

Prevalence and determinants of *Streptococcus pneumoniae* infections among children under five years at Entebbe Regional Referral Hospital in Wakiso District. A cross-sectional study.

Joash Wasswa*, Hasifa Nansereko, Anthony Isaiah Ssekitoileko, Francisco Ssemuwemba
Mildmay Institute of Health Sciences

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ABSTRACT

Background

Streptococcus pneumoniae remains a leading cause of pneumonia morbidity and mortality among children under five years. Socio-demographic and environmental factors influence nasopharyngeal carriage and transmission risk. The study aims to assess the prevalence of *Streptococcus pneumoniae* and examine its association with socio-demographic determinants among children under five years at Entebbe Regional Referral Hospital.

Methods

A retrospective total enumeration approach was used. All medical records of children under five years diagnosed with *Streptococcus pneumoniae* infections at the pediatric ward at Entebbe Regional Referral Hospital were retrieved and reviewed. Records from 151 patients were included if they contained complete demographic data, clinical diagnosis, and laboratory confirmation by culture. Collected data were entered in Microsoft Excel, cleaned, and exported to SPSS Version 20.0 for analysis. Analysed data were presented in the form of percentages and frequencies in tables, pie charts, graphs, and narratives.

Results

The overall prevalence of *Streptococcus pneumoniae* was 23.8% (36). Males represented 67.5%; females 32.5%. Crowded households recorded the highest prevalence, 15.2%. Low-income households (15.2%), indoor biomass fuel use (14%), household smoking 15.2 %, wet season 14.6 %, the highest prevalence; parents who had primary education at 10.5 %. Overcrowding, household smoking and low income showed highest prevalence 15.2%, by wet season 14.6%, indoor biomass fuel use 14%, and least among high income earners.

Conclusion

The findings indicate that *Streptococcus pneumoniae* infection among children under five remains a significant public health concern, with household socio-economic and environmental conditions potentially contributing to transmission. Addressing these modifiable conditions may help reduce the burden of infection among young children.

Recommendation

Health facility outreach programs should target crowded households for intensive health education by health facility outreach programs.

Keywords: *Streptococcus pneumoniae*, Pneumococcal infection, Children under five, Socio-demographic determinants, Environmental factors

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Corresponding author: Joash Wasswa
Mildmay Institute of Health Sciences

Background

Childhood pneumonia remains a leading contributor to morbidity and mortality among children under the age of five, with the burden disproportionately higher in low- and middle-income countries. The discrepancy between developing and developed nations has long been noted, with available epidemiological data showing substantially elevated incidence rates in resource-limited settings. This disparity partly reflects structural inequities in access to preventive interventions such as vaccination programs, prompt diagnostic services, and adequate medical treatment. Global health agendas, such as the Millennium

Development Goals initiated by the WHO and UN, explicitly sought to reduce under-five mortality by applying targeted measures against pneumonia through immunisation campaigns, lowering environmental risks, improving early detection, and facilitating treatment accessibility (Salma, 2013).

Beyond broad international targets, country-specific realities shape how pneumonia manifests as a health challenge. In many parts of sub-Saharan Africa, infections like pneumonia frequently occur in synergy with other high-burden diseases such as malaria and diarrheal illnesses. For Uganda specifically, acute lower respiratory infections

(ALRIs) are second only to malaria in terms of morbidity and are recognised as the primary cause of death among children under five. Malnutrition plays a compounding role by increasing susceptibility and severity; it is estimated to underlie more than half of childhood deaths across the region (Savic, 2015).

