

# Furanni

Enhancing Health Outcomes for Young Girls and Women through Arts & Craft Education

End of Programme Report  
(March 2025)



## 1. BACKGROUND

Between August 2024 and February 2025, Five Cowries Arts Education Initiative (FCI), in partnership with Nigeria Health Watch, delivered Furanni. Furanni used art-based sessions and activities to engage and educate adolescent girls and young women on context-specific Sexual Reproductive Health and Rights (SRHR) topics across three LGAs in Kano State. Furanni disseminates health behaviour change messages within communities through the conversations and interactions participants have with their families and peers. The programme employs storytelling through stitching and embroidery activities to engage and educate participants while encouraging them to tell their unique stories. Furanni engaged eighty-six (86) girls and young women in Dala, Ghari, and Wudil LGAs, spanning the three senatorial zones of Kano State. The programme aimed to:

1. Improve the knowledge base and awareness of adolescent girls on their reproductive health within the cultural, traditional, and religious contexts of the host communities.
2. Build their confidence to demand quality and dignified care at healthcare facilities.
3. Support improved health-seeking behaviour related to SRHR, primarily for adolescent girls and young women in Kano.



## **2. DELIVERABLES AND ACTIVITIES**

### **2.1 Stakeholder Engagement.**

We engaged local leaders in our target communities to secure their support, with a particular focus on Wudil, which was a new area for FCI. The Hakimi assigned his secretary to ensure that we received the necessary support. The secretary also introduced us to the leadership of the local Women's Centre, with which we collaborated for programme delivery. We received strong backing from local leaders and other community members across all three LGAs.

### **2.2 Hub Set Up.**

With the support of the Hakimi and the leadership of the Women's Centre in Wudil, we established a new hub space within the Centre's premises. We conducted basic renovations, including painting and rehabilitating the toilets, as well as providing mats and essential furniture to ensure the space was suitable for use. To promote hygiene, we installed a handwashing unit. Additionally, we identified a hub facilitator, nominated by local leaders, and provided training to equip her for facilitating follow-up sessions. This ensures the sustainable development of local capacity.

With our hubs in Ghari and Dala already operational, we acquired creative learning materials for all three hubs, stocking them as necessary. The hubs were open to programme participants and other community members during the weekly drop-in sessions and remain accessible for participants to drop in, even after the completion of the programme.

### **2.3 Selection of participants.**

Furanni targeted adolescent girls and young women of reproductive age who need the Sexual Reproductive Health and Rights (SRHR) knowledge the most. With the support of the local leaders who nominated participants that meet the age requirement from their communities, we onboarded eighty-four (84) girls and young women across Dala, Ghari and Wudil LGAs for the programme. The onboarding process followed a briefing session for the nominees in each of the LGAs. While some participants relocated from their communities within the first three weeks of the programme and were replaced, we had to accommodate additional participants in the course of the programme. Halfway into the programme, a father in

Dala requested the Mai Unguwa speak with us to engage her daughter, having seen the behavioural changes her friend's daughter- who was a participant exhibited. At the end of the programme, we fully engaged eighty-six (86) participants.

<b>LGA</b>	<b>Target no. of participants</b>	<b>No. of participants engaged</b>
Dala	25	27
Ghari	25	34
Wudil	25	25
<b>Total</b>	<b>75</b>	<b>86</b>

*Table 1: Breakdown of participants directly engaged per LGA*

## **2.4 Participants' Kits**

All eighty-six (86) participants received a kit containing essential materials for basic stitch work and embroidery, including yarn, scissors, fabric, office pins, and needles. At the end of the programme, participants received another kit that contained personal hygiene items such as menstrual pads, deodorants, and toothbrushes. Each participant also got a souvenir kit of a notepad, biro, and water bottle courtesy of Nigeria Health Watch.

## **2.5 Resource Development**

FCI developed resources specifically designed to engage participants in sexual and reproductive health and rights (SRHR) topics in a way that respects their cultural and religious contexts. These activity-based resources serve as a foundation for conversations that start in community hubs and continue in households.

### **2.5.1 Worksheets**

FCI developed a six-part worksheet with input from health experts and local communities. Each fabric-printed worksheet conveys a key health message related to Sexual and Reproductive Health and Rights (SRHR), antenatal care, facility delivery, health workers' responsibilities, and birth control in Hausa. With each worksheet, participants learn

two new stitches that serve as a backdrop for discussions about the topic of the month. Participants share and stitch their stories on the worksheets. They then take the worksheets home to further discuss the lessons learned with their family members. At the end of the programme, the six worksheets were stitched together to create an artwork that represents the participants' cumulative stories. We also provided the participants with leaflets that offered further information on each topic learned for the month.

