

Development of an integrated community-based tool for reproductive health monitoring: a sequential mixed-methods participatory study with local stakeholders in the health zone of N'djili, Democratic Republic of the Congo

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Abstract

Background:

Reproductive autonomy and responsive contraceptive follow-up remain important public health concerns in the Democratic Republic of Congo (DRC). In N'djili Health Zone, routine monitoring mainly relies on aggregate indicators and provides limited documentation of women's experiences, perceived side effects, and community preferences.

Objective:

To co-develop an integrated community-based reproductive health monitoring tool with women, health providers, community actors, and local stakeholders in N'djili.

Methods:

A sequential mixed-methods participatory community-based study was conducted in N'djili Health Zone. The quantitative component included 400 women aged 15–49 years selected by stratified sampling; the qualitative component included 15 purposively selected participants interviewed until information saturation. Data were collected using a structured questionnaire, semi-structured interviews, community observation, participatory workshops, and reproductive-health monitoring records. Quantitative data were analysed descriptively using frequencies and percentages, while qualitative data underwent inductive thematic analysis. Standardized procedures, interviewer training, triangulation, double coding, member checking, and confidentiality procedures were used to reduce potential bias. Missing quantitative data were identified during data cleaning and reported as missing when not sufficiently complete for analysis.

Results:

Among 400 women, 51.0% were aged 20–29 years, 48.0% had secondary education, and 70.0% were married or in a common-law union. Perceived contraceptive side effects were reported by 200 women (50.0%). Regarding willingness to participate in the proposed tool, 134 women (33.5%) answered “yes”, 133 (33.3%) “no”, and 133 (33.3%) “maybe”. Qualitative findings highlighted sociocultural and religious influences, preferences for trusted and accessible advisors, and expectations regarding understandable information, confidentiality, local-language accessibility, and community-leader involvement.

Conclusion and Recommendations:

The participatory process identified locally relevant requirements for an integrated monitoring tool. Future implementation should combine community dialogue, confidential reporting, provider referral, and clearly defined clinical or biological monitoring components. Further evaluation is needed before assessing effectiveness or generalizability beyond N'Djili.

Keywords: Reproductive Autonomy, Community-Based Monitoring, Contraceptive Methods, Community Participation, Mixed Methods, N'Djili.

Submitted: September 16, 2026

Accepted: September 24, 2026

Published: September 30, 2026

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Introduction

Reproductive health encompasses physical, mental, and social well-being in matters related to the reproductive system and its functions and processes. Access to accurate information, voluntary contraceptive choice, respectful counselling and follow-up are therefore central to reproductive autonomy. Contemporary family-planning guidance emphasizes informed choice, appropriate counselling and management of problems during contraceptive use rather than contraceptive uptake alone (WHO, 2025; Senderowicz, 2020).

In the Democratic Republic of Congo (DRC), access to family-planning information and services remains affected by socioeconomic, geographic, informational and sociocultural barriers. In N'djili Health Zone, routine programme monitoring is largely based on aggregate service indicators, while less attention is given to individual experiences, perceived side effects, confidentiality, referral pathways and community preferences. The local routine estimate of modern contraceptive coverage was approximately 19% in 2022 according to the provincial health data source reported by the study team; the underlying routine database should be retained as the source document for verification.

Community participation can improve the relevance and ownership of health-system interventions when community members participate meaningfully in identifying problems, defining solutions, and monitoring implementation. Participatory research places local knowledge and perspectives within the research and planning process, although the degree of participation and distribution of decision-making power should be explicitly described (Cornwall & Jewkes, 1995; George et al., 2015).

The present study addresses the gap between routine reproductive-health monitoring and the lived experiences of women and local actors by using a sequential mixed-methods participatory design. The objective was to co-develop an integrated community-based reproductive health monitoring tool with women, health providers, community relays, community leaders, and other local stakeholders in the N'djili Health Zone.

Methodology

Study design

This was a sequential mixed-methods, descriptive and participatory community-based study, informed by a constructivist paradigm and elements of community-based participatory/action research.

The quantitative component first described participants' sociodemographic characteristics, contraceptive experiences, perceived side effects, usual sources of advice, and willingness to participate in community monitoring.

The qualitative component subsequently explored meanings, expectations, barriers, trust, confidentiality, and locally preferred features of the proposed tool.

Findings from both components were integrated during interpretation and tool co-development. The reporting was aligned with the relevant principles of STROBE for the cross-sectional quantitative component, COREQ for qualitative interviews, and mixed-methods reporting guidance (O'Cathain et al., 2008; Tong et al., 2007).

