Prevalence of surgical site infection and associated factors after cesarean section in Ethiopia: systematic review and meta-analysis

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Abstract

Background

Surgical site infection (SSI) affects up to one third of patients who have undergone a surgical procedure. It is a significant cause of surgical patient morbidity, mortality and human and financial costs threat. The national prevalence of surgical site infection among mothers who undergo for cesarean section and its risk factors are not well investigated in Ethiopia. Therefore, this systematic and meta-analysis conducted to estimate the pooled prevalence of surgical site infection and associated factors after cesarean section in Ethiopia.

Methods

Original articles were searched in PubMed/MEDLINE, EMBASE, CINAHL, Google Scholar, HINARI portal (which includes the SCOPUS, African Index Medicus, and African Journals Online databases), and Cochrane Library. Data were extracted using a standard data extraction checklist that developed according to Joanna Briggs Institute (JBI). The I² statistic was used to quantify heterogeneity across studies. Funnel plot asymmetry and Egger’s tests were used to check for publication bias. A fixed effect model was used to estimate the pooled prevalence of surgical site infection. Odds Ratio (OR) with 95% Confidence Interval (CI) was also used to determine the association of identified variables with surgical site infection. Statistical analysis was conducted using STATA software.

Result

From initial 179 identified articles, 11 were eligible for inclusion in the final meta-analysis. The pooled estimate of surgical site infection after cesarean section in Ethiopia was 9.72% (95%CI: 8.38, 11.05). PROM >12hrs (OR=5.02, 95%CI: 2.65, 9.51), duration of labor>24hrs (OR=3.69, 95%CI: 2.41, 5.65), chorioamnionitis (OR=9.11, 95%CI: 5.21, 15.93), anemia (OR=4.75, 95%CI: 2.42, 9.33) and having vertical skin incision (OR=4.17, 95%CI: 2.90, 6.02) were factors significantly associated with surgical site infection after cesarean section.

Conclusion

The prevalence of surgical site infection after cesarean section in Ethiopia was high. Therefore, Minister of Health with its stake holders should emphasis on community and institution based programs in manner to prevent those factors listed above that have significant effect on surgical site infection.

Introduction
Health care-associated infections (HAI) are acquired by patients while receiving care, and represent the most frequent adverse event affecting patient safety worldwide. It is estimated that hundreds of millions of patients are affected by HAIs each year, leading to significant mortality and financial losses for health systems. Currently evidences shows that surgical site infection (SSI) is the most surveyed and frequent type of HAI in low- and middle-income countries and affects up to one third of patients who have undergone a surgical procedure [1]. SSI is infection related to an operation procedure that occurs at or near surgical incision within 30 days of operation or after one year if an implant is placed. It can be either incision (superficial: involving the skin and subcutaneous tissues and deep: involving the deeper soft tissues of the incision, such as muscle or fascia) or organ space (involving any part of the anatomy other than the incised body layers (skin, fascia, and muscle layers))[2].

The number of surgical procedures performed now a day in worldwide continues to rise, and surgical patients are initially seen with increasingly complex comorbidities. Cesarean section is one of most commonly practiced surgical procedures. Potential complications such as: SSI that associated with any type of surgical procedure including cesarean section represents a well-known significant cause of surgical patient morbidity and mortality with consecutive human and economic losses. Despite of SSI is the most preventable HAIs using evidence-based strategies ,still the problem is represented with high prevalence (11.7%) which accounts for high human and financial costs [3]. A narrative review conducted in Sub-Sharan Africa reported SSI after cesarean section was timely increasing (15.6%)[4]. SSI patients required prolonged hospitalization, reoperation and readmission [5]. The majority of infection-associated costs arise from prolonged hospitalization, with additional expenditure attributable to medical staff and treatment. As the demand for surgical procedures rises, the incidence and associated costs of SSI will likely escalate [6].

Many factors influence surgical wound healing and determine the presence of infection. Patient-related (endogenous) and process/procedural-related (exogenous) variables are the primary factors that increase the chance of SSI. There are also non modifiable variables such as age and gender that contribute for high prevalence of SSI. On the other hand there are other potential factors, such as nutritional status, tobacco use, correct use of antibiotics and the intraoperative technique that can
increase the likelihood of positive surgical outcome [3].