### **2.5.2 Facilitator's Guide**

We have created a guide for hub facilitators and trainers to support them during workshops and drop-in sessions for each worksheet. These guides, available in both English and Hausa, outline the key messages that participants are expected to learn, along with other instructions for the facilitators.

### **2.5.3 Video Resources**

We created instructional videos demonstrating the stitch-making procedures that participants learned during the programme. These short, interactive videos are designed to assist both the hub facilitators and the participants. They allow the delivery team to train the hub facilitators on the stitches virtually, thus overcoming the barriers posed by distance.

## **2.6 Workshops.**

For each of the six months of the programme, we delivered one workshop in each of the communities we engaged, making a total of eighteen (18) workshops across the three LGAs. During each workshop, FCI trainers, supported by the hub facilitators deliver each of the six themes the programme focuses on as listed below:

Workshop 1 Menstrual health and hygiene.

Workshop 2 Sexual reproductive health and rights – STIs and UTIs.

- Workshop 3 Antenatal care.
- Workshop 4 Birth complications.
- Workshop 5 Postnatal care.
- Workshop 6 Birth spacing

During the workshops, participants engaged in creative learning sessions focused on the topic of discourse for the month. We provided creative materials for the workshops and the drop-in sessions. In response to participants' requests, we invited the heads of PHC closest to the hub in each of the three communities during workshop 4 to clarify and resolve some of the issues participants experience whenever they visit the PCHs.

## **2.7 Weekly Drop-in Sessions**

Following the monthly workshops, participants visited the hubs to reinforce their learning and engage in guided conversations with the hub facilitators while practising their stitching skills. Although the hubs are open weekly: on Thursdays in Wudil and Ghari and Fridays in Dala, each participant was required to drop in at the hub every fortnight. Additionally, the drop-in session provided an avenue for participants' expression and social listening. Participants shared their thoughts and stories from their everyday experiences as they relate to SRHR.

## **2.8 Final Day Celebration**

To mark the end of the programme, we held a closing ceremony in each of the three hubs between 19<sup>th</sup> and 21<sup>st</sup> February 2025. This event which was supported by Nigeria Health Watch, saw participants share their key learnings from the six-month programme. Each participant got a certificate of participation and a kit of souvenirs.

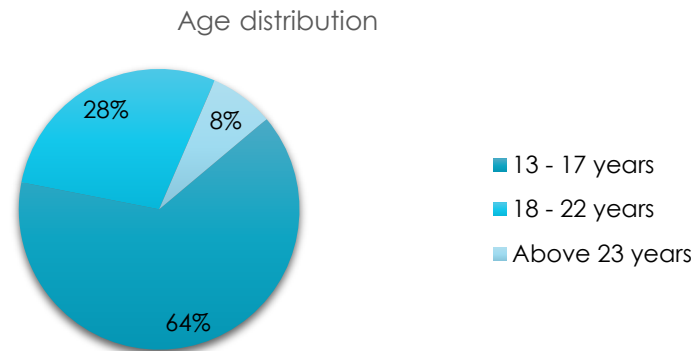
## **3. ASSESSMENT AND EVALUATION**

To monitor the improvement in participants' knowledge in alignment with the programme objectives, we developed an assessment framework that includes self-reported survey questions to track behaviour changes in participants in the short

term, and a quiz section to evaluate participants' learning on the programme. The participants completed the baseline, mid-term, and final assessments which were available in Hausa and English, and administered digitally via Kobocollect. A total of 81 entries were consistent from baseline to end-term assessment and the following analysis was based on these entries.

