialist and Outreach Assistants will create culturally proficient and low literacy accessible printed materials promoting our FGM services and educational workshops while the Peer Navigators will distribute and post the notices and handouts at daycare centers, schools, churches, mosques, other CBO's, agencies that provide services to the community, laundromats, barber shops, markets, healthcare providers, etc. NSDI outreach staff will also conduct tabling, introduce our services, and circulate information at community events our target audience is likely to attend.

EDUCATION -- Our educational campaign will include two online 10-minute videos, "Family and Women's Healthcare" and "Behavioral Wellness". Information will be provided by subject experts -- with translations. Links to other videos exploring the journeys of FGM survivors will be available on our website as will a free interactive mobile and discreet FGM app that is convenient and can preserve one's privacy. The app will include two tabs, one educational, the other providing resources for culturally competent medical, behavioral wellness, and legal assistance. The app will integrate a translator such as Google Translator with 103 languages or will use software to provide five different language translations (the most common

spoken by our refugee and immigrant communities – Amharic, Somali, Arabic, French, and Swahili). This unique app will be developed by a qualified IT professional we have used to develop a similar app in the past. These technological approaches will be available on our social media sites and on an interactive webpage of the NSDI Los Angeles and San Diego websites. The program will also include the two workshops with subject matter experts mentioned above as live 1.5-2-hour workshops each occurring once a year at both locations. Men will be recruited and invited to attend and participate in these workshops which will discuss the prevention of FGM. Interpreters will be present at these workshops.

NSDI knows that immigrant and refugee men will be a huge part of the solution to precipitate and accept FGM prevention and the cessation of the practice. In this spirit we will create a male advisory committee to help us develop a culturally relevant curriculum to educate males on their important role to end FGM practices. This curriculum will be merged into our second workshop "Behavioral Wellness". We will recruit 5-10 men who are members of three generations, starting at age 18 and including their father's their grandfather's generations. The advisory group will telecommute bi-weekly for 1.5-hour meetings over a four to six-month period. Like our female peer navigators these men will receive incentives for their participation.

SERVICES – NSDI will provide behavioral healthcare counseling by culturally competent behavioral health professionals who are immigrants themselves and will provide volunteer hours for the program. Counselors will address client's individual needs and preserve their safety and confidentiality by not sharing information and keeping file locked up at all times when not in use. Counseling will be available for FGM victims as well as family members including husbands. Should COVID-19 social distancing practices still be active during any part of the grant period, counseling, therapy and case management will be delivered via teletherapy

technology currently used by NSDI. We will make referrals to culturally competent medical providers and legal services. NSDI will also provide case management in regard to any additional previously unmentioned needs our participants may have including sourcing food, clothing, shelter, unemployment, victim of crime services, and victim compensation programs. Our job training program for Certified Nursing Assistants will be available and career development and job placement guidance will be provided at our offices.

ADVOCACY – NSDI will brief lawmakers, decision-makers and public health officials at the local (focusing on Greater Los Angeles especially) and state levels on our program and at the same time educate them about FGM and the need for stronger laws and enforcement. The NSDI president & CEO will participate in conferences and share information about our FGM program at networking and coalition meetings with African Communities for Health Coalition, Antelope Valley Partners for Health, the Female Genital Mutilation Taskforce of Greater Los Angeles, the Los Angeles Refugee Forum, the San Diego Refugee Forum, East African Coalition, Social Advocates for Youth (SAY San Diego) - Crawford Community Connection and Refugee Families Together Network, and the MIND network). NSDI will host quarterly meetings with community stakeholders including schools, daycare providers in high impact areas and social service and health care providers. This will serve three purposes. It will give us an opportunity to let these stakeholders know about the progress of our program, educate them about FGM, and transform these entities into allies for our cause who will then send the message further into the community notifying more potential clients including young girls at risk of cutting and their families.

SERVICE CHALLENGES -- "Cultural Modernity: Addressing FGM in Greater Los Angeles and San Diego Counties" will work to solve the issues previously identified as barriers

to achieving services for FGM victims and those at risk on pages 3 and 4 with the exception of barrier 1) lack of FGM law enforcement (we will let the grantee of Purpose Area 1 address this). Please see below how the program will address the issues and support our goals or objectives.

2) The stigma preventing FGM victims from seeking medical and behavioral wellness help will be countered through the support of FGM survivors and education. Our program plan includes the use of Peer Navigators from area refugee and immigrant communities. These women will be FMG survivors themselves or cultural peers who have embraced FGM prevention and will provide emotional support to women who need to receive life-changing and lifesaving care and live in fear of being stigmatized by their community, family and friends. The Peer Navigators will provide a network and a new community of support from peers who have stepped outside the outdated cultural beliefs to accept life confirming practices. Part of our educational process will include videos of women who have, in spite of stigmas, sought medical care and FGM reconstruction procedures and share their journeys.

3) Women are stigmatized for advocating against the practice of FGM. We will be educating men about the deleterious health effects of FGM and their responsibility to help prevent a new generation from becoming victims of crime. If men stand up and say they will allow their sons and grandsons to marry women who have not been circumcised, we will achieve cultural modernity and the end of an age-old abhorrent human rights violation and gender-based violent practice of FGM which ruins lives of women and girls.

4) The size and prevalence of the FGM problem is unknown because it is well hidden in the community. Our FGM Peer Navigators and outreach staff will network within the community and connect with victims of crime and girls at risk. The program will record numbers of underserved victims and those at risk enabling estimations of the size and depth of the problem.

5) Although there is a shortage of culturally competent healthcare providers, we will provide contact information for those providers that meet our standards for cultural competence. Additionally, we will encourage refugee and immigrant women to go into medical professions by providing them entry level training as certified nursing assistants (CNAs).

6) Cultural, lingual, and trust barriers exist for women who seek help and they most likely are not aware of what medical procedures are available. Our Peer Navigators who will provide emotional support, "Family and Women's Health", "Behavioral Wellness" workshops, our interactive mobile app, culturally competent counselors, and our referrals to culturally competent providers will address these issues by providing emotional and educational support with a discussion of relevant medical procedures.

7) Although privacy regulations prevent us from keeping a database of FGM victims and girls at risk, our outreach and networking campaign will rediscover already known FGM victims and girls at risk along with those who have not been discovered in the past. Additionally, we will educate the whole family about prevention avoiding the issue of organizing victims through the use of a database.

Capabilities and Competencies

FGM is a subject NSDI, (b)(6) a health educator and a refugee from (b)(6) has been very familiar with since its founding in 2001. NSDI has supported an estimated 3,000 FGM victims over the last 19 years. The organization has provided education and translations on FGM health issues, made medical referrals, provided education to refugees and immigrants on U.S. laws that govern FGM, applied for health insurance for FGM clients and taken them to the hospital. Five years ago, we began providing behavioral health services and

counseling specifically for women and girls affected by FGM. More than 90% of our African female refugee and immigrant clients have self-reported they are victims of FGM.

The mission of the organization is to educate, support, and offer training to refugee and immigrant women and their families to help them overcome barriers to social and economic self-reliance. Since its inception, NSDI has provided culturally and linguistically proficient services to refugees and immigrants on topics ranging from reproductive health education and FGM to employment to domestic violence. Because of our extensive background and trusted status in the community, our primary populations are receptive to the information and resources we provide.

A core function of NSDI's programming is to provide culturally and linguistically proficient services to refugees and immigrants. As a community-based initiative, we continuously strive to work with like-minded partners to generate widespread impact. NSDI belongs to several consortia including the Female Genital Mutilation Taskforce of Greater Los Angeles, the Los Angeles Refugee Forum, African Communities for Health Coalition, Antelope Valley Partners for Health, the San Diego Refugee Forum, East African Coalition, Social Advocates for Youth (SAY San Diego) - Crawford Community Connection and Refugee Families Together Network, and the MIND network. We refer clients to culturally competent health care providers such as Glendale Health Center, Antelope Valley Health Center, and Family Health Centers of San Diego.

NSDI provided the outreach and education components for the U.S. Department of Health and Human Services' three-year grant funded program (2016-2019) for developing culturally competent medical care and prevention for FGM victims. NSDI developed all educational and advocational materials, including 3-D models of the four types of FGM for the education of law enforcement and academia; an FGM report titled "Defenseless Against Female

Genital Cutting"; A Factsheet: Female Genital Cutting in California; NSDI Infographics 1 & 2: FGC, a Reality in San Diego (this includes a breakdown on practices by country of origin and who is at risk in San Diego County); an FGM Power Point Presentation; a tool kit containing a list of short- and long-term health conditions associated with FGM; and championed State of California, Senate Resolution – 17, introduced by Senator Toni Atkins citing February 6, 2017 as Female Genital Mutilation and Cutting Awareness Day in California; and an FGM video discussion with FGM victims and culturally competent healthcare practitioners made in collaboration with Family Health Centers of San Diego.