Socio-demographic factors exert a strong influence on pneumonia incidence patterns. Children from economically disadvantaged families or those living in rural areas face elevated risks. Limited maternal education correlates with increased hospitalisation rates for paediatric pneumonia cases. Interestingly, some analyses have observed paternal education exerting even stronger effects when included jointly in explanatory models. (Rashidah & Cliffe, 2023). Household poverty often accompanies work conditions that hinder regular healthcare engagement, especially in populations where measuring income objectively is challenging due to widespread subsistence farming or informal labour arrangements. (Nambuya *et al.*, 2025)

Environmental risk factors compound socio-economic vulnerabilities. Exposure to second-hand tobacco smoke can impede respiratory immune defence by reducing phagocytic function and impairing activity in airway epithelial cells. This impairment facilitates bacterial adherence within the respiratory tract, thereby increasing colonisation potential for pathogens like *Streptococcus* species (Ogwang, 2017). Overcrowded living environments similarly heighten transmission probability through sustained close contact, an issue markedly evident in refugee camp settings where case numbers have been documented at higher proportional rates compared to non-camp communities (Mengstie, 2022). Variations in housing quality between regions may partially explain observed spatial differences in pneumonia admissions and mortalities; poorer housing conditions aligned geographically with higher burdens underscore the environmental contribution (Wanyana, Migisha, King, Bulage, *et al.*, 2024).

From an etiological perspective, *Streptococcus pneumoniae* is consistently highlighted as a dominant agent causing systemic infections in paediatric cases. Studies have reported its recovery from multiple clinical specimens, including cerebrospinal fluid, sputum, throat swabs, and blood cultures at strikingly high proportions. For instance, over three-quarters of isolates from throat swabs were streptococcal, even though overall prevalence rates varied between regions (Onalo *et al.*, 2011). The study aims to assess the prevalence and socio-demographic determinants of *Streptococcus pneumoniae* infections among children under five years of age at Entebbe Regional Referral Hospital in Wakiso District.

METHODOLOGY

Study Design and Rationale

A retrospective cross-sectional study based on review of past and current medical/ laboratory records using a structured data abstraction form. This design allowed estimation of the prevalence of *Streptococcus pneumoniae*

at a defined point in time using existing records, and enabled exploration of socio-demographic and clinical determinants without prospective data collection. Using routine records makes the study relatively economical and feasible, and provides baseline information useful for planning public-health interventions such as targeted awareness campaigns.

Study Area

The investigation was conducted within the clinical and operational confines of Entebbe Regional Referral Hospital, a prominent health facility situated in Wakiso District in central Uganda. This institution serves as a tertiary referral centre, receiving pediatric patients from both urban catchments within Entebbe municipality and extensive rural areas that stretch along the Lake Victoria shoreline and into adjacent district territories. Data collection was done during the period of February 2026 to April 2026.

Study Population

The study population did not involve physical patients but rather the review of records from children aged below five years who presented to the pediatric services at Entebbe Regional Referral Hospital with clinical profiles suggestive of pneumonia or invasive *Streptococcus pneumoniae* disease and tested positive.

Inclusion Criteria

All records from 151 patients, both male and female children below 5 years whom they tested for *Streptococcus pneumoniae*.

Exclusion criteria

All children above 5 years, and children below 5 years with incomplete data.

Sample Size Determination

The Kish-Leshone sample size determination formula was used to determine the number of individuals who were included in the sample from a larger population for the research study.

Formula:

$$N = \frac{z^2 pq}{d^2} \text{ (Kish, Leslie. 1965)}$$

Where;

N	=	required sample size
d	=	degree of accuracy/allowable error (0.05%)
z	=	confidence limit (1.645 at 90% level of confidence)
p	=	16.8% (Kanyange <i>et al.</i> , 2025)
Q	=	1-P
Therefore, N	=	$\frac{(1.645)^2 (0.168) (1-0.168)}{(0.05)^2}$
	=	$\frac{2.706025 \times 0.139776}{0.0025}$

= 151

Therefore, a sample size of 151 children's records of children under 5 years were included in the study.