In Ethiopia different studies were tried to assess the prevalence SSI after cesarean section and associated factors. But those articles done about SSI were reported with wide range findings [7-17]. These fragmented studies revealed that SSI after cesarean section ranged from 6.8% in Southern Nations, Nationalities, and Peoples Region (SNNPR) [11] to 13.7% in Amhara region [15]. Those studies also tried to investigate associated factors with SSI after cesarean section. From the factors, premature rapture of membrane more than 12hrs (PROM) [10, 12-14, 17], duration of labor more than 24hrs [10, 11, 13, 17], Chorioamnionitis [10, 12, 13, 17], anemia [8, 11, 12, 17] and vertical incision of the skin [7, 10-13] were identifies as a common factors that associated with SSI after cesarean section in Ethiopia.

The available few evidences in Ethiopia about the prevalence of SSI and its associated factors are represented with inconclusive and inconsistent findings which might be an obstacle for policy makers to amend the intervention strategies. Therefore, this systematic review and meta-analysis aimed to estimate the pooled prevalence of SSI after cesarean section and associated factors in Ethiopia at the national level.

**Methods**

**Searching strategies**

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Protocols (PRISMA-P) checklist guidelines[18]. Potentially relevant articles were comprehensively searched using PubMed/MEDLINE, EMBASE, CINAHL, Google Scholar, HINARI portal (which includes the SCOPUS, African Index Medicus, and African Journals Online databases), and Cochrane Library. In addition, related articles were found from review of the grey literature available on local shelves, institutional repositories and from reviewing the cross-reference list of already identified articles. Electronic database searches were conducted from 5 May to 20 June 2019. The key terms used for the PubMed database searches were: “Prevalence”, “magnitude”, “surgical site”, “infection”, “cesarean section”, “associated factors” and “Ethiopia”. Endnote citation manager software version X7 for Windows was utilized to collect and organize search outcomes and
for removal of duplicate articles.

**Population:** studies conducted on reproductive age women were included.

**Exposure (E):** studies done on post cesarean section were considered.

**Outcome (O):** studies conducted and reporting SSI after cesarean section were included.

**Inclusion criteria**

Articles were included based on the following criteria:

1. published in English
2. conducted in Ethiopia
3. observational studies (cross sectional, case control and cohort)
4. Had clear out come about surgical site infection after cesarean section

**Exclusion criteria:** after examining the titles and abstracts of articles using eligibility, irrelevant articles were excluded. Then those articles considered as relevant were reviewed and those which didn’t have the outcome of interest were also excluded from this systematic review and meta-analysis.

**Quality of assessment**

The database search results were exported and duplicate articles were removed using EndNote software (version X7; Thomson Reuters, New York, NY). We used the Newcastle–Ottawa quality assessment scale adapted for cross-sectional studies [19, 20]. The scale is used to score the articles under three categories:

1. Selection (score 0–5);
2. Comparability (score 0–2 ); and
3. Outcome (score 0–3); total score range 0–

The first section scored focuses on the methodological quality of each study (i.e., sample size, response rate, and sampling technique). The second section of the tool considers the comparability of different outcome groups in the study based on the study design and analysis. The last section of the tool is deal about the outcomes and statistical analysis of the original study. Two authors (TG and AN)
gave score for each primary studies. The third author was considered in case of disagreement. Then studies with a score of ≥6 out of 10 were considered as high quality after reviewing different relevant literatures. Identified articles with methodological problems and incomplete reporting of results in the full text were excluded from the final meta-analysis.

We assessed and evaluated the methodological quality and risk of bias in the studies that were selected using the 10-item rating scale developed Hoy et al. for prevalence studies (Appendix-1)[21]. Sampling, data collection, reliability and validity of study tools, case definition, and prevalence periods were included in the tool. The rating scale categorized as having low risk of bias (“yes” answers to domain questions) or high risk of bias (“no” answers to domain questions) for each articles. Each study was assigned a score of 1 (Yes) or 0 (No) for each domain, and these scores were summed to provide an overall study quality score. Scores of 8-10 were considered as having a “low risk of bias”, 6-7 a “moderate risk”, and 0-5 a “high risk”. For the final risk of bias classification, disagreements between the reviewers were resolved via consensus.

**Data extraction procedure**

Data were independently extracted by two authors using standardized data extraction format that developed according to 2014 Joanna Briggs Institute Reviewers’ Manual [22]. The tool includes Authors, Region, study setting, study year, study design, sampling technique, sample size and prevalence of SSI after cesarean section as well as factors associated with SSI after cesarean section. Articles that fulfilled the predefined criteria were used as a source of data for the final analysis.