In 2016, NSDI was the primary organizer of MIND (Matters Involving Neuro-Disorders), a network of CBO's, government agencies, educators, healthcare, and behavioral healthcare providers. NSDI has been in the forefront of identifying mental health issues affecting our refugee and immigrant populations not only because of war, genocide, torture, and starvation, but also because of FGM and its victims dealing with trauma, fear, depression, and anxiety.

In 2017, NSDI was awarded a $260,000 2-year grant from California Governor's Office of Emergency Services, Victim Services & Public Safety Branch for the education of refugees and other underserved victims of crime about behavioral wellness and the provision of therapeutic counseling services, victim compensation services to the community including FGC victims. The program was renewed for another year and will end in December 2020. Thus far the program has served more than 300 individuals and their family members with the committed help of volunteer Behavioral Health Navigators from the community and volunteer mental health professionals. NSDI has fulfilled all reporting requirements and achieved its annual goals.

For our new FGM program, the NSDI Los Angeles and San Diego offices will be staffed by five personnel spending approximately equivalent amounts of their time working with each of

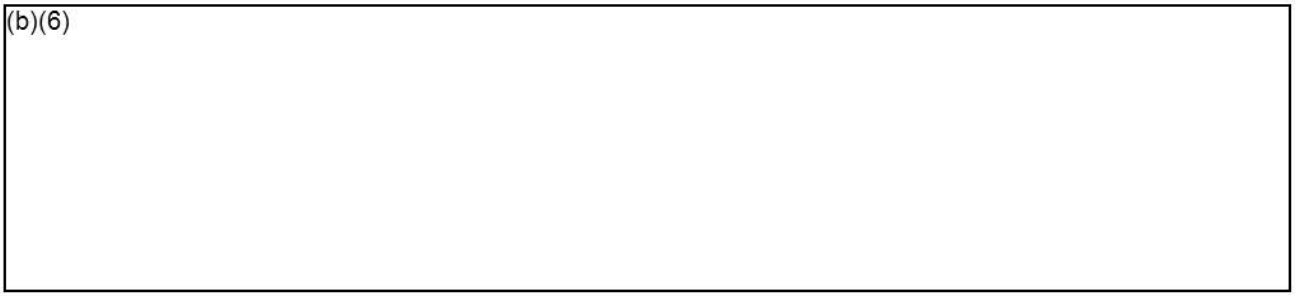
the two areas. This will include the (b)(6) (b)(6) Additionally, the Los Angeles office and the San Diego office will each have an Outreach Assistant and volunteer Peer Navigators from the refugee and immigrant communities we serve.

(b)(6)

(b)(6) will handle (b)(6), manage higher level administrative tasks, consolidate partnerships with collaborators, perform advocacy, network with other organizations, and participate in coalition meetings and conferences. She will be the face of the NSDI FGM program.

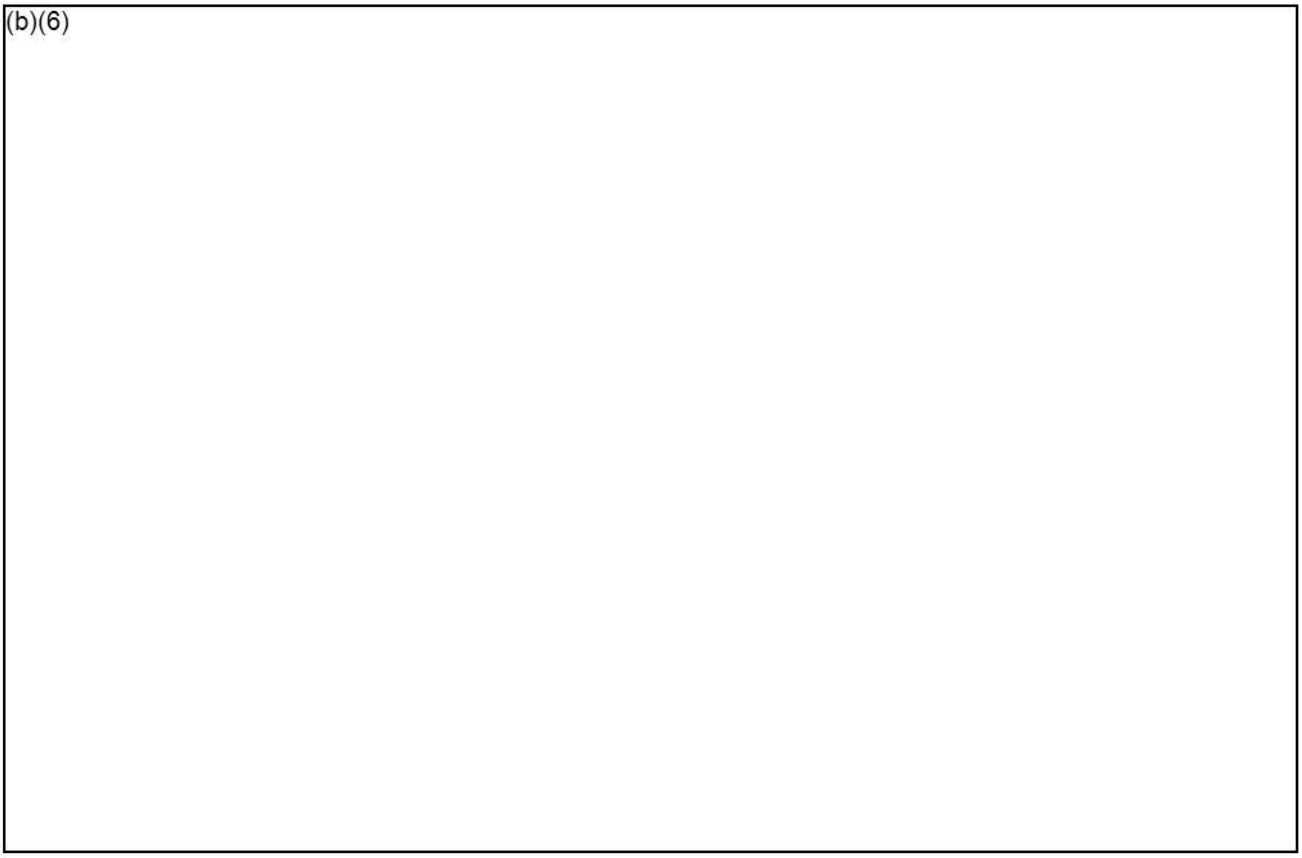
(b)(6)

(b)(6)



(b)(6)

for the organization. She will be responsible for the financial reporting for the FGM program and making sure the fiscal end of the project is sound. She will also purchase supplies and interact with the bookkeeper. Previously (b)(6) and will provide technical assistance to the Senior Program Manager and new Program Manager as needed.



(b)(6) She will establish reporting procedures, manage data, and produce reports quarterly for the NSDI FGM program in Los

Angeles and San Diego. (b)(6) will also supervise the Program Manager (to be hired). (b)(6) earned her Bachelor of Arts degree from (b)(6) with a focus in International Studies, Anthropology, and Spanish. She studied in (b)(6) and worked as a health education volunteer in (b)(6). (b)(6) has worked in underserved communities of (b)(6) Her experience includes youth empowerment, violence prevention, and health and nutrition initiatives. (b)(6) currently oversees the (b)(6) (b)(6)

Program Manager (to be hired) will develop, organize and facilitate workshops, develop a new FGM mobile app and web page, engage subject-matter experts for workshops, and stakeholders. The position will report to the Senior Program Manager and will supervise the Community Engagement Specialist and Outreach Assistants. The program manager will also interface with the volunteer Peer Navigators for the project. This staff position will require a minimum of a bachelor's degree, at least two years coordinating or managing service programs, the ability to work productively with people of other cultures, and excellent communication and organizational skills. The ability to speak at least one other language is preferred.

(b)(6) will spearhead outreach for the FGM program. She will be the frontline representative for NSDI meeting new and potential clients, connecting them with direct services, and providing case management. (b)(6) graduated from (b)(6) with a degree in Philosophy and a minor Global Health. Before joining NSDI, she worked for the (b)(6) While at (b)(6) was (b)(6) for the (b)(6) which is a youth outreach program working to empower students and their families to achieve their long-term

personal and professional aspirations. (b)(6) is passionate about addressing health disparities and the inequitable access to quality healthcare that affect our most vulnerable communities.