Sampling Technique

A retrospective total enumeration approach was used. All medical records of children under five years diagnosed with or tested for *Streptococcus pneumoniae* infections at the pediatric ward at Entebbe Regional Referral Hospital were retrieved and reviewed. Records from 151 patients were included if they contained complete demographic data, clinical diagnosis, and laboratory confirmation by culture.

Sampling Procedure

The sampling procedure was conducted through ethical clearance, and administrative permission was obtained to access medical and laboratory records. The hospital's Laboratory Information System and pediatric inpatient/outpatient registers were used as the sources of data. All records of patients aged below 5 years with a laboratory request or result for *Streptococcus pneumoniae* testing were extracted; each retrieved record was screened against the eligibility criteria.

Research Variables

Dependent Variable

The dependent variable is the presence of pneumonia among children aged five years and below, with a focus on laboratory and clinical confirmation of *Streptococcus pneumoniae* infection.

Independent Variable

Independent variables encompass a broad set of socio-demographic, environmental, health-related, and behavioural attributes.

Data Collection Tools

For socio-demographic and child clinical history data, a structured abstraction tool to extract demographic, clinical, and laboratory data was employed. Clinical history elements were extracted from pediatric physician records maintained by the hospital's medical file system. This information included previous episodes of respiratory illness, confirmed pneumonia events, and concurrent illnesses like diarrhoea or measles known to compound respiratory vulnerability.

Quality Control

Data source: 10% of records were double-extracted by a second researcher to check for accuracy. Discrepancies were resolved by consensus.

De-identification: All personal identifiers were removed and replaced with study codes to maintain confidentiality. Standard operating procedures were followed.

Data Collection Procedure

This study used secondary data obtained through a retrospective review of existing records and current laboratory results. No new data was collected from patients. The procedures involved the following steps:

Data source: Records were obtained from the hospital database, files, and records.

Access & permissions: Ethical approval was secured from the laboratory manager and permission to access records.

Data extraction: Relevant variables, including [age, diagnosis date, and treatment outcome], were extracted using a standardised data abstraction form.

De-identification: All personal identifiers were removed and replaced with study codes to maintain confidentiality.

Piloting the Study

Before the full-scale implementation of the research, pre-testing was conducted to evaluate the feasibility and robustness of the research methodology. This pilot phase involved approximately 10% of the calculated sample size, which is roughly 15 participants, and was carried out at Kajjansi Health Centre IV. This facility was selected for the pilot study because it shares similar socio-demographic and clinical characteristics with Entebbe Regional Referral Hospital, yet remains distinct from the primary study site to prevent contamination of the final data pool.

The primary objective of the pilot was to assess the clarity, flow, and cultural appropriateness of the questionnaire. It allowed the researcher to identify ambiguous questions that caregivers might misinterpret and to estimate the average time required for each interview. Additionally, the pilot served as a "dry run" for the logistical aspects of specimen handling and transportation. Feedback gathered during this phase was used to refine the data collection tools and clinical protocols, ensuring that the main study proceeds with improved efficiency and that the instruments are optimised to capture accurate data regarding the determinants of pneumococcal infection.

Data Management and Analysis

Collected data were entered in Microsoft Excel, cleaned, and exported to SPSS Version 20.0 for analysis.

The analysed data were presented in the form of percentages and frequencies in tables, pie charts, graphs, and narratives.

Ethical Considerations

A written introductory letter from the Administrator of Mildmay Institute of Health Sciences was presented to the management and staff of Entebbe Regional Referral Hospital along with a detailed explanation of the researcher's intention to carry out the study in the area. Informed consent was sought from the respondents, during which the Researcher introduced himself, explained the

purpose of the study, the safety of the process, and the benefits of the study.

To preserve confidentiality, all collected data, both interview responses and laboratory findings, were anonymised at the point of capture using coded identifiers in place of personal names. Identifiable information like addresses or parent names were excluded from analytical datasets. Laboratory request forms employed codes matching anonymised case records. Physical files

containing raw data were stored in secure cabinets within the pediatric department accessible only to designated study staff.