### 3.1 Age distribution of participants

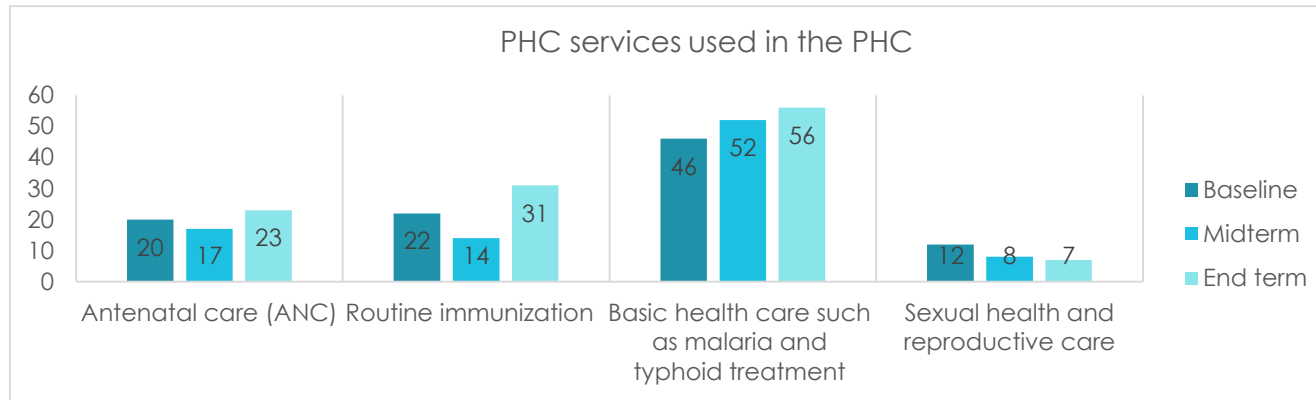
Just over half (52) of the participants assessed were between the ages of 13 and 17 years while another 23 were between the ages of 18 and 22 years. Only 6 participants were 23 years old or older as shown in the figure below. The age distribution demonstrates the programme's focus on girls and young women of reproductive age who need the knowledge the most.



### 3.2 The services participants use in the PHC in their communities.

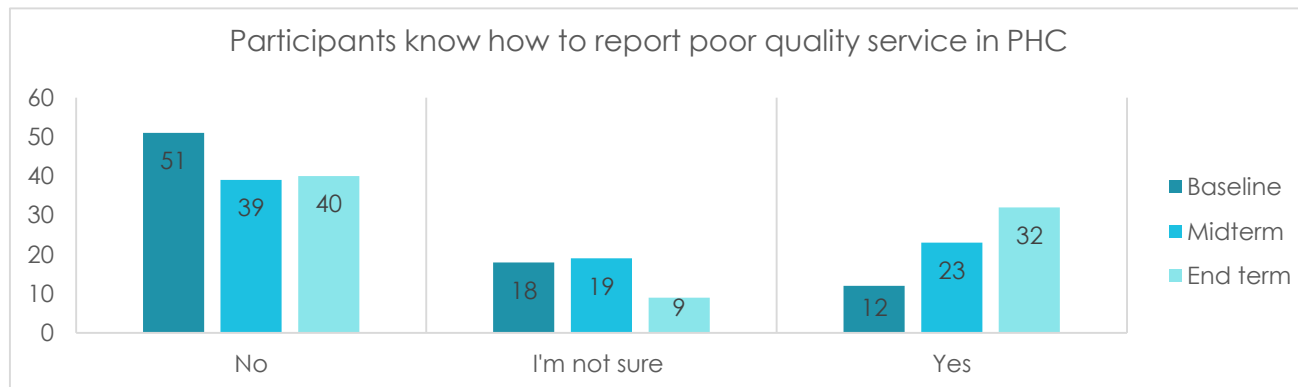
From baseline to end-term assessments, participants accessed basic healthcare services - more than any other service from the PHCs. Also worthy of note is how the demand for basic healthcare services increased within the time of reference. Antenatal care and routine immunization were both significantly high with a generally increasing trend during the programme. Sexual and reproductive health services were the least accessed services and showed a slowing trend during the time of review as shown in the figure below. The very low access to sexual health and reproductive care services suggests that there might be access barriers including social (such as feeling ashamed to access the service), infrastructural

(such as lack of specialists in the PHCs) or a lack of awareness that the service is available at the PHCs. Participants may have however accessed sexual health and reproductive care in other facilities other than PHCs.



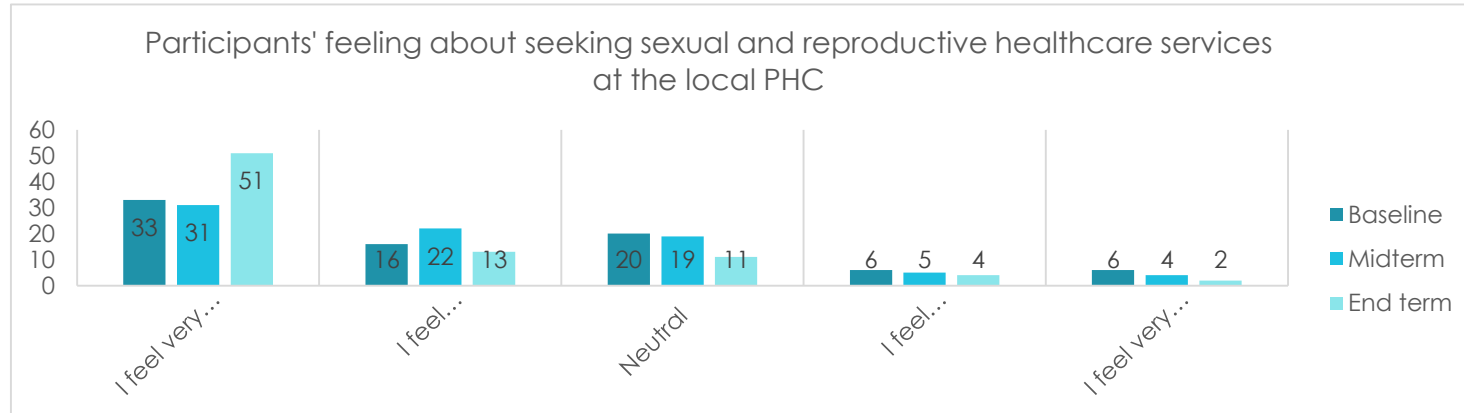
### 3.3 Participants' knowledge of reporting structures for poor quality services in PHC.