Outreach Assistants (two to be hired) will support the Community Engagement Specialist and report to the Program Manager one in Greater Los Angeles and one in San Diego County. This position will create handouts promoting NSDI workshops and services for those affected by FGM, electronic newsletters and social media outreach, manage data as needed for the project and support volunteer Peer Navigators with community outreach. Requirements for this position include at least one year of college with continued enrollment, good communications and technical skills, and the ability to work productively with people of other cultures. Preferred interests in women's health, anthropology, international relations, minority studies, diversity, cultures or languages from Africa, Asia or the Middle East.

Peer Navigators - will be knowledgeable about the cultural practice of FGM or will be victims themselves. They will provide emotional/cultural support to FGM victims, promote the project – deliver the message to refugee and immigrant communities, by frequenting events, parks, formal/informal gatherings, via social media, email, and by telephone. They will also deliver and post notices and handouts to schools, churches, mosques, CBO's, agencies that provide services to the community, laundromats, barber shops, markets, healthcare providers.

FGM Curriculum Advisory Committee – male community volunteers will be recruited to help NSDI create a workshop curriculum that is responsive to their cultural predispositions and will sensitively educate other men about the deleterious mental and medical health effects of FGM and the important benefits of ending the cultural practice for women, men, and society.

Behavioral Health Professionals – will be providing volunteer counseling services for FGM victims and their families. Our counseling staff is comprised of (b)(6), Ph.D.

with a PsyD in Psychology, (ABD) and a M.A. in Counseling and (b)(6) (b)(6) with a Ph. D. in Educational Psychology and an M.A. in Counseling Psychology. We will be recruiting additional culturally competent mental health professionals for the program.

Plan for Collecting Data Indicating Performance Measures

Our Senior Program Manager will collect and track our performance data using the Oasis case database system with the assistance of our Outreach Assistants. Most of the data will initially be collected via office walk-in through an interactive electronic sign-in which interfaces with Oasis. Clients and potential clients will be asked to respond to questions relevant to our program and performance tracking needs.

In addition to producing a final report describing program activities, promising practices, challenges, encountered, and how to address those challenges, we will be collecting the following data and reporting quarterly: 1) Number of participants who experience our counseling services and the frequency that they attend counseling sessions; 2) Number of participants who receive warm hand-off referrals and accompaniment for medical or legal service; 3) Number of participants who take advantage of our career development, job training or placement services; 4) Number of individuals we connect with via our different outreach modes and activities (social media, email, telephone, our website, posted notices, events, gathering places); 5) Number of potential FGM victims we identify; 6) Number of individuals who access each of our educational workshop videos online; 7) Number of individuals who access our FGM webpage; 8) Number of individuals who download our FGM app. 9) Number of communications with our advocacy audience and whom has been contacted; 10) Number of stakeholder attendees at our quarterly FGM meetings; 11) Number of conferences, networking and coalition meetings relevant to FGM attended by staff. 12) Participants in our educational workshops will be given written or oral pre-

and post-surveys to determine behavioral attitude changes. A count of survey responses will be included in our evaluation process.

Additionally, to meet the specific requirements of the OVC we will collect the following information indicating grant performance measures during the reporting period: 1) Percent of victims served who are new (and number of individuals who are new will be reported); 2) Percent of victims served who were the victims of a violent crime; 3) Average number of services provided per victim; 4) Total number of individuals who received services; 5) Total number of anonymous contacts received; 6) Number of new FGM clients who received services for the first time; 7) Numbers of new clients self-reporting in each ethnicity category, gender identity category, and age category; 8) Numbers of clients and anonymous individuals who received services by victimization types (categories), numbers who reported more than one type of victimization, and numbers of victims who fall into one or more "Special Classifications" categories; 9) Number of individuals assisted with a victim compensation application during the reporting period; 10) Report the types of services provided (information and referral, personal advocacy/accompaniment, emotional support/safety services, shelter/housing services, criminal/civil justice system assistance); 11) Total number of individuals who received services by one of six different service types and number of times each service was provided; 12) Total number of individuals who received personal advocacy/accompaniment services and numbers in each of ten subcategories - total numbers of individuals receiving emotional support/safety services and numbers occurring in each of seven categories, total number receiving shelter/housing services and numbers in each of three categories, total number receiving criminal/civil justice system assistance and numbers in each of 11 categories.

Abstract

Cultural Modernity: Addressing FGM

in Greater Los Angeles and San Diego Counties

Niles Sisters Development Initiative (NSDI) is applying to the OVC under Purpose Area 2: Project Sites (OVC 2020-17555) for funds in the amount of $299,980 to provide the above titled program to FGM victims and girls at risk of FGM who are members of refugee and immigrant communities originating in Africa, Asia, Eastern Europe, South America and the Middle East. NDSI will serve a wide range of Greater Los Angeles and San Diego County communities. Included are Glendale, Antelope Valley, Little Bangladesh, East Hollywood, South Fairfax, El Cajon, City Heights, Lemon Grove, Linda Vista, and Southeast San Diego.

Project activities include the provision of behavioral health counseling, education, prevention strategies, advocacy for FGM prevention, referrals to culturally competent healthcare providers and pro bono legal services, entry level training in nursing and job placement. All services will be provided via technology while social distancing continues to be an issue.

NSDI will host quarterly meetings with community stakeholders including schools, daycare providers, and social service and health care providers in high impact areas. Partners for NDSI's FGM program include: Female Genital Mutilation Taskforce of Greater Los Angeles, the Los Angeles Refugee Forum, the San Diego Refugee Forum, African Communities for Health Coalition, Antelope Valley Partners for Health, East African Coalition, Casa Cornelia Law Center, Social Advocates for Youth (SAY San Diego) - Crawford Community Connection and Refugee Families Together Network, and the MIND network. We will refer FGM clients to Glendale Health Center, Antelope Valley Health Center, and Family Health Centers of San Diego for culturally competent medical services.

OMB Approval No. 0348-0043

APPLICATION FOR

2. DATE SUBMITTED	APPLICATION IDENTIFIER
06/03/2020	

1.TYPE OF SUBMISSION	3. DATE RECEIVED BY STATE	STATE APPLICATION IDENTIFIER
Application Non-Construction	4. DATE RECEIVED BY FEDERAL AGENCY	FEDERAL IDENTIFIER

5. APPLICANT INFORMATION

Legal Name	Organizational Unit
Nile Sisters Development Initiative	Administration

Address (city, state, and zip code)	Name and telephone number of the person to be contacted on matters involving this application
5532 El Cajon Blvd. Suite 5 San Diego, California 92115-3642	(b)(6)

6. EMPLOYER IDENTIFICATION NUMBER (EIN)	7. TYPE OF APPLICANT
(b)(4)	Human Services Organization

8. TYPE OF APPLICATION	9. NAME OF FEDERAL AGENCY
Revision	Office for Victims of Crime

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT
Number: 16.582 CFDA Title: Crime Victim Assistance/Discretionary Grants	Cultural Modernity: Addressing FGM in Greater Los Angeles and San Diego Counties

12. AREAS AFFECTED BY PROJECT	
Los Angeles and San Diego, CA	

13. PROPOSED PROJECT		14. CONGRESSIONAL DISTRICT(S) OF	
Start Date:	Ending Date:	a. Applicant	b. Project
10/01/2020	09/30/2023	CA53	CA53,CA28

15. ESTIMATED FUNDING		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. Federal	$299,980	This preapplication/application was made available to the state executive order 12372 process for review on 04/29/2020
b. Applicant	$0	
c. State	$0	
d. Local	$0	
e. Other	$0	
f. Program Income	$0	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?
g. Total	$299,980	N

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS REQUIRED.

a. Typed Name of Authorized Representative	b. Title	c. Telephone number
(b)(6)		
d. Signature of Authorized Representative		e. Date Signed

Task plan, Year 1

Objective	Activities	1	2	3	4	5	6	7	8	9	10	12	Deliverables
Objective 1 To increase safety and improve well-being of women who have endured FGM/C	Expanding existent holistic wrap-around direct services to women. See the stages below	x	x	x	x	x	x	x	x	x	x	x	50 victims of FGM served. 100% receive professional help; 70% provided with FGM/C women wellness education; 100% to access healthcare; 70% - mental health services
	Training UST service providers	x	x										2 case managers, 5 liaisons and 2 supervisors trained
	Recruiting participants			x	x	x	x						
	Intake and service planning		x	x	x								50 intake and 50 services plans
	Service provision according to the service pan			x	x	x	x	x	x	x	x	x	
Objective 2 To facilitate faster integration of FGM/C victims into the US society	Providing community referrals and follow ups that address all needs of women with FGC and girls at risk survivors	x	x	x	x	x	x	x	x	x	x	x	At least 100 community referrals utility assistance through benefit coordination; 200 follow-ups will be conducted
Objective 3 To generate families' opposition to FGM/C	Parents education				x	x	x	x	x	x	x	x	30 parents will attend groups and 30 will meet individually with case workers. 40% will change their attitude towards FGM/C; 80% will learn about the harm of the procedure.