RESULTS

Sociodemographic characteristics of participants.

Table 1: Shows the sociodemographic characteristics of the study.

Variables	Category	Frequency (N)		Percentage (%)		Total Frequency (N)	Percentage (%)
		Male	Female	Male	Female		
Age group	0 days - 4 months	8	5	5.3	3.3	13	8.6
	5months-1 years	30	15	19.9	10	45	30
	1 year-2years	10	6	6.6	4	16	10.5
	3years -5years	54	23	35.7	15.2	77	51
Total		102	49	67.5	32.5	151	100
Gender	Male	102	—	67.5	—	102	67.5
	Female	—	49	—	32.5	49	32.5
Total		102	49	67.5	32.5	151	100
Religion of caregivers	Catholic	44	20	29.1	13.2	64	42
	Protestant	23	12	15.2	8	35	23.3
	Moslem	32	15	21.2	10	47	30.7
	Others	3	2	2	1.3	5	4
Total		102	49	67.5	32.5	151	100
Variable	Category	Frequency (N)		Percentage (%)		Total Frequency (N)	Percentage (%)
		Male	Female	Male	Female		
Education level of caretakers	Primary	9	5	6	3.3	14	8.7
	Secondary	37	15	24.5	10	52	34.7
	Tertiary	55	26	36.4	17.2	81	54
	No response	1	3	0.6	2	4	2.6
Total		102	49	67.5	32.5	151	100

The study involved 151 respondents, of whom 67.5% (102) were male children and 32.5% (49) were female children. Most participants were aged between 3-4 years (51%), followed closely by 5months-1 year (30%), while 10.5% were aged between 1-2 years and 8.6% were aged between 0 days - 4months.

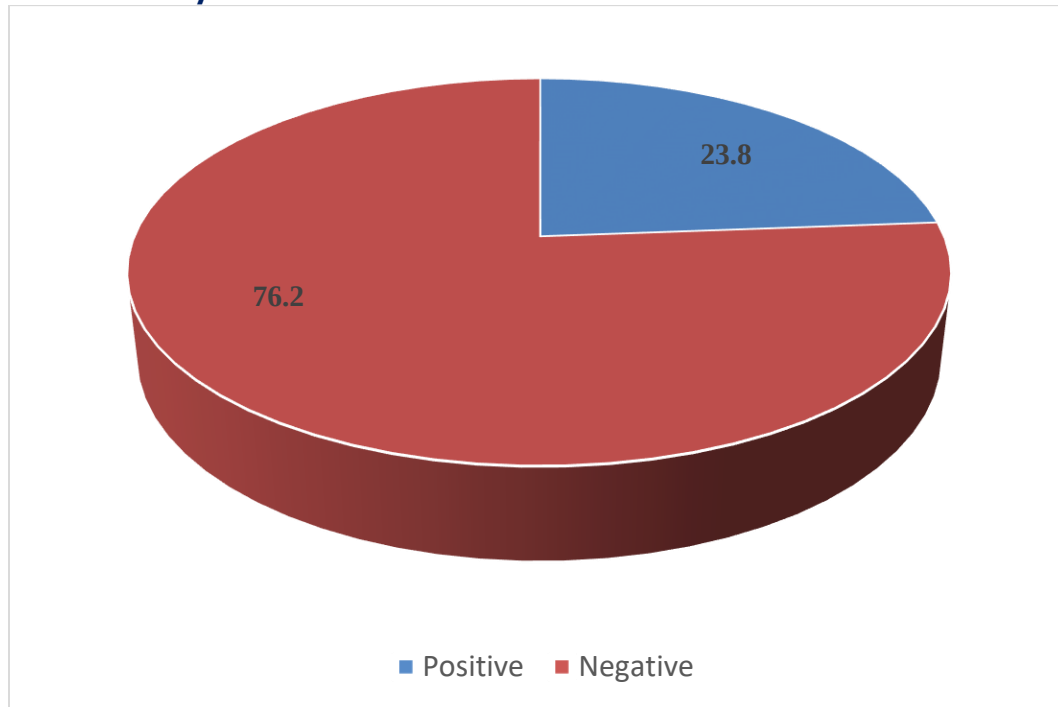
For religion, most participants' caretakers were Catholics, 42% (64), Muslims, 30.7% (47), Protestants, 23.3% (35), and the least were from other religions, 4% (5)