To assess how effectively the programme helps build participants' confidence to demand quality and dignified care at healthcare facilities, we asked them whether they knew how and where to report poor service if they experienced it in the PHC. At the end of the programme, 32 participants indicated that they were aware of the reporting process for service quality failures in PHCs, compared to only 12 participants at the baseline. This improvement is supported by a consistent decline in the number of participants who do not know and or are not sure they know how to report service failure in the PHCs as shown below.

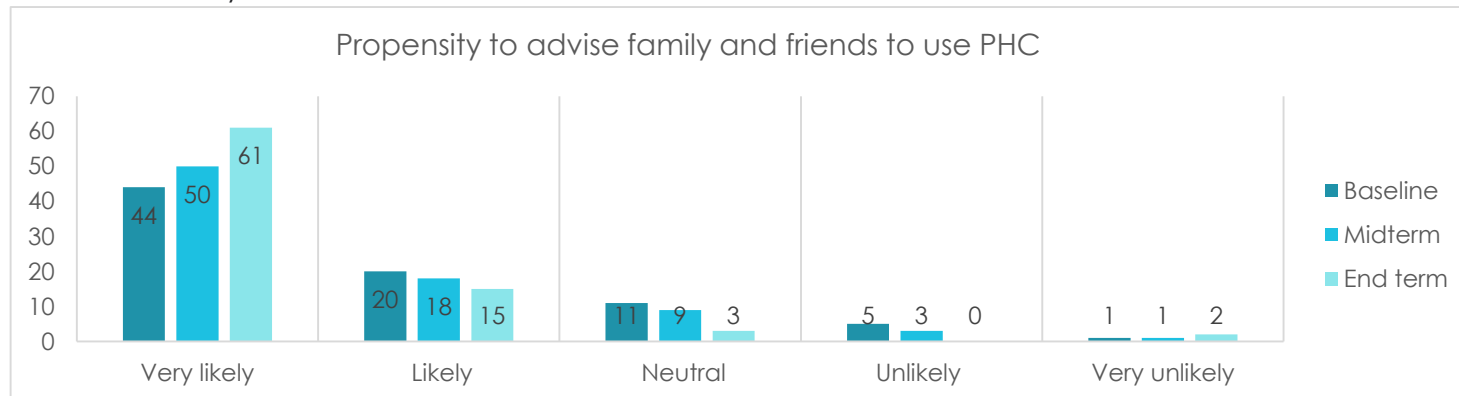


### 3.3 Participants' feelings about seeking sexual and reproductive healthcare services at the local PHC

To evaluate how well Furanni enhances health-seeking behaviour as it relates to SRHR, we assessed participants' level of comfort in seeking sexual and reproductive healthcare services at the local PHCs using a Likert scale. At the end of the programme, a greater number of participants (64) reported feeling either 'very comfortable' or 'comfortable' seeking these services, compared to only 49 at baseline. Additionally, the number of participants who felt 'slightly uncomfortable' or 'very uncomfortable' seeking these significantly decreased from 12 at baseline to 6 at the end-term as shown below.