	1. Individual meetings mothers of at-risk girls					**x**	**x**	**x**	**x**	**x**	**x**	**x**	20 mothers will meet with case workers
	2. Individual meeting with fathers of at-risk girls									**x**	**x**	**x**	10 fathers will meet with case workers
	3. Parenting groups W=women; M=men (2 sessions bi-weekly)						W	W	M		W	M	30 individuals to attend the groups
Objective 4 To influence FGMC-related norms in ethnic communities and to educate larger community about this issue	Identifying community liaisons Somali=S; Liberian=L; Sierra Leone=S/L; Ethiopian/Eritrean =E; Arabic Speaking =A	S E	L A	S/ L									5 community leaders will be recruited in five ethnic communities and 5 community liaisons will be providing information in immigrant communities;
	Training community leaders and liaisons					**x**	**x**	**x**	**x**	**x**			5 community liaisons will be trained to provide FGM/C information and identify girls at risk
	Community Presentations					**x**	**x**	**x**	**x**	**x**			10 community presentations and trainings will be offered to service providers in the area
	Recruiting members for the Community Response to FGM/C Coalition			**x**	**x**		**x**	**x**	**x**	**x**			
	Coalition Launch										**x**	**x**	First meeting and plan of action
Outreach and professional education	The picture and plan in proposal		**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	At least 8 organizations working in healthcare, education and law enfacement will be reached

Time-task plan, Part 1, Year 2 and 3

Objective	Activities	Period if implementation	Deliverables
Objective 1: To increase safety and improve well-being of women who have endured FGM/C	Recruitment Service delivery	All months Y2 and Y3	50 clients Y 2 50 clients Y3 100% to receive professional help; 70% provided with FGM/C women wellness education; 100% to access healthcare; 70% - mental health services
Objective 2: To facilitate faster integration of FGMC victims into the US society	Community referrals and follow ups	All months Y2 and Y3	200 referrals and 300 follow ups in 2 years
Objective 3: To generate families' opposition to FGMC	Parenting education	Family meetings: mothers: months 3,5,7,9,13, 15, 20, 22 Fathers: 4, 6, 8, 16 and 21 Groups: 2, 11, 16, 22	40 parents to attend groups, and 60 to meet individually in two years
Objective 4: To influence FGM/C-related norms in ethnic communities and to educate larger community about this issue	Ethnic community education and professional workshops	Throughout two years every month FGM/C protocols for education and healthcare will be developed in Sept. of Y3.	Coalition will meet quarterly, 16 healthcare, education and law enfacement organizations will be reached**;** FGM/C protocols for education and healthcare will be developed

DIRECT SERVICES AND PREVENTION OF FEMALE GENITAL MUTILATION/ CUTTING IN COLUMBUS, OHIO

A. DESCRIPTION OF THE ISSUE

The proposed project will serve FGM/C victims and the girls at risk in Central Ohio.

The Need for The Project. *a) FRM Prevalence Communities in Central Ohio:* More than half a million females in the United States have either undergone F.G.M./C. or are at a serious risk. The conclusion doubles or triples earlier estimates, according to the analysis by the Population Research Bureau and the Centers for Disease Control and Prevention (CDC).[1] Such increase is a result of the growth in the number of immigrants from FGM/C-practicing countries living in the United States. Some women consider immigration as a chance to reevaluate the practice, others see cutting as antidote to western sexual culture and women empowerment ideas. "The illegality of FGC in host communities often drives the practice underground; it persists by enlisting the help of traditional circumcisers within the immigrant community or by sending girls to relatives in the home country for vacation cutting"[2]. Women from FGC-affected societies face a culture of silent endurance; many are oblivious to the severity of complications. Three sending countries—Egypt, Ethiopia, and Somalia—account for 55 percent of all U.S. women and girls at risk. The FGM/C is 91% in Egypt, 74 % in Ethiopia, and 98% in Somalia. These alarming statistics are reflected very clearly in Ohio, where 24,329 women are at risk and the State ranks 9th nationwide for the FGM danger.[3] Columbus, Ohio is the 7th top metro area, with estimated 18,150

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[1] M. Mather, C. Feldman-Jacobs; *Summary of PRB Methods to Produce Estimates of Women and Girls Potentially at Risk of FGM/C in the United States*; https://www.prb.org/wp-content/uploads/2016/02/prb-unitedstates-fgmc-methodology-1.pdf

[2] https://www.wvxu.org/post/ohio-criminalizes-female-genital-mutilation#stream/0

[3] https://theohiostar.com/2018/09/05/columbus-ranked-7th-in-top-metro-areas-where-women-and-girls-are-at-risk-for-female-genital-mutilation/

women[4] at risk of undergoing FGM (75% of all women at risk in Ohio). FGM/C is most commonly performed on girls between the ages of 4 and 15. In U.S., school-age girls are most at risk and, therefore, there is an urgent need to equip school staff—including teachers, counselors, nurses, coaches, and principals—with the knowledge to detect the socio-emotional signals of this practice and aid in its prevention.

Many women in Columbus communities are at higher risk of FGM as the plurality of African immigrants have found home in Greater Columbus (97% U.S. women/girls at risk are coming from Africa). Central Ohio is home to the second largest Somali community of 45,000 people. Ethiopia and Eretria have FGM's prevalence at 75%. It is especially persistent within Oromo, Amhara, and Tigray ethnic groups. All these groups are represented in Central Ohio (25,000 Ethiopian population). In addition, families from Egypt, Kenya, Nigeria, Morocco, Liberia, Sierra Leone, Sudan and other FGM prevalence countries live in the area.

b) FGM Impact: Women with FGM are at extremely high risk of adverse pregnancy and OBGYN complications. Study after study indicates specific painful outcomes in these women. They require pain management and specialized obstetric planning. Female genital cutting brings chronic infections, infertility, complicated childbirth, and mental health problems such as anxiety, depression and PTSD. Secondly, the FGM/C has a strong matriarchal support. The procedure is enacted by women, mostly female relatives, who arrange the cutting ritual, hold the girls down during the procedure, which is performed by a female. However, evidence indicates that maternal opposition to FGMC is negatively associated with cutting a daughter, if a mother comprehends its health and life complications. [5] Our own findings also indicate that it is imperative to engage men as well. Based on our interviews with male members of FGC-

[4] https://www.newsrecord.org/opinion/opinion-we-should-care-about-female-genital-mutilation/article_c6c99cdc-fa39-11e8-82c1-abd352f33c5a.html

[5] K. Yount, et.al "*Community gender systems and a daughter's risk of female genital mutilation/cutting*…; Open Source Journal, March 6, 2020, published online, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7059929/

practicing communities, at least 65% are either against the procedure, or don't exhibit a strong support. Men are far less likely to experience being blackballed than a woman if they speak against the procedure.

US Together has a long history of serving FGM victims through general case management and specialized victim services. We discovered that adverse emotional, mental, sexual and reproductive health consequences of FGM are often aggravated by sexual violence and discrimination. Many women with FGC have been raped back in their old counties and refugee camps. Some had children as result of sexual violence. These women are often shamed and stigmatized by their communities, which puts them at risk of sexual harassment, discrimination and violence.

c) *Attempts to address FGM in Ohio:* In 2018 Ohio became the 28-th state that criminalizes FGM. The law prohibits the procedure; bans transferring the girls abroad for the purpose of having FGM performed and provides for severe sanctions for any doctor who performs the procedure. Violation of the law is a second-degree felony. *Challenges to improving outcomes for victims:* However, there is still no good sense of what a productive intervention against FGM in Ohio is. US Together is the only organization that implemented a specialized program for FGM victims even before the law passed the state Congress. We continue facing a lot of barriers, as addressing the FGM in Somali community is such a taboo that our UST staff have received threats and demands to stop talking about it. We continue serving FGM victims and have developed a promising approach to tackle this problem that will be discussed in the next section.