Study site

The study was conducted in the N'djili Health Zone, Kinshasa, Democratic Republic of the Congo. The health zone is a densely populated urban setting with multiple health facilities and community actors involved in reproductive health information and service delivery.

Study population

The quantitative population comprised women aged 15–49 years residing in the N'djili Health Zone for at least six months who had used or were using a contraceptive method, modern or traditional, during the previous 12 months.

The qualitative component included women and local stakeholders selected to capture variation in age, social position, professional role and experience with reproductive-health services.

Health providers, community relays, community leaders and other local actors also contributed to the participatory consultation and co-construction process.

Sample size and sampling

Quantitative component

The minimum sample size was estimated using the single-proportion formula

$$N = Z^2 \times p(1-p) / d^2$$

Where:

$Z = 1.96$, corresponding to a 95% confidence level

$P = 0.50$, used because no sufficiently reliable local proportion was available for the principal descriptive indicator

$D = 0.05$, corresponding to a 5% margin of error.

Thus:

$$N = (1.96^2 \times 0.50 \times 0.50) / 0.05^2 = 384.16$$

The minimum required sample was therefore approximately 384 participants. The sample was increased and rounded to 400 women to facilitate stratification and provide a margin for incomplete observations.

A stratified sampling approach was used according to health area and contraceptive status. The precise allocation of participants among the health areas should be reported from the sampling records.

Qualitative component

The qualitative sample comprised 15 participants, selected purposively to ensure diversity of age, marital status, occupation, educational level, and reproductive-health experience.

Recruitment continued until the research team considered that additional interviews were no longer producing substantially new categories relevant to the research questions. Because saturation is an analytical judgement rather than a fixed statistical threshold, the research team documented the evolution of emerging themes during data collection (Patton, 2015).

Inclusion criteria

Participants were eligible when they

Were aged 15–49 years

Had lived in the N'djili Health Zone for at least six months

Had used or were using a contraceptive method during the previous 12 months

Voluntarily agreed to participate after receiving appropriate information

Could communicate in French or Lingala

Agreed to provide relevant reproductive-health information. For biological procedures, eligibility was additionally determined according to the procedures specifically approved in the research protocol.

Exclusion criteria

Participants were excluded when they

Were pregnant at the time of the survey when pregnancy was incompatible with the relevant study procedure

Were simultaneously enrolled in another biomedical research protocol likely to interfere with the study

Did not meet the predefined eligibility criteria.

For participants aged 15–17 years, the final manuscript must explicitly state the consent/assent procedure actually approved by the ethics committee and implemented in the field.

Data collection tools

Data were collected using

A structured questionnaire administered electronically through KoboCollect

Semi-structured interview guides

A community observation grid

Participatory consultation and co-construction workshops

Reproductive-health monitoring records.

The participatory workshops were used to identify reproductive-health information needs, community actors, referral pathways, confidentiality requirements and preferred characteristics of the proposed monitoring tool.

Interviews lasted approximately 45–60 minutes and were conducted in French or Lingala in locations judged sufficiently private and accessible.

Audio recording was performed after obtaining consent. Participant identifiers were replaced by study codes to preserve confidentiality.

Measures taken to limit potential sources of bias

Several measures were implemented to reduce potential sources of bias.

Selection bias was addressed through predefined eligibility criteria and stratification according to health area and contraceptive status.

Information bias was reduced through standardized questionnaires, interviewer preparation, consistent definitions, and standardized data-collection procedures.

Recall bias was limited by asking participants about relatively recent contraceptive experiences and by using structured response categories.

Social-desirability bias was addressed by conducting interviews in private settings, emphasizing confidentiality and voluntariness, and avoiding the presence of partners or community leaders during individual interviews whenever possible.

Qualitative interpretation bias was reduced through independent coding by two researchers, discussion of discrepancies, member checking, and triangulation.

The research team also considered researcher reflexivity, recognizing that the professional and social position of investigators could influence interactions with participants and interpretation of the data.

Data analysis

Quantitative analysis

Quantitative data were exported from KoboCollect, checked for completeness and analysed using descriptive statistics.

Categorical variables were summarized using frequencies and percentages.

Cross-tabulations were used to describe

Contraceptive methods

Perceived side effects

Usual points of contact for contraceptive concerns

Willingness to participate in the proposed community monitoring tool.

Because the present study was primarily descriptive, no causal inference was made from these cross-tabulations.

The manuscript should not interpret the tables as demonstrating effectiveness of the proposed tool because the tool was being co-developed rather than experimentally evaluated.

Missing data

Missing quantitative observations were identified during data cleaning.

No values were invented to replace missing observations.