**Outcome measurements**

The primary outcome of this systematic review and meta-analysis was the pooled prevalence of SSI after cesarean section. SSI is infection related to cesarean section that occur at or near surgical incision within 30 days of operation or after one year if an implant is placed[2]. For analysis of the second outcome (risk factors of SSI after cesarean section), we extracted data on factors that had been found to be related to SSI after cesarean section in the literature, such as the presence of PROM (> 12hrs), Chorioamnionitis, duration of labor (> 24hrs), anemia and type of incision of the skin (vertical vs horizontal).
**Data analysis**

All the needed information on the articles were extracted using Microsoft Excel spreadsheet form and exported to STATA (version 14; Stata Corp, College Station, TX) for further analysis. The existence of statistical heterogeneity was assessed using Cochran’s Q statistic and quantifies using inverse variance ($I^2$) and its corresponding $p$-value with fixed effect model of analysis. A value of 25%, 50%, and 75% were used to declare the heterogeneity test as low, medium and high heterogeneity[23]. Comparison of original articles using tabulation was computed to assess some clinical or methodological heterogeneity among the studies (Table-1). Visual examination of funnel plot asymmetry, Begg-Mazumdar Rank correlation tests and Egger’s regression tests were utilized to check for publication bias[24]. The estimated pooled prevalence of SSI after cesarean section was computed using forest plots with the 95% CI. Log odds ratio was used to identify factors associated with SSI after cesarean section.

**Results**

**Article selection**

First of all, 179 articles related to SSI after cesarean section and associated factors were identified using electronic data bases. After reviewing their titles, 49 articles were removed due to duplication. The remaining 14 articles title and abstract were reviewed and, 116 articles were excluded with a reason of irrelevancy. From the remaining 14 articles, 3 articles [25-27] were excluded due to the absence of the outcome of interest. Finally 11articles were eligible and included for the final analysis (Figure-1).

**Characteristics of the primary articles**

In this meta-analysis, 4351 mothers were included with 100% response rate. All studies were published from 2017 to 2019 except two studies published in 2011[9] and 2013[15]. All articles were conducted through cross sectional study design. The smallest and the largest sample size were 131[9] and 770[15] respectively. Among the included studies, the lowest prevalence was reported from SNNPs [11] and the highest prevalence was reported from the Amhara regional state [15]. From the total studies included under this systematic review and meta-analysis, most of them were
conducted at SNNPs [8, 11, 16] and Amhara regional states [7, 10, 14, 15]. All the included studies were conducted at the institutional (hospital) based using cross sectional study design with 100% response rate (Table-1).

Table 1; Descriptive summary of eleven studies included in the meta-analysis of SSI after cesarean section and associated factors in Ethiopia 2009-2018

| Author         | Region   | Study year | Sample size | Prevalence (%) | Factors listed                                                                 |
|----------------|----------|------------|-------------|----------------|--------------------------------------------------------------------------------|
| Mamo et al[13] | Oromo    | 2015       | 384         | 9.4            | PROM, prolonged labor, chorioamnionitis and vertical skin incision              |
| Gelaw et al[12]| AA       | 2017       | 474         | 8.4            | PROM, anemia, chorioamnionitis and vertical skin incision                      |
| Aklilu et al[8]| SNNPR    | 2017       | 325         | 12.9           | anemia                                                                        |
| Amenu et al[9] | Oromo    | 2009       | 770         | 11.4           |                                                                                 |
| Wedajo et al[16]| SNNPR | 2012       | 592         | 11             |                                                                                 |
| Azeze et al[7] | Amhara   | 2018       | 383         | 7.8            | Vertical skin incision                                                        |
| Gelaw et al[11]| SNNPR    | 2016       | 384         | 6.8            | Prolonged labor, anemia, and vertical skin incision                           |
| Mulu et al[15] | Amhara   | 2011       | 131         | 13.7           |                                                                                 |
| Gedefaw et al[10]| Amhara | 2018       | 447         | 9.4            | PROM, prolonged labor, chorioamnionitis and vertical skin incision            |
| Rose et al[14] | Amhara   | 2016       | 247         | 8.6            | PROM                                                                           |
| Wondemagegn et al[17]| Tigray | 2016       | 206         | 11.7           | PROM, prolonged labor, chorioamnionitis and anemia                            |

**Prevalence of SSI after cesarean section in Ethiopia**

The pooled prevalence of SSI after cesarean section in Ethiopia was 9.72% (95%CI: 8.38, 11.05) (Figure-2). In this systematic review and meta-analysis the heterogeneity test showed that there was no any type of heterogeneity detected, $I^2 = 0.0\%$, $p$-value = 0.517. The absence of publication bias was also insignificant as suggested by objective test of Begg’s and Egger’s test, which showed with $p$-value of $p=0.392$ and $p=0.293$ respectively.