Lack of resources and training to implement anti-FGM services and advocacy is obvious. There is still a serious deficiency of specialized services that have capacity, expertise and cultural understanding. Large gaps in the delivery of services to FGM victims exist in healthcare, social services, law enforcement and child protection services. US Together discovered that most

healthcare professionals to whom we refer our FGM clients have not been trained on the implications of FGM, and many did not even know that the practice existed in the U.S. US Together conducted eye-opening trainings at the Ohio State University Medical Center and Primary One clinic; and were flooded with questions and requests for more information. Currently, there are no validated screening tools available to American clinicians. "At our many FGM presentations and educational sessions health workers, nurses and/or social workers were always surprised by the information on female genital mutilation. They were unaware that these practices occurred in the United States, or that some Muslim family members would send their daughters back to their original home country to have the procedure completed. Many health practitioners communicated that they will need more education on how to treat the needs of these young women and how to combat the secret procedure in America"[6] There are no clear protocols within child protection services on how to act when the child is at risk of undergoing the procedure in the U.S. or abroad. The problem is complicated by the fact that multiple FGM practicing ethnic groups differ in language, culture, and traditions. Therefore, it is crucial to engage representatives of ALL practicing communities into outreach and service delivery activities.

How funding will support the project's value to victims by achieving the stated goals: We believe that eradication and prevention of FGM/C in Central Ohio's immigrant communities will ultimately occur at the intersection of public education, advocacy, community engagement and holistic direct services to the survivors. Prevention and intervention strategies will be be culturally and religiously sensitive and utilize experienced representatives of ethnic communities, such as doctors, attorneys, faith leaders, and others. If funded, we will facilitate greater continuity of care, build trust and inform culturally

[6] Excerpt from the US Together' s report to the Office on Violence against Women, 2018.

appropriate services within ethnic immigrant communities where there is a high prevalence of FGM.

B. PROJECT DESIGN AND IMPLEMENTATION PLAN

The Strategy for Project Implementation

The project is coalition-based and is built on the three pillars: 1) direct services to women with FGM and prevention services targeting the girls at risk; 2) outreach and education in FGM prevalent communities; 3) creation of community coalition with the aim to support survivors, change the FGM culture and mindset and work towards eradication of the practice in Central Ohio. The program will be implemented within the social ecological model, which stresses multiple levels of influence (individual, familial, and community).[7]

How the Strategy will Address the FGM Issue, Support and Meet Goals and Objectives

1) The coalition approach to direct services will be based on the **AT-HOME** model, e.g. services are **A**ccessible, **T**imely, **H**olistic, **O**riented to individual needs; **M**ulti-disciplinary, and **E**mpowering. Interventions are strength-based and work within family systems. Practitioners will work with women holistically, striving to meet their diverse needs.

2) Educational efforts focus on cooperation with extended families and parents, influential community leaders, and other support networks. The strong emphasis will be done on working with parents separately from each other. The Mothers' Education Program focuses on daughters' health risks associated with cutting will be developed. This information will be delivered by respected members of ethnic communities who are healthcare professionals.

3) The community coalition will include violence against women and rape centers; ethnic community and faith leaders, local government representatives (such as Ohio Office on New

[7] Bronfenbrenner, U. (1977). *Toward an experimental ecology of human development*. American Psychologist, 32(7), 513-531.

Americans and Franklin County New American Advisory Council); health care and education professionals, social workers, universities, law enforcement and others. The coalition will participate in community-based programs that improve our understanding of the needs of communities with respect to FGM/C and provide awareness and educational material to help prevent FGM/C from occurring in the communities. Overall the Coalition will seek the ways to overcome various barriers that prevent progress and effective solutions from being presented to the affected communities. UST will develop FGM/C-related educational competencies through trainings and assessments of acquired knowledge.

4) To implement effective strategies, we will carry out the program within diverse cultural contexts, e.g. the program will target distinctive ethnic communities, such as Somali (45,000), Ethiopian/ Eritrean, Sudanese (1,500 community members), Sierra Leone (5,000 people), Kenyan, and Liberian (6,000 people, according to the Liberians in Columbus, Inc.).

Project Goals: 1) To alleviate impact of FGM on women's physical and mental health through holistic direct services and community referrals; 2) to increase FGM's impact awareness in practicing immigrant communities and to identify persons at risk; 3) to build community awareness and response to the issue of female cutting in Franklin County. **Project Objectives:** *Objective 1:* To increase safety and improve well-being of women who have endured FGM. *Tasks*: To expand existent holistic wrap-around direct services to women, and to implement these services within ethnic practicing communities. *Deliverables*: 150 victims of FGM will be served in three years; *Expected Outcomes*: 100% will receive professional help (mental health, healthcare, economic integration, and/or legal assistance), and 70% will be provided with FGMC/women health-specific wellness education. *Objective 2*: To facilitate faster integration of FGMC victims into the U.S. society. *Tasks*: To provide culturally specific resources and services that address legal, economic, healthcare, housing, safety, child care, employment, and other needs of the survivors;

Deliverables: more than 300 community and in-house referrals will be made: *Expected Outcomes*: 100% will access healthcare; 70% - mental health assistance; 95% - financial literacy/employment; 75% - rental and utility assistance through benefit coordination. *Objective 3:* To generate families' opposition to FGM; *Task:* To lead parenting education at the family level with parents-separately with mothers and fathers focusing on wellness education; motherhood and health, consequences of FGM, and taking on a more active role in the lives of the daughters. *Deliverables:* 160 parents will attend groups and individual educational and support sessions in three years; *Expected Outcomes*: 40% will change their attitude towards FGM; 80% will learn about health and psychological harm of the procedure. *Objective 4*: To influence FGM-related norms in ethnic communities and to educate larger community about this issue. *Task*: a) create the Community Response to the FGM/C b) to identify and train ethnic community leaders about the effects of the procedure; c) to conduct professional trainings for local service providers. *Deliverables*: The Coalition will be launched in 2021; 5 community leaders will be recruited in five ethnic communities and 3 community liaisons will be providing information within immigrant communities; 30 community presentations and trainings will be offered to service providers in the area.

Project Phases, Staff Responsibilities, Interim Deliverables, and Final Products:

Phase 1- Startup. Strategic planning, communities access analysis; staff hiring, recruitment and training. *Activities*: candidates' interview, volunteer recruitment, staff orientation and training. The training is a full day undertaking, consisting of two parts: a) *Female Genital Mutilation: Why does it continue to be a social and cultural force?* Facilitated by (b)(6) Overview of the Ohio Senate Bill 214, the law which prohibits FGM in the State. *Interim deliverable*s: community liaisons hired, existent staff transferred to the project, volunteers

[8] Sociologist, expertise in Women's Health, FGM/C, culture/religion, the gender opportunity gaps

recruited. *Phase 1 Final Products***:** Staff passes post-training quiz. *Final Products*: certificates of training completion; two -year strategic plan; *Staff responsible*: (b)(6)

(b)(6)

Phase 2: Ethnic community outreach, professional education, client recruitment, office adjustments. *Interim deliverables:* Community and faith leaders approached; schedule of initial meetings is developed; based on results of the meetings, follow up meetings are planned for the full year; presentations for community leaders and professional education start, the schedule is developed for the entire year; clients recruitment starts; brain storming meetings with experts to discuss the development of the protocol for direct services and child protection. *Interim deliverables:* Leveraging a list of stakeholders is developed, planning for the creation of the Coalition is started. Convening a stakeholders meeting; developing outreach materials. *Staff responsible*: Community liaisons, outside experts (targeting (b)(6)

(b)(6) others to be identified), (b)(6)

and (b)(6)

Phase 2 Final Products: educational materials, flyers against FGM to be placed in the UST office, 12 individual meetings with community/faith leaders are held in first quarter, the List of stakeholders is developed, serves as starting point for the recruitment of Coalition members; 1st Stakeholders meeting is convened.

Phase 3: Direct Service Delivery and Community Outreach Continuum (the latter is described on p. 12-13)

Interim Outcomes	Tasks	Activities	Staff Responsible	Final Product
Client-centered service plans	To assess and plan for positive outcomes	Intake→needs assessment→ service plan	Case manager	Individual Service Plan

(b)(6)

Service plan implementation	To assist victims to achieve their goals	Direct services and /referrals	Case manager	Service Outcomes evaluation results
In-house referrals	To meet clients' multiple needs	Legal services, urgent needs, employment, medical case management, women empowerment	Case manager ➞services provides within UST	Case notes/confirmation of appointments
Community Referrals	To ensure access to services	Individual Community referrals and follow up;	Case Manager ➞Community partners	Service Results evaluation
Support Groups and individual counseling	To improve clients' emotional well-being and awareness about victims' rights	Quarterly support groups for survivors of trauma	Case Manager, community liaisons and bi-lingual facilitators	Final knowledge acquisition assessment Report.

The Time-Task Plan *is offered at the end of this proposal as it is not included as part of the 20-page narrative limit.*

How the Project Deliverables Will Be Developed?