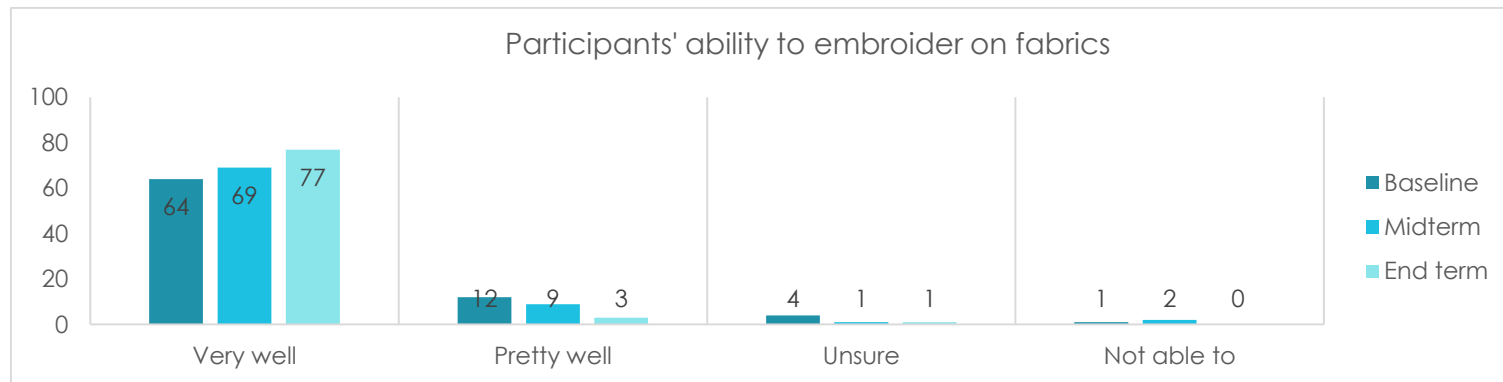


As the programme advanced, participants demonstrated a growing inclination to recommend primary healthcare (PHC) facilities to their friends and family as shown below. This indicates that Furanni has a ripple effect, which will persist as primary beneficiaries become advocates for PHC facilities in their communities, ultimately reaching secondary and tertiary beneficiaries indefinitely.



### 3.4 Participants' ability to embroider on fabrics.

Furanni is a health education programme that utilizes stitching and embroidery to engage participants. The data indicates that most participants improved their embroidery skills, even though they already possessed these skills, as shown in the figure below. By incorporating embroidery and stitching—skills that participants are both familiar with and interested in—Furanni effectively educates them on sexual and reproductive health and rights (SRHR) topics. This may have contributed to their full engagement and commitment throughout the six-month programme, during which no attrition was recorded.