For education level of caretakers, the tertiary-educated participants were 54% (81), followed by those with a secondary education, 34.7% (52), while those with primary education were 8.7% (14).

Prevalence of Streptococcus Pneumoniae

Figure 2: Pie chart showing the Prevalence of Streptococcus Pneumoniae among children less than five years.

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Socio-demographic determinants associated with Streptococcus Pneumoniae

The table presents the prevalence of Streptococcus Pneumoniae across selected social and demographic characteristics among the 151 study participants.

Table 2 shows the social demographic determinants associated with Streptococcus pneumoniae

Variable	Category	Frequency	Negatives	Positives (n)	Prevalence (%)
Household level	Crowded >3 persons/room	88	65	23	15.2
	Not crowded <= 3 persons per room	63	50	13	0.9
Income earning	Low income earning	73	50	23	15.2
	Middle/ high income	78	65	13	0.9
Environment exposure	Indoor biomass fuel use	72	51	21	14
	No biomass fuel use	79	64	15	9.9
	No household smoking	41	28	13	8.6
	Household smoking	110	87	23	15.2
Seasonal wealth variability	Wet season	75	53	22	14.6
	Dry season	76	62	14	9.2
Parental Education					

No formal education	38	28	10	6.6
Primary education	71	55	16	10.5
Secondary	30	24	6	4
Tertiary Education	12	8	4	2.6

At the household level, Prevalence was higher among participants from crowded households, defined as more than 3 persons per room. Of the 88 participants living in crowded conditions, 23 tested positive, yielding a prevalence of 15.2 %. Participants from non-crowded households had a lower prevalence of 0.9%.

Income level showed a clear difference in prevalence: participants from low-income households had a prevalence of 15.2 % compared with 0.9% among participants from middle- or high-income households.

Environmental exposure, both indoor biomass fuel use and household smoking, was associated with increased prevalence. Participants exposed to indoor biomass fuel had a prevalence of 14 % versus 9.9 % among those not exposed. Similarly, household smoking was linked to a prevalence of 15.2%, higher than the 8.6 % observed in households without smoking.

Seasonal variability: a seasonal pattern was evident, with higher prevalence during the wet season (14.6%); the dry season was 9.2%.

Parental Education: the highest prevalence was observed among participants whose parents had primary education at 10.5%, followed by those with no formal education at 6.6%. Participants with parents who had secondary and Tertiary education had lower prevalence of 4% and 2.6%, respectively.

Discussion

According to the study findings, the overall prevalence of *Streptococcus pneumoniae* among children under 5 years was 23.8 % (36).

These findings indicate that nearly 1 in 4 children in the study population carried the organism; these findings align with the substantial global burden of pneumococcal disease reported in low- and middle-income countries.

The study findings are in agreement with a study by (Rashidah *et al.*, 2023) in sub-Saharan Africa, where *Streptococcus pneumoniae* remains a leading cause of childhood morbidity and mortality, with approximately 1621 cases per 100000 children in 2018 and a prevalence of 15.8%.

The findings are also in agreement with another study (GBD, 2023) that estimated 197,000 children under 5 years died of *Streptococcus pneumoniae* infection, with an incidence rate of 0.29 episodes per child-year

Within Africa, the study findings are in agreement with Nigerian studies (Adamu *et al.*, 2023) that reported a nasopharyngeal carriage prevalence of 22.6%. Another study in south-east Nigeria reported a prevalence of 11% for *Streptococcus pneumoniae* among children under 5 years (Nnaji *et al.*, 2024)

The agreement could be due to similar settings with comparable levels of household crowding, low vaccination coverage, and limited access to health care.