Direct Services to FGM/C Victims: The cornerstone of direct services is the comprehensive coordination of services through a synergy of intensive case management, advocacy, community referrals follow-up. All services described below are rendered based on service plans based on FGM/C survivors' individual needs assessment. Very important role is given to in-house and community referrals. *Case Management*: Case manager/advocate will provide intake and needs assessment, develop service plans, and conduct coordination of care. Based on victim's needs' assessments, the Service Plan will be created jointly with clients. It will identity short and long-term goals focused on attaining, maintaining and achieving safety and resiliency outcomes. Case managers will have contact with clients at least once a month to discuss progress, identify new needs and determine how to facilitate access to needed services. In addition, for those clients who signed consents to release information, case managers will hold status phone calls with community service providers to evaluate the progress of each client, and to advocate on their

behalf. Case managers will maintain accurate case notes about referrals and follow up. Once the victim feels they can navigate services and their situation on their own (approximately 6-12 month), the client can be discharged from the program. Emergency Assistance: urgent needs will be identified at the intake. Depending on the nature of these needs, we will provide emergency assistance, including food and clothes, enrollment into benefits, childcare, utilities and rental assistance programs, access to education and benefits. Advocacy: confidential assistance to victims via advocacy and resource information; court advocacy; helping victims receive benefits for which they are eligible. Trauma-Healing Counseling will be provided by UST counselor Souhad Chbeir, LPC, an Arabic speaker, and will include individual counseling and group therapy with professional interpreters present at their appointments; emotional support and guidance; Women Support Group (by means of ethnic group, details are in the Time Task Plan): Open-ended discussion group sessions in native languages will provide a safe environment for participants to share personal experiences, thoughts, and feelings in small, confidential gatherings. Groups will meet for 90 minutes bi-monthly. The female genital cutting will not be used in the title of this group. The group will focus on women health, issues with pregnancies and education about C-section and other medical intervention that are often utilized with patients who have been cut, barriers to accessing healthcare. Gradually the groups will come to the issues of FGM/C. The groups will be led by a health professional (b)(6)

(b)(6) will be consulted on best candidates to lead this group). Mother/Daughter Communication program will help immigrant mothers better communicate with their daughters. In 4 sessions they will explore: significant events over the course of their life; exploring wellness and healthcare together; critical skills in active listening and communication; and ideas and strategies for making their connection better. These activities will

(b)(6)

prepare moms to start the Health and Wellness Education Program for mothers of teenage girls. The project will target factors associated with psychological, health and legal implications of FGM in the U.S. Health education interventions will be tailored to specific sociodemographic and socioeconomic factors, various traditions and beliefs of the mothers. Evidence suggests that these factors are vital and require intensive consideration at every stage of the intervention. The program is based on scientific evidence that health education increases the possibility of effective attitude in mothers towards the procedure, which can lead to collective change in behavior and sustainable prevention of FGM/C[11].

Interpreting Services: UST will provide professional interpretation and translation services to the women with FGM, at risk youth and extended families, as well as to our community partners who serve them. Services will be available in all languages spoken in Columbus and will be delivered face-to-face, via phone or video, in regularly scheduled and unscheduled appointments. Interpreting services will be available 24/7/365, after-hours and during crisis intervention. The services meet standards recommended by the National Council on Interpretation in Health Care. We work with extensive network of 200 contractor interpreters into and from 75 languages. All interpretation services requests will be received at the UST Interpreting Call Center and entered into the computer system. *Legal Services:* UST in house legal services will offer VAWA, U-VISA applications, and provide citizenship/naturalization services by BIA accredited representatives. *Volunteerism:* Volunteers are instrumental in implementation of this project. Volunteers will provide transportation, emotional support, accompany to appointments, qualified volunteers will provide financial, medical and legal consultations.

[11] Twelve studies identified conclude that It is vital to provide health education for FGM/C. All reviewed in the S. Waigwa, et.al *Effectiveness Of Health Education as an Intervention Designed to Prevent Female Genital Mutilation/Cutting (FGM/C): A Systematic Review;* Reproductive Health, 2018; 15: 62 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5897952/;

Clients' safety and confidentiality will be protected via the following protocol: access to linguistically and culturally competent advocates, who will provide safety planning, including connection with victims' services, such as emergency shelter and legal assistance. Victims can be granted a 24 -hour hospital stay via SARNCO, while their emergency housing and legal situation is cleared. Victims' demographic data, telephone number, medical records, immigration status, and other information, and a fact of their enrollment in the program will be protected. Exceptions to confidentiality are as follows: Signed release, and Ohio mandatory reporting laws for child or vulnerable adult abuse, and Duty to Warn, as UST is a mandatory reporter. The victims will be notified at the beginning service provision that we are a mandated to report and warn as required by the Ohio Law (5122-3-12 Duty to Protect).

Outreach to at-risk individuals and communities.

1) We will recruit ethnic community liaisons in each identified community. We plan include them into the Coalition which we start putting together in the first quarter of the project. With the help of these liaisons we identify the gaps in resources and services within their respective communities.

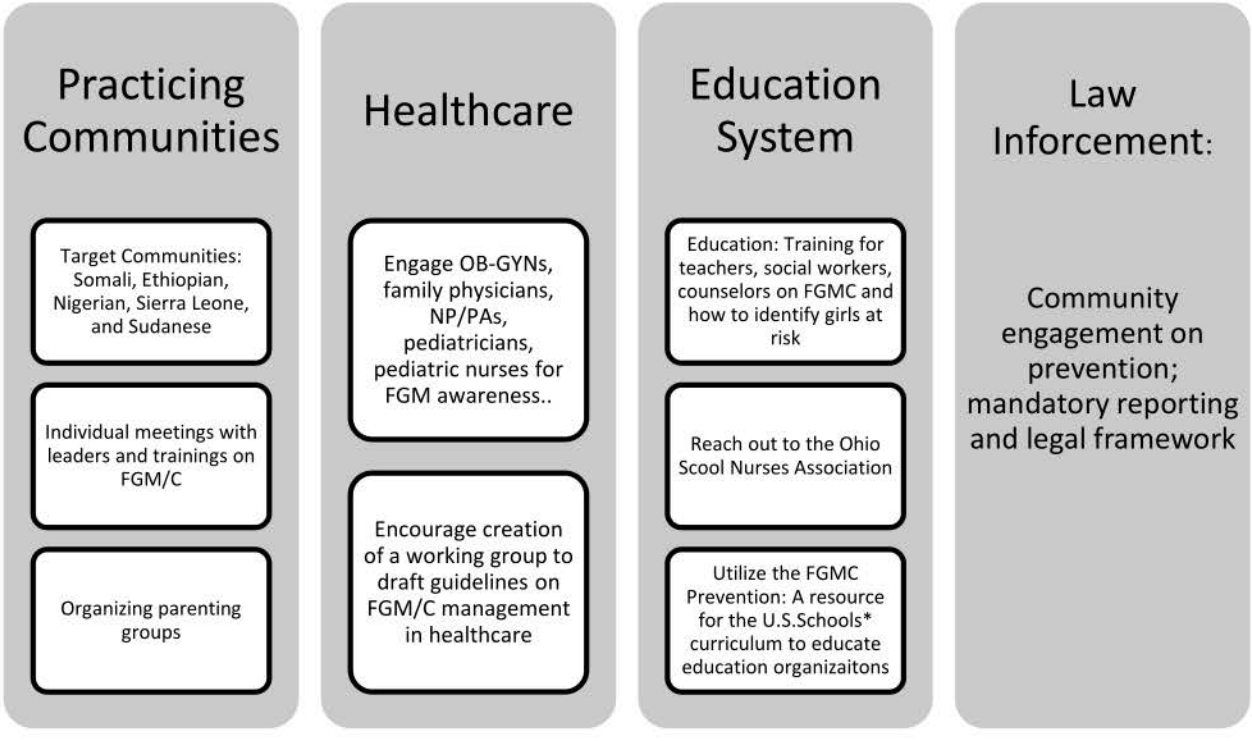
2) UST will offer the three professional development workshops a year to service providers and community organizations. The topics are as follows: FGM/C Prevention: the Resource Guide for the Schools[12]; FGM/C 101; Trauma-informed Case Management with FGM Victims; Volunteer Work with FGM victims; Recommendations on Responding to FGM/C in Healthcare Sector[13]. We will offer quarterly trainings on how to work with interpreters to law enforcement and victims' services, with the focus on working with interpreters in child protection situations.

[12] https://safesupportivelearning.ed.gov/sites/default/files/fgm-c-prevention-school-resource-final.pdf

[13] https://d3n8a8pro7vhmx.cloudfront.net/equalitynow/pages/319/attachments/original/1527600493/2016_Violence_Against_Girls_Summit_on_FGM_C_report_web_cmprsdv4_0.pdf?1527600493

3) UST will develop overall outreach strategies activities plan. We will utilize social marketing, community events and media to educate the public about the issue of FGMC in the US. UST will develop outreach materials in various languages, and ethnic community liaisons will distribute these materials in houses of worship, ethnic businesses, community centers, grocery stores, etc.