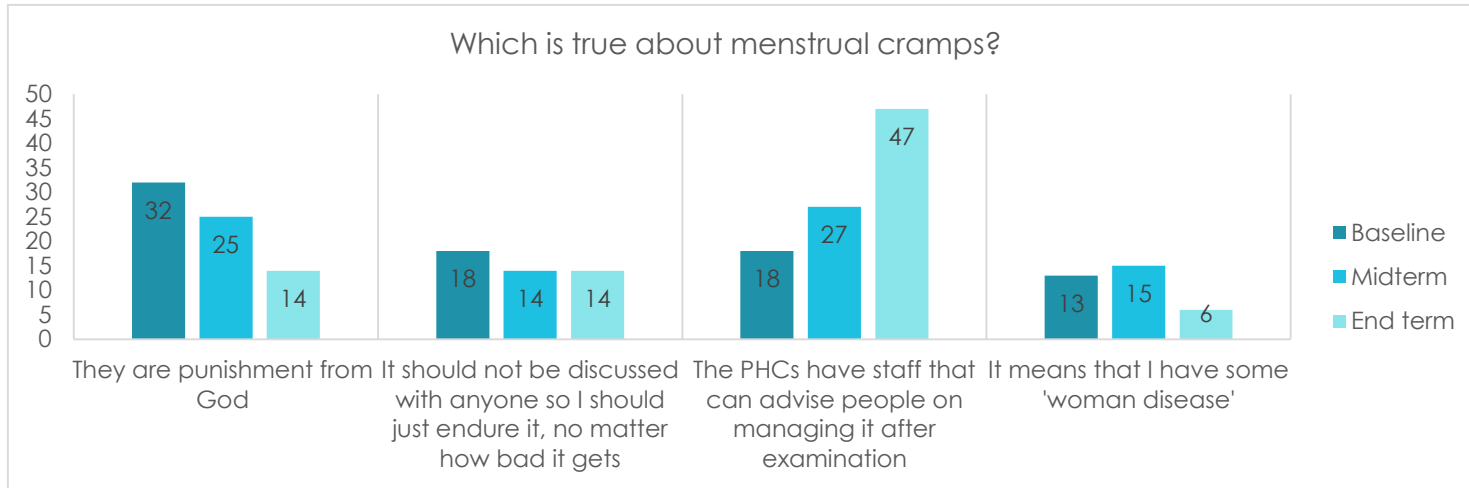


### 3.5 Participants' knowledge about menstrual health.

We tested the participants' knowledge about menstruation by asking them to identify which of four options is not appropriate when experiencing menstrual cramps. More than half of the participants answered the question incorrectly, with many believing it is acceptable to take medication recommendations from their friends. Additionally, more than a quarter of the participants were unaware of the benefits of using hot water bottles to alleviate menstrual pain, and another ten participants did not believe that adequate rest could be helpful. By the mid-term assessment, the participants had gained the correct information. By end term, 75% (61) of the assessed participants recognized that it is not advisable to seek drug recommendations from friends and family. They also became aware that rest, hot water bottles, and gentle massage can be beneficial, as illustrated in the figure below.

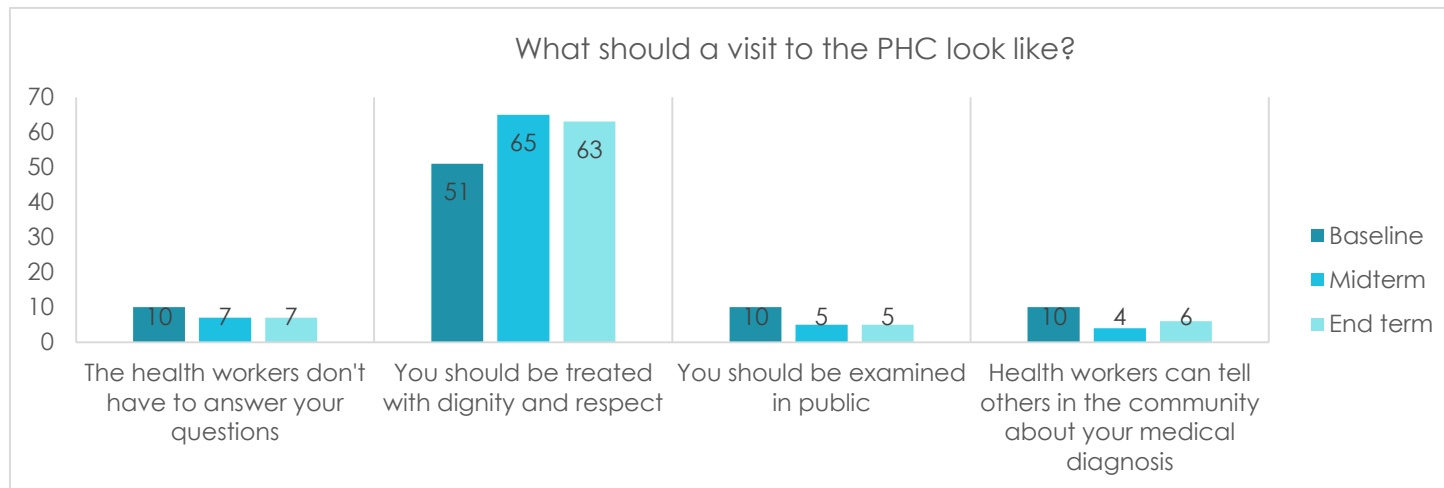


Similarly, we investigated common beliefs and practices as well as misconceptions about menstruation. At baseline, only 22% (18) of participants were aware that PHCs have staff that can advise them on how to manage menstrual cramps. Another 40% (32) considered it a punishment from God, 22% (18) believed they should not discuss issues related to menstruation with anyone and 16% (13) attributed menstrual pain to STIs and UTIs. Having participated in Furanni, participants demonstrated better awareness. For example, by endterm assessment, 58% (47) of the participants now know that they can get help in their local PHCs for menstrual-related care and menstrual cramps are not punishment from God nor a confirmation that they have STIs/UTIs. More participants also now know that there is nothing to be ashamed of discussing their menstrual health with appropriate people as shown below. Despite the progress recorded, 42% (34) of participants still maintain their old beliefs about menstruation, suggesting a deep-rooted, ingrained mental model is at play, especially given the young age of the participants. As Furanni ensured that local capacities were developed, we believe these mental models will eventually be modified as participants continue to reinforce their knowledge through reflection and community-based discussions.



### 3.6 Demanding high-quality and dignified care at healthcare facilities.

We assessed the participants' understanding of their right to receive quality and dignified care at the healthcare facilities. The demand for high-quality and respectful service at PHCs is hinged on users' awareness of this right. Initially, 63% of participants were aware of their right to quality and dignified service at the PHCs. However, after participating in the programme, awareness improved to 77% by the end term, as shown below.