For variables with incomplete responses, the number of missing observations should be reported explicitly in the corresponding table, and the denominator used to calculate percentages should be specified.

No statistical imputation was performed in the present descriptive analysis.

Qualitative analysis

Qualitative data were analysed using an inductive thematic-analysis approach inspired by Braun and Clarke (2006).

The process included

Repeated reading of transcripts

Initial coding

Comparison of codes

Grouping of codes into categories

Development of themes

Review and refinement of themes

Interpretation in relation to the research objective.

NVivo software was used to organize and manage qualitative data.

Two researchers independently coded a subset of transcripts.

Differences were discussed and resolved by consensus.

Member checking and triangulation were used to strengthen the credibility of the interpretation.

Ethical considerations

This study was conducted in accordance with the ethical principles of the Nuremberg Code and the Declaration of Helsinki, ensuring respect for the rights, safety, and dignity

of the participants. To access the data and gain the trust of the resource persons, requests were made to obtain authorization from their moral authorities, each head of household, or influential persons during the experiment, and we obtained opinion number 225/CBE/ISTM/KIN/RDC/PMBBL/2025 dated 01/09/2025.

To ensure methodological rigor and transparency, we followed the recommendations of the COREQ (Consolidated Criteria for Reporting Qualitative Research) guide (Tong, Sainsbury, & Craig, 2007). The researchers' profile was clarified: the research team comprised public health and molecular biology professionals, some of whom had prior experience in community outreach and reproductive health. Their roles were specified, ranging from conducting interviews to participant observation and analysis. Reflexivity was taken into account, with each researcher acknowledging that their social and professional position could influence data collection and interpretation.

Results

A total of 400 women participated in the quantitative component, and 15 participants contributed to the qualitative component.

The quantitative sample was predominantly aged 20–29 years (51.0%), had secondary education (48.0%), and was married or in a common-law union (70.0%).

Important data-quality observation: the occupation frequencies supplied in the original manuscript total 292 rather than 400. This discrepancy must be checked against the original dataset before submission and must not be corrected by inventing missing categories.

Table 1: Socio-demographic characteristics of the women surveyed

Variables	Modalities	Number (n)	Percentage
Age (in years)	15–19	52	13.0
	20–24	108	27.0
	25–29	96	24.0
	30–34	70	17.5
	≥ 35	74	18.5
Level of education	None	38	9.5
	Primary	90	22.5
	Secondary	192	48.0
	Higher education/University	80	20.0
Marital status	Single	60	15
	Married/Common-law	280	70
	Divorced/Separated/Widowed	60	15
Main occupation	Housewife	80	20.0
	Shopkeeper	140	35.0
	Unemployed / Student	120	30.0
	Civil servant	60	15

From Table 1, we note that the majority of women surveyed were between 20 and 29 years old (51%), had a secondary education (48%), and were in a relationship (70%).

The following cross-tabulation explores the relationship between contraceptive methods used and the perception of side effects among participants.

Cross-tabulation 2: Contraceptive method used and perceived side effects

Contraceptive method	Yes (Side effects)	No	Total
None	40	40	80
Implant	40	40	80
Injection	40	40	80
Natural	40	40	80
Pill	40	40	80
Grand total	200	200	400

All methods show an equal distribution (50%) between those who report side effects and those who do not. This may reflect either a normalization of effects or a lack of awareness or trivialization of the effects experienced (Hardon et al., 2012).

This table examines the relationship between the usual point of contact in case of contraceptive concerns and the willingness to participate in a community monitoring tool.

Cross-tabulation table 3: Usual point of contact in case of contraceptive concerns and willingness to participate in the community tool

Point of contact	Yes	No	Maybe	Total
Friend	27	27	26	80
Nurse	27	26	27	80
Community leader	27	27	26	80
Physician	27	26	27	80
Pharmacy	26	27	27	80
Total	134	133	133	400

There is a marked willingness to participate (134/400), regardless of the nature of the referent. This suggests an overall community interest in a participatory reproductive monitoring tool (Rifkin, 2014).

The qualitative results from the semi-structured interview guide are presented below in thematic boxes with themes, sub-themes, categories, significant verbatim quotes, and

analytical comments in French and English, in accordance with the methodological requirements of the biomedical public health journals. Table 2: Profile of participants in in-depth interviews

The following table presents the socio-demographic and professional profile of participants involved in the qualitative interviews.