However, the study findings of 23.8% prevalence are in disagreement with other studies by Anis *et al.* (2021) that showed a pooled prevalence of 36.0%, higher than the study findings at Entebbe Regional Referral Hospital. The disagreement could be due to much higher exposure to cigarette smoking and runny nose, which are strong predictors of carriage in Indonesia and Bajau compared to Uganda.

According to the study findings, a higher prevalence of *Streptococcus pneumoniae* was found in crowded households, with a prevalence of 15.2%; this is in agreement with (Rashidah *et al.*, 2023), who reported that overcrowding increases the probability of repeated close contacts with infectious individuals.

The study findings also revealed a higher prevalence among participants exposed to indoor biomass fuel use 14% and household smoking 15.2% This is in agreement with Rashidah & Cliffe, (2023) that indicated indoor air pollution from wood or charcoal stoves facilitates airway irritation and reduces mucociliary clearance efficiency, making bacterial colonisation more likely.

The study findings also revealed that low-income earners had a prevalence of 15.2%; this is also in agreement with Cliffe *et al.* (2023), which indicated that low-income families face structural barriers in accessing care, including transport costs.

Prevalence was highest among children whose parents had no formal education, at 6.6%; this is in agreement with Surafel *et al.* (2023), who revealed that low education attainment limits caregiver understanding of disease symptoms and affects health-seeking behaviour. The prevalence was high in the wet season (14.6%); this is in disagreement with other studies that showed a higher prevalence in the dry season compared with the wet season.

Conclusion

The study revealed that the overall prevalence of *Streptococcus pneumoniae* was 23.8 % (36). Males represented 67.5% and Females 32.5%

Prevalence was higher among participants from crowded households at 15.2%. Participants from low-income households had a prevalence of 15.2 % compared with 0.9% among participants from middle- or high-income households. Both indoor biomass fuel use and household smoking were associated with increased prevalence. Of 14% and 15.2%, respectively, a seasonal pattern was evident with higher prevalence during the wet season (14.6%); the

highest prevalence was observed among participants whose parents had primary education at 10.5%.

Among the social demographic determinants associated with *Streptococcus pneumoniae*, overcrowding, household smoking, and low income all showed the same highest prevalence (15.2%), followed by the wet season 14.6%, indoor biomass fuel use 14%, and, least, high-income earners.

Recommendation

Health facility outreach programs should target crowded households for intensive health education by health facility outreach programs.

Health facilities should strengthen policies that promote access for low-income families.

Community members should scale up seasonal preparedness before the wet season.

Community leaders should launch a smoke-free and clean home campaign at the community level.

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List of abbreviations

ALRIs: Acute Lower Respiratory Infections.

WHO: World Health Organisation.

UN: United Nations

SPSS: Statistical Package for Social Sciences

Source of funding

The study was not funded.

Conflict of interest

The authors did not declare any conflict of interest.

Data availability

Data are available upon request.

Author contribution

Wasswa Joash: Conceptualization, Funding acquisition, Methodology, Investigation, Data curation, Writing – original draft

Hasifa Nansereko: Software, Formal analysis, Visualisation

Anthony Isaiah Ssekitolesko: Resources, Supervision, Validation

Francisco Ssemuwemba: Project administration, Writing – review & editing

Author biography

Joash Wasswa is a student of a diploma in medical laboratory at Mildmay Institute of Health Sciences.

Hasifa Nansereko is a supervisor at Mildmay Institute of Health Sciences

Anthony Isaiah Ssekitolesko is a supervisor at Mildmay Institute of Health Sciences

Francisco Ssemuwemba is a supervisor at Mildmay Institute of Health Sciences

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