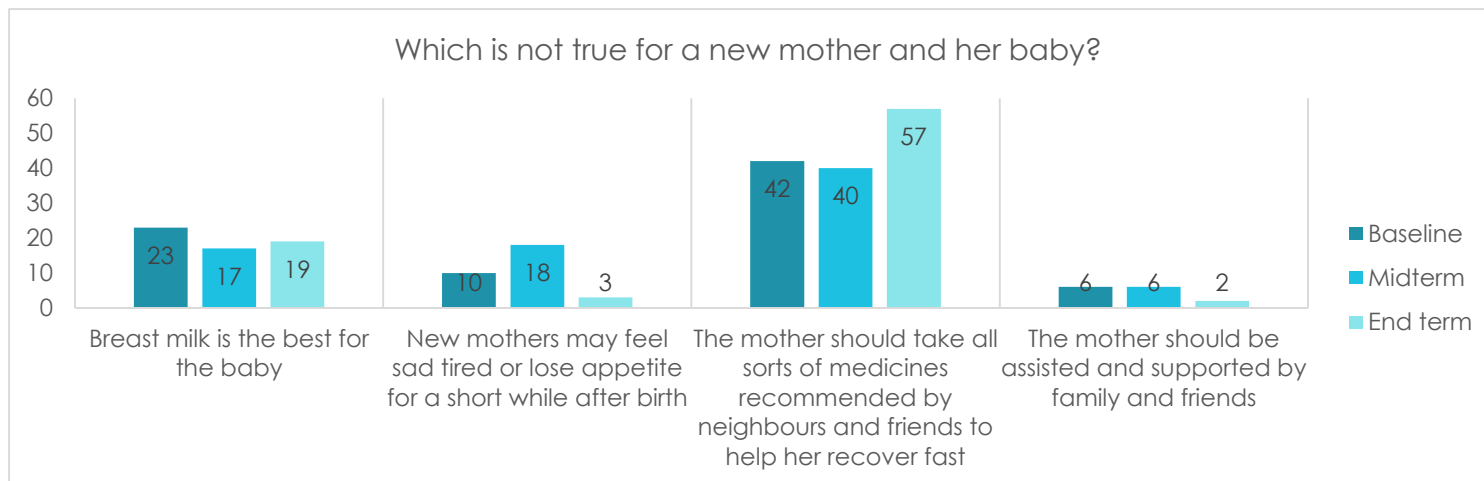


The relatively high baseline figures indicated that there might be barriers to accessing quality and dignified services at the PHCs, beyond just the PHC users' awareness, such as knowing whom to hold accountable for service failures. Based on this observation, we invited the heads of the PHCs nearest to each of the hubs to provide clarity on some questions that the participants had and to establish an accountability framework for facility users.

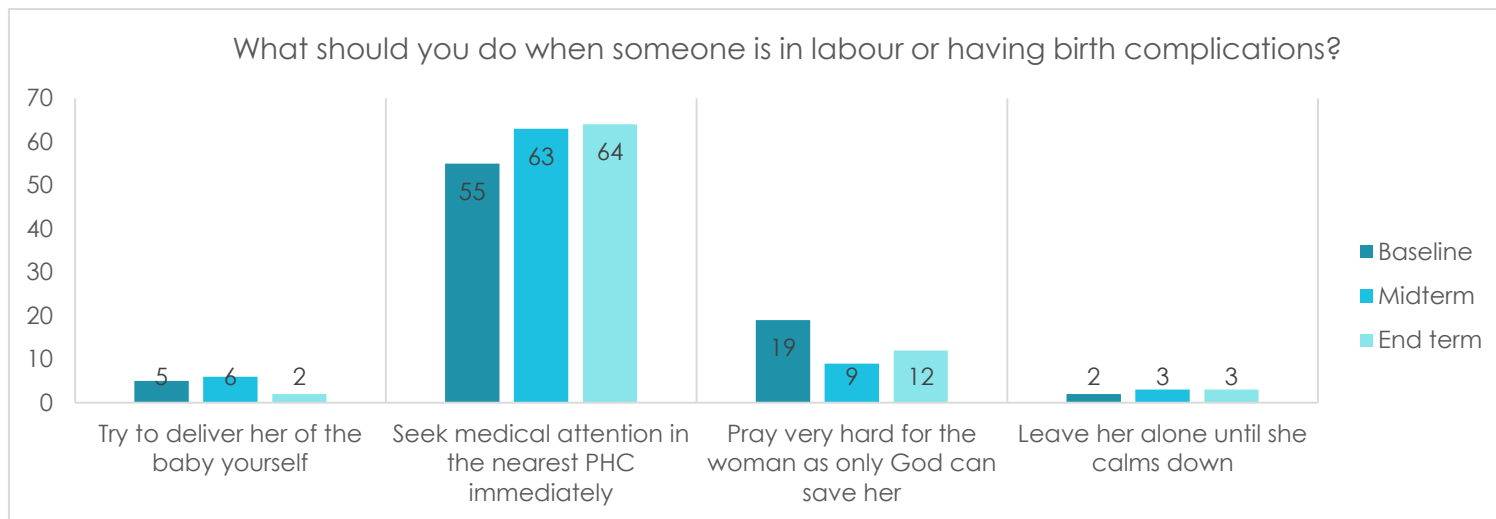
### 3.7 Participants' knowledge of maternal health.