The picture below illustrates the outreach component of the program.



Community Partnerships: *Pro bono legal services*: Advocating Opportunity; Legal Aid Society of Columbus; and Ohio Domestic Violence Network (ODVIN). *Healthcare:* Primary One, MediCare and Noor Clinic, Charitable Pharmacy of Central Ohio. *Mental health counseling:* North Community Counseling, Syntero, and Ohio GuideStone. *Victims Advocates*: Sexual Assault Response Network of Central Ohio (SARNCO). *Ethnic Communities and Spiritual Support*: Our Helpers (Somali), Sierra Leone Club of Columbus Ohio, Liberians in Columbus, Inc., United Nigeria Association, Egyptian Students' Association at The Ohio State University, St. Mary's Coptic Orthodox Church, Ethiopian Community Organization Inc., Ethiopian Orthodox Tewahedo Church; Masjid Al Noor Islam Society, IbnuTaymiyah Masjid and Islamic Center, and many

others. *Mainstream support to refugees and immigrants*: Community Refugee & Immigration Services, YMCA, various school districts, Franklin County Job and Family Services Children services, and others. *Older Adult Care*: Central Ohio Area Agency on Aging will consult and enroll older FGMC victims into long term care programs including PASSPORT, MyCare Ohio, the Ohio Home Care Waiver and the Franklin County Senior Options Program. *Law Enforcement*: Franklin County Sheriff Department.

A plan for submitting financial and progress report: semi-annual progress reports will be submitted by April 30 and September 30 each year. Financial reports will be submitted quarterly.

C. CAPABILITIES AND COMPETENCES

UST mission and overall experience and expertise: US Together (UST) is on a mission to assist refugees and immigrants escaping violence, oppression, and extreme poverty to find safety in Ohio by facilitating their resettlement, easing integration, helping build vibrant communities, and advocating on their behalf. Since 2003, we have served close to 7000 individuals in Columbus, Range of Services: comprehensive assessment for mental illness, torture, GBV and domestic violence; housing, cash assistance, food and clothes; benefit applications, and economic integration programming.

UST Experience Managing Federal Grants and *Financial Capability*: including Department of Justice (OVW and OVC), Administration for Children and Families - Office of Refugee Resettlement; and Homeland Security - Citizenship and Naturalization Services. As a recipient of federal, state, and/or local grants, UST have implemented accounting procedures to generate and track data to maintain compliance to OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations. Many of UST's large federal grants include disbursement of direct expenses to eligible clients; UST has developed customized reports that clearly detail these disbursements to both the client and the funder. Internal controls regarding

access to the accounting system; approvals of disbursement requests; signed acknowledgement for each disbursement from the client; and weekly reporting to program staff ensure that grant activity is closely monitored. Additionally, an external audit has been performed by independent auditors for the past six fiscal years (our most recent fiscal year audit is underway).

Organizational Experience and expertise in addressing FGM/C

The following stories illustrates how we work with the survivors of FGM and other types of gender- based violence.

****

(1)

Mouna (not a real name) is from Mauritania and is a client of our Culturally Specific Services to the Victims of Sexual Assault program since January 2020. She has a college degree in accounting and worked as a cashier back home. Mouna was arrested by the police when she was taking a video of them beating protesters. She was accused that she was part of the opposition and jailed. In the jail she was tortured and raped. She was released in March 2019 and moved to the U.S. in July 2019. She underwent the female cutting back in her old country. She was subjected to the procedure as at the age of 9 and has gynecological issues because of severe infection she had as a result of FGC. Mauna could not treat her ailment prior to arriving to the U.S. She reported that the incidence still gives her nightmares until today and she wants to help advocate against such a horrific practice. Our medical case manager connected the client to the OBGYN clinic, helped her understand her special needs due FGM. Through UST's Interpreting Services Department, we were further able to provide interpretation and translation support for her, so she could file a petition for asylum and work authorization. We also connected Mouna to the food pantry and arranged donations of culturally appropriate clothes. UST in-house mental

health counselor helped her reduce her anxiety symptoms so that she could gain confidence, mastery, functionality with her day-to-day life.

****

(2)

(b)(6) is (b)(6) woman from Somalia. She had FGM/C at age 7 years old. In Somalia she worked as a maid, and was raped by her boss. She told her mother who immediately took her to a small village where no one knew her and forced to undergo type 3 FGM, infibulation: narrowing of the vaginal opening through the creation of a covering seal. This practice is extremely painful and distressing, damages sexually sensitive skin and is an on-going infection risk. (b)(6) live in (b)(6) now. In (b)(6) she had a child. She was in labor for 36 hours, and the doctors didn't know how to help her as they had no experience with FGM patient.

US Together has been serving survivors of FGM for more than 15 years. Close to 400 Somali women have been provided with intensive medical and behavioral case management, access to healthcare such as quality OBGYN care. We started educating professional community on FGM at the times the issue has not even been raised in Ohio, as Somali refugee community was just starting to form in Columbus. We provide these women with life skills education and information about wellness, women healthcare, and personal hygiene. The "Refugee Women's Empowerment" class is created specifically for Swahili, Arabic and Somali-speakers (likelihood of FGM is high). The class is focused on building self-esteem, so that these women can feel enabled to pursue their goals in the U.S. More than 50 women have graduated from this program. Since 2016 US Together is funded by the Department of Justice to serve the survivors of sexual

assault from African countries and South Asia, and victims of crime (VOCA) who are limited English proficient. Most of our African women come from Somalia and Ethiopia; we also serve women from Congo, Liberia, Mauritania, Benin, Cameroon, Niger, and other counties with high FGM prevalence. In 2019 we have served 46 clients in the VOCA program who are victims of gender-based violence, trafficking sex and labor, physical assault, torture, hate crimes, kidnapping, homicide of the loved ones among others. 17 of them are FGM and sexual assault survivors. All clients have been receiving mental health counseling, intensive medical case management, 50% received legal services. Direct services to sexual assault survivors from African nations is another program which provided specialized services to FGM/C women because survivors experienced FGMC in the past. Overall, in 2019 alone we served *40 FGM/* sexual assault survivors from Somalia. Most of them were single mothers and some are pre-literate. Here is the note provided by our case manager (b)(6) as part of her reporting to the DOJ-OVW: "An important and tragic shared factor among African women is the practice of Female Genital Mutilation. During this reporting period program staff outreached to Somali community, conducted community meetings and focus groups addressing this issue". Services provided to FGM/sexual assault survivors include medical and intensive case management, community referrals, accessing support services, immigration issues, parenting, safety planning for at risk young women, FGM and sexual assault education, overview of available services, intake and service planning.

Just in one of the past reporting periods (b)(6) conducted 16 community trainings for child-care staff (35), teachers (131), social workers, nurses (78), mental health professionals, victims' advocates, and social workers (49) and 21 volunteers. In 2019 she trained 200 healthcare workers. After conducting a productive trainings UST formed a partnership with Ohio State University Wexner Medical Center to conduct ongoing FGM trainings for 200 nurses,

physicians, and care coordinators. Two young women, former clients of the program, volunteered to share their experiences and participate in a panel discussion with medical professionals. Through this training, professionals heard from actual survivors how this procedure changed their lives and what the survivors expected from healthcare providers. Overall, since 2015 we have educated more than 400 professionals and community leaders. As a result, we've seen an influx of referrals to our services. Ohio State University Hospital OBGYN made referrals from West Africa communities. Between 2015 and 2018 we implemented the special project that delivered holistic direct services to survivors of torture. We served 300 survivors (106 in Columbus), 60% of them were women, and at least 60% of were FGM survivors.

Interpreting Services to The Survivors: Since 2004, the agency operates interpreting services, with mission to assure that no Limited English Proficiency (LEP) individual is excluded from the community just because they cannot understand what is being said or written. Over the last eight years US Together provided 110,000 interpretation appointments. All UST interpreters (200 individuals speaking 75 languages) are trained. Their competency is assessed via oral and writing testing. Most interpreters are trained on Human Services protocols and Interpreting in crisis situations, including domestic and child abuse.

Staffing structure, staff members' qualifications and how the project will be managed.

(b)(6) will oversee the compliance and financial aspects of the program. The project will be overseen by (b)(6) (b)(6) who has 20 years of refugee and immigrant program, development and management, including 10 years of managing specialized refugee family and women project on national level through her previous employment with (b)(6) (b)(6) the (b)(6) will serve as program coordinator and staff supervisor.