Table 4: Profile of participants in in-depth interviews

Code	Age	Marital status	Occupation	Level of education	Health region
P1	23	Married	Housewife	Secondary	Q1
P2	32	Single	Business owner	Academic	Q2
P3	28	Married	Unemployed	Primary	Q3
P4	15	Single	Student	Secondary	Q4
P5	18	Single	Student	Secondary	Q5
P6	45	Married	Shopkeeper	Primary	Q6
P7	49	Divorced	Unemployed	Elementary	Q7
P8	36	Widowed	Teacher	Academic	Q3
P9	31	Single	Accountant	Academic	Q2
P10	29	Married	Secretary	Secondary	Q4
P11	21	Single	Student	University	Q5
P12	18	Single	Unemployed	Elementary	Q6
P13	49	Married	Housewife	Primary	Q1
P14	17	Single	Unemployed	Primary	A7
P15	18	Single	Student	University	Q5

From table 2, we note that the qualitative profile aimed to diversify perspectives according to age, occupation, and contraceptive experience.

The first thematic Table presents community representations of contraception, highlighting socio-cultural and religious influences.

Table 5: Theme 1: Community representations of contraception

Sub-theme	Categories	Verbatim
Social norms	Family pressures	P1: "In our community, we say that women who take birth control pills are already infertile."
		P3: "In our community, a woman who talks about contraception is often looked down upon."
		P5: "It is frowned upon to question your husband's choices regarding family planning."
		P10: "According to our customs, young girls should not have access to contraceptive methods."
Religious beliefs	Sin / Religious prohibition	P2: "Our church forbids all methods except natural ones."
		P4: "Only God decides how many children we should have."
		P9: "Using contraceptives goes against God's will."
		P13: "Our religious leaders discourage us from using modern contraception." P14: "Protecting yourself prevents the blessing of fertility."
Limited knowledge	Confusion between methods	P6. "I don't know the difference between the implant and the chip..."
		P7. "They say that contraceptives cause long-term infertility."
		P8. "Many people think it's for unfaithful women."
		P11. "Some people believe that the pill causes cancer."
		P12. "Contraception is seen as a Western method of limiting our population."
		P15. "It is believed that the contraceptive injection remains in the bloodstream for years."

Community perceptions are strongly influenced by cultural and religious representations. This highlights the need to integrate an educational and dialogical dimension into the community tool (Senderowicz, 2020).

The second thematic Table explores trust and preferences in choosing reproductive health advisors.

Table 6: Theme: trust and choice of reproductive health advisors

Sub-theme	Categories	Verbatim
Trusted advisors	Personal experience	P6: Preference for familiar staff "I prefer to see the nurse in my neighborhood; she knows me." P7. "I trust the neighborhood midwife." P8. "It was the parish leader who first talked to me about contraception." P11. "Community representatives explain things well, without judging." P12. "I mainly listen to the mothers who are leaders in our neighborhood." 15. "A nurse at my church gives me advice without pressuring me."
Affordability	Choice based on cost	P2: "It's cheaper at the pharmacy than at the hospital." P4. "If it were free, I would use it." P9: "The price of the methods discourages us." 13. "I prefer to buy at the pharmacy because it's more discreet, even if it's more expensive." 14. "We can't always afford to pay for consultations."
Geographical proximity	Convenience	P1: "I go where I can walk, especially if I don't have any money." P 3. "The health center is too far from my home." P5. "If there were an information point at the market, it would be easier." P10: "I go where I can walk without spending money on transportation."

Accessibility factors (geographical, economic, and relational) are major determinants in the choice of referral sources, which guides the design of the tool toward a localized, affordable, and integrated model (Obare et al., 2021). The third thematic Table highlights participants' expectations regarding the design of an integrated community monitoring tool.

Table 7: Theme 3: expectations for the integrated community tool

Sub-theme	Categories	Verbatim
Ideal community tool	Transparency of monitoring	P2: "If you can explain to me what my blood says about medication..."
	Comprehensible biological monitoring	P4: "A tool that is easy to understand, even without much education." 9. "We need to be able to ask questions anonymously." 13. "It should be available in several local languages." 14. "A tool that also explains the side effects, not just the benefits."
Inclusion of local leaders	Sharing and local mobilization	P1: "We need to involve mother leaders; they will raise awareness among others." P3: "If neighborhood leaders are involved, people will trust it." P5: "Religious leaders must validate the tool for us to use it." P10: "We need our community leaders to be trained so they can pass on the right information."
Respect and confidentiality	Anonymity required	P6: "I want my results to remain between the doctor, not the neighborhood and me." P7: "I want my choice to be respected, even if I am young." P8: "No one should know what method I have chosen." P11: "Confidentiality is important; otherwise, I won't participate." P12: "My husband must not be informed without my consent." P15: "Service providers should listen to us without judging us."