To track participants' learning about maternal health on the programme, we asked them to identify the incorrect statement about a new mother and her baby among four options. At baseline, just over half of the participants (42) recognized that a new mother should not take medication recommendations from friends and neighbours. By end-term however, 70% (57) demonstrated this awareness.

Additionally, 28% of the participants were unaware that breast milk is the best food for a baby, and another 12% did not realize that new mothers might experience feelings of sadness, fatigue, or loss of appetite for a short period after giving birth. Both of these figures showed significant improvement by the end of the programme as shown below. This improvement may be understandable, considering that Furanni might have been the first opportunity for many participants to engage in a factual discussion about maternal health.



Furthermore, we investigated the participants' likely response to an imminent labour or birth complication. Seventy-nine per cent (64) of the participants demonstrated awareness that they needed to seek urgent medical attention by the end-term, compared to sixty-eight per cent (55) at baseline, indicating improvement. Additionally, twenty-three per cent of participants would have preferred prayer for the woman in labour over seeking medical attention, as illustrated in the figure below. While this statistic improved slightly, future iterations of Furanni may need to explicitly inform participants that both options are not necessarily mutually exclusive – one should seek medical attention and then pray if needed.



#### **4. CHALLENGES AND LESSONS LEARNED**

1. Some participants in secondary school faced time constraints, which limited the feasible time for workshops to after school hours. This limitation reduces the available time for workshops, especially since the team needed to travel to two of the delivery communities. We learned the importance of developing local capacity early on by training hub facilitators. This approach allowed us to make follow-up sessions more flexible to accommodate participants' schedules, as the hub facilitators live in the communities. Training the hub facilitators also empowered them to lead sessions, which created a sense of psychological safety for participants, making them more open to the Sexual and Reproductive Health and Rights (SRHR) messages.
2. The Baseline assessment was challenging to administer partly because some participants are not digitally literate and particularly because some participants cannot read. The delivery team had to guide participants who faced this difficulty through the assessment process. We have learned that it may be beneficial to offer an oral assessment option for participants who cannot read.
3. Some participants moved from their communities between the initial briefing session and workshop 1, necessitating the replacement and onboarding of new participants.
4. There was more interest in the programme than anticipated, particularly in the communities where FCI already has a presence. As a result, the delivery team had to accommodate more participants than originally planned. Additionally, we needed to indirectly engage some individuals we could not directly engage in the programme.
5. Myths and misconceptions about sexual and reproductive health and rights (SRHR) often vary locally and are deeply rooted in community members. These beliefs are sustained by a general silence surrounding the topic, which has become an unspoken rule. Creating safe spaces for programme participants to discuss SRHR allows them to reflect on long-held beliefs and discover factual information about them.
6. Participants are more likely to share their stories when they start by doodling their ideas. Often, they reveal stories they might not have shared otherwise after being encouraged to doodle. This could be because doodling helps them clarify

their thoughts or because it creates a sense of psychological safety that makes them more comfortable sharing their experiences.

- 7. Economic factors like inflation created operational challenges for delivery as costs and prices consistently rise during delivery.



## 5. GALLERY



First, we supported the programme participants to articulate their learning and personal stories into coherent messages. By doing this, they are able to connect the messages to their everyday experience in their communities.



Then, we listened to them tell us how what they have just learned connect with their experience, and why it matters. Zainab Safiyanu in Ghari LGA (bottom left frame) explains birth spacing using her stitch work during Workshop 6 which focused on birth control.



We got very busy stitching and making embroideries and in the process, we had engaging conversations that helped us understand the lived realities of the participants and effectively educated them.



To ensure sustainability, we focused on developing local capacity in the communities. Maimuna Sulaiman, the hub facilitator in Wudil (bottom left frame) is able to facilitate a session independently, just like the facilitators in our other hubs.



We had fun while learning and we are very proud of our achievements



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