(b)(6) serves as (b)(6). She oversees project development and implementation of all Federally, State and County-funded employment projects, victims' services financial literacy and women' empowerment. (b)(6) is experienced manager, with more than 15 years of in the non-profit sector, with special expertise in affordable housing and benefits eligibility. (b)(6) holds a Master of Science in Communication and Marketing and the Graduate Certificate in Public Administration. (b)(6) is current (b)(6) (b)(6) and will serve as case manager/advocate. She has served more than 50 FGM victims in past two years and represents the Somali community. (b)(6) healthcare case manager and Arabic speaker will provide specialized care and consultations to the FGM survivors with medical and mental health issues. (b)(6) has BS in pharmacology, has many years of case management experience and three years of experience providing victims of crime services. (b)(6) M.Ed. and bi-lingual in Arabic, will serve as school liaison to conduct FGM and sexual assault awareness/prevention activities in area schools. (b)(6) has 8 years of experience working with (b)(6) (b)(6) and serves as (b)(6) school liaison coordinator. (b)(6) the BIA specialist will provide legal services, including VAWA application, U-visas, citizenship and integration.

New Positions: Three community liaisons will be hired as contractors. Ethnic community liaisons serve as resources for community members, assist the program in outreach and providing information to communities. Community Liaisons are expert "bridge-builders" who are bi-cultural and bi-lingual. Knowledge and Skills: Ability to communicate verbally and in written communication in both English and primary foreign language, experience working with victims and systems advocacy, excellent communication and presentation skills.

IY. PLAN FOR COLLECTING THE DATA:

Program evaluation process will follow OJP performance data reporting requirements, provided in the Grant Performance Measurement and Progress Reporting Information. We will review the program's performance measures, focusing on numbers, narrative, or other data that need to collect after we access OJP's performance measurement page, if funded. We will monitor ongoing processes and the progress towards the goals and objectives of service plans through a) PDP data collection; b) regular reports and face-to-face quarterly monitoring by program coordinator and annually by program director; and d) outcome evaluation. *Collecting and tracking the data*: case managers will collect initial data through intake. All data will be entered into a computer system designed to support and track our multidisciplinary services. The system is developed to measure, analyze, review, and improve performance of service providers that work in interdisciplinary settings, by utilizing the following data gathered through the intake and service plan follows up: (1) Service Date/Time; (2) Service Provider; (3) Victim's name; Age at intake; and Gender; (4) Country of Origin/ethnicity; (5) Language and Immigration status; (6) Employment status; (7) Length of time in the U.S. at (8) Religion; (9) Housing status; (10) FGM Survivor type/risk factors (primary or secondary); (11) List of services/activities is entered into the system and periodically updated by case managers. The system tracks activities in following categories: legal, medical, behavioral, group sessions, case management; type and date of services; follow-up information, client's progress information (entered monthly); and intervention outcomes via self-reporting and providers' notes (semi-annually). The results will be measured by program notes, self-report victims' survey, journal logs, and scales to measure improvement in health and mental health, where 1 = improvement, and 5 = good improvement.

Task plan, Year 1

Objective	Activities	1	2	3	4	5	6	7	8	9	10	12	Deliverables
Objective 1 To increase safety and improve well-being of women who have endured FGM/C	Expanding existent holistic wrap-around direct services to women. See the stages below	x	x	x	x	x	x	x	x	x	x	x	50 victims of FGM served. 100% receive professional help; 70% provided with FGM/C women wellness education; 100% to access healthcare; 70% - mental health services
	Training UST service providers	x	x										2 case managers, 5 liaisons and 2 supervisors trained
	Recruiting participants			x	x	x	x						
	Intake and service planning		x	x	x								50 intake and 50 services plans
	Service provision according to the service pan			x	x	x	x	x	x	x	x	x	
Objective 2 To facilitate faster integration of FGM/C victims into the US society	Providing community referrals and follow ups that address all needs of women with FGC and girls at risk survivors	x	x	x	x	x	x	x	x	x	x	x	At least 100 community referrals utility assistance through benefit coordination; 200 follow-ups will be conducted
Objective 3 To generate families' opposition to FGM/C	Parents education				x	x	x	x	x	x	x	x	30 parents will attend groups and 30 will meet individually with case workers. 40% will change their attitude towards FGM/C; 80% will learn about the harm of the procedure.

	1. Individual meetings mothers of at-risk girls					**x**	**x**	**x**	**x**	**x**	**x**	**x**	20 mothers will meet with case workers
	2. Individual meeting with fathers of at-risk girls									**x**	**x**	**x**	10 fathers will meet with case workers
	3. Parenting groups W=women; M=men (2 sessions bi-weekly)						W	W	M		W	M	30 individuals to attend the groups
Objective 4 To influence FGMC-related norms in ethnic communities and to educate larger community about this issue	Identifying community liaisons Somali=S; Liberian=L; Sierra Leone=S/L; Ethiopian/Eritrean =E; Arabic Speaking =A	S E	L A	S/ L									5 community leaders will be recruited in five ethnic communities and 5 community liaisons will be providing information in immigrant communities;
	Training community leaders and liaisons					**x**	**x**	**x**	**x**	**x**			5 community liaisons will be trained to provide FGM/C information and identify girls at risk
	Community Presentations					**x**	**x**	**x**	**x**	**x**			10 community presentations and trainings will be offered to service providers in the area
	Recruiting members for the Community Response to FGM/C Coalition			**x**	**x**		**x**	**x**	**x**	**x**			
	Coalition Launch										**x**	**x**	First meeting and plan of action
Outreach and professional education	The picture and plan in proposal		**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	At least 8 organizations working in healthcare, education and law enfacement will be reached

Time-task plan, Part 1, Year 2 and 3

Objective	Activities	Period if implementation	Deliverables
Objective 1: To increase safety and improve well-being of women who have endured FGM/C	Recruitment Service delivery	All months Y2 and Y3	50 clients Y 2 50 clients Y3 100% to receive professional help; 70% provided with FGM/C women wellness education; 100% to access healthcare; 70% - mental health services
Objective 2: To facilitate faster integration of FGMC victims into the US society	Community referrals and follow ups	All months Y2 and Y3	200 referrals and 300 follow ups in 2 years
Objective 3: To generate families' opposition to FGMC	Parenting education	Family meetings: mothers: months 3,5,7,9,13, 15, 20, 22 Fathers: 4, 6, 8, 16 and 21 Groups: 2, 11, 16, 22	40 parents to attend groups, and 60 to meet individually in two years
Objective 4: To influence FGM/C-related norms in ethnic communities and to educate larger community about this issue	Ethnic community education and professional workshops	Throughout two years every month FGM/C protocols for education and healthcare will be developed in Sept. of Y3.	Coalition will meet quarterly, 16 healthcare, education and law enfacement organizations will be reached**;** FGM/C protocols for education and healthcare will be developed

OMB Approval No. 0348-0043

APPLICATION FOR	2. DATE SUBMITTED 04/30/2020	APPLICATION IDENTIFIER
1.TYPE OF SUBMISSION	3. DATE RECEIVED BY STATE	STATE APPLICATION IDENTIFIER
	4. DATE RECEIVED BY FEDERAL AGENCY	FEDERAL IDENTIFIER

5. APPLICANT INFORMATION

Legal Name	Organizational Unit
US Together, Inc.	Social Integration Services
Address (city, state, and zip code) 1415 E Dublin Granville Rd. Suite 100 Columbus, Ohio 43229-/358	Name and telephone number of the person to be contacted on matters involving this application (b)(6)
6. EMPLOYER IDENTIFICATION NUMBER (EIN) (b)(4)	7. TYPE OF APPLICANT Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education
8. TYPE OF APPLICATION New	9. NAME OF FEDERAL AGENCY Office for Victims of Crime
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE Number: 16.582 CFDA Title: Crime Victim Assistance/Discretionary Grants	11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT DIRECT SERVICES AND PREVENTION OF FEMALE GENITAL MUTILATION/ CUTTING IN COLUMBUS, OHIO
12. AREAS AFFECTED BY PROJECT	

13. PROPOSED PROJECT		14. CONGRESSIONAL DISTRICT(S) OF	
Start Date: 10/01/2020	Ending Date: 09/30/2023	a. Applicant OH12	b. Project OH12

15. ESTIMATED FUNDING		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
a. Federal	$298,801	
b. Applicant	$0	Program is not covered by E.O. 12372
c. State	$0	
d. Local	$0	
e. Other	$0	
f. Program Income	$0	17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT? N
g. Total	$298,801	

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS REQUIRED.

a. Typed Name of Authorized Representative	b. Title	c. Telephone number
(b)(6)		
d. Signature of Authorized Representative		e. Date Signed