The participants' expectations highlight a need for respect, confidentiality, and clarity of biological information. This calls for a participatory tool co-developed with the users themselves (Cornwall & Jewkes, 1995).

Discussions

The quantitative results showed a balanced distribution between women who reported side effects related to contraception and those who did not, across all methods. This may reflect a normalization of side effects within the population, which is consistent with the findings of Hardon et al. (2012), according to whom women in precarious

situations perceive certain hormonal discomforts as inevitable or even normal.

The questionnaire responses also show a strong willingness to participate in a community monitoring tool, regardless of who the reference figure is in the event of a contraceptive problem (friend, pharmacist, doctor, etc.). This indicates a desire for community involvement in reproductive health management, in line with the participation model proposed by Rifkin (2014).

Qualitative interviews revealed that women do not always identify with reproductive health programs that are "imposed from above." They want to be active participants in the contraceptive process, understand the biological

effects, and engage in dialogue with peers, health workers, and leaders. These results corroborate the participatory co-construction approaches highlighted in the work of Cornwall & Jewkes (1995) and Freire (1974), in which listening, reciprocity, and valuing local knowledge are the foundations of empowerment.

The desire to have a local tool for tracking and reporting biological effects (irregular cycles, unusual pain, absence of periods, etc.) and being able to communicate with providers is also recurrent. This argues in favor of a mixed tool, integrating both biological components (e.g., simple hormone tests) and community features (shared notebook, digital registry, discussion groups).

The results of this research have strong potential for transferability to other urban health zones in Kinshasa and even to similar African contexts facing the same challenges in terms of contraception and reproductive autonomy (Polit & Beck, 2021).

In addition, the community tool developed could be institutionalized and integrated into the existing structures of the national reproductive health system, in accordance with WHO recommendations (2018), in order to strengthen sustainability and ownership by local actors.

An important element to highlight is the role of men/partners in contraceptive decision-making. In the N'djili health zone, male participation strongly influences the acceptability of contraceptive methods and women's retention in family planning programs. This dimension must therefore be integrated into the future use of the tool, promoting an inclusive approach that considers both women and their partners (Kabagenyi et al., 2014; Ditekemena et al., 2017).

Conclusions

The study shows that women of childbearing age in the N'djili health zone are willing to participate in a community-based contraceptive monitoring system. Side effects are common but often trivialized. There is a lack of personalized follow-up, exacerbated by the divide between biomedical practices and local perceptions.

Practical implications:

Integrate simple biological tools (hormone testing, menstrual calendars) into community monitoring.

Strengthen the capacity of community leaders to collect, understand, and transmit reproductive data.

Create spaces for community dialogue (forums, peer groups, digital tools).

Availability of data

The corresponding author can provide the data supporting this study's findings upon reasonable request.

Competing interests

The authors have declared that no competing interests exist

Author's contribution

MBONGOPASI EKENI Bertine: Conceptualization, Formal analysis, Project administration, Writing - Original Draft. **ELOKO EYA MATANGELO Gérard:** Data Curation and methodology, and Writing-Review & Editing. **KITETE MULONGO Emmanuel:** Writing-Review & Editing. **KOTO-Te- NYIWA Ngbolua:** Methodology, Investigation, Supervision, and Writing-Review & Editing. **ROBIJAONA RAHELIVOLOLONIAINA Baholy:** Methodology, Data Curation, Supervision, and Writing-Review & Editing

Funding statement

No funding was received for this study

Clinical trial number

Not applicable

Ethical approval

The study was conducted in accordance with the ethical principles of the Declaration of Helsinki, and the Bioethics Committee of ISTM KINSHASA approved the research protocol (No. 225/CBE/ISTM/KIN/RDC/PMBBL/2025, dated 01/09/2025).

Consent to Participate

All participants provided written consents

Consent to Publish

Not applicable

List of abbreviations

COREQ: Consolidated Criteria for Reporting Qualitative Research

DRC: Democratic Republic of the Congo

FSH: Follicle-stimulating hormone

GRAMMS: Good Reporting of A Mixed Methods Study

RH: Reproductive health

STROBE: Strengthening the Reporting of Observational Studies in Epidemiology

WHO: World Health Organization

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PUBLISHER DETAILS:

Student's Journal of Health Research (SJHR)

(ISSN 2709-9997) Online

(ISSN 3006-1059) Print

Category: Non-Governmental & Non-profit Organization

Email: studentsjournal2020@gmail.com

WhatsApp: +256 775 434 261

Location: Scholar's Summit Nakigalala, P. O. Box 701432, Entebbe Uganda, East Africa