**Publication bias**

In this systematic review and meta-analysis the symmetry of funnel plot and non-significance of Egger’s test indicated that publication bias was not significant. As demonstrated below in the funnel plot it shows symmetric (Figure-3) and Egger’s test $p$-value = 0.259 (95% CI: -0.541- 1.907).
Factors associated with SSI after cesarean section

The association between PROM more than 12hrs and SSI after cesarean section was reported in five articles [10, 12-14, 17]. Mothers with PROM more than 12hrs were 5.02 times more likely to have SSI after cesarean section as compared with mothers with PROM ≤12hrs, OR=5.02 and (95%CI: 2.65, 9.51). Duration of labor more than 24hrs and the risk of SSI after cesarean section were also reported among the four included studies [10, 11, 13, 17] The likelihood of SSI after cesarean section was 3.69 times higher among mothers with duration of labor more than 24hrs as compared with mothers whose labor duration was ≤24hrs, OR=3.69 and (95%CI: 2.41, 5.65). There was also significant relationship between SSI after cesarean section and chorioamnionitis as reported from the four articles [10, 12, 13, 17]. Mothers with chorioamnionitis were 9.11 times more likely to develop SSI after cesarean section as compared with mothers without chorioamnionitis, OR=9.11 and (95%CI: 5.21, 15.93). Anemia was also another contribution factor of SSI after caesarian section as reported from in the following four articles [8, 11, 12, 17]. The risk of developing SSI after cesarean section among mothers were 4.75 times higher among anemic mothers compared to non-anemic mothers, OR=4.75 and (95%CI: 2.42, 9.33). Once more, vertical incision of skin was also another risk for SSI as reported by the following five articles [7, 10-13]. Mothers who had history of vertical skin incision during cesarean section had increased risk of SSI compared with mothers who had history of horizontal skin incision for the cesarean section, OR=4.17 and (95%CI: 2.90, 6.02).

Discussion

This Systematic review and meta-analysis was conducted to identify the pooled prevalence of SSI after cesarean section and associated factors in Ethiopia. We found high prevalence of SSI after cesarean section in Ethiopia with an overall prevalence of 9.72% (95%CI: 8.38, 11.05). This systematic review and meta-analysis reported a higher prevalence as it was compared with the sphere standard of CDC guidelines of SSI. SSI after cesarean section is considered as an indication of quality of health care service. However, it represented with high figure that make the quality of health care service to be questionable in Ethiopia. Although several endogenous risk factors are there, it can be possibly explained by that limited and ineffective implementation of evidence based SSI
prevention strategies recommended by CDC may increase the problems. This includes limited and ineffective administering of antimicrobials before 1hr of procedure, prolonged preoperative admission of patients, longer duration of procedures and inability to prevent obstetric complications (PROM, chorioamnionitis)[28]. It was also much higher than among studies conducted in Nova Scotia and New Zealand reports of SSI prevalence; 2.7% and 5.2% [29, 30] respectively.

This systematic review and meta-analysis was lower as compared with a reports from India (8.9 %), England (9 %), Norway (9.1%) and Nigeria (9.6%)[31-34]. It was also much lower than from reports of Jordan (14.4%), Malaysia (18.8%), a systematic review from Sub-Saharan Africa (15.6%) and Egypt (16.7%) [4, 35-37]. Hence, application of evidence based strategies should be there, like timely administration of appropriately selected prophylactic antibiotics, use of a chlorhexidine-alcohol based preparation, use of suture for skin closure, maintenance of glycemic control in the postoperative period, showering (full body) with soap (antimicrobial or non-antimicrobial) or an antiseptic agent on at least the night before the operative day, normothermia should be maintained in all patients, increased fraction of inspired oxygen should be administered during surgery and after extubation in the immediate postoperative period for patients with normal pulmonary function undergoing general anesthesia with endotracheal intubation and transfusion of blood products should not be withheld from surgical patients as a means to prevent SSI [3, 38].

Our finding was also further investigated about the contributing factors of SSI after cesarean section. PROM >12hrs, duration of labor >24hrs, chorioamnionitis, anemia and having vertical skin incision all had increased risk of developing SSI after cesarean section.

Mothers who experienced PROM more than 12hrs had increased risk of SSI than mothers who experienced PROM ≤12hrs duration. This is possibly justified by that feto-placental membrane is one of the barrier essential for prevention or protection of ascending and iatrogenic infection of the membrane (chorioamnionitis). If this protective barrier is breached by any means, it will lose infection prevention. This can lead to ascending and iatrogenic (during per-vaginal examination) infections and will be bacteria reservoir (micro-organisms) and over growth. Unsterile membrane including the fluids
which contain infection causing micro-organisms (such as bacteria) will have an access to other organs and tissues during cesarean section that can be potential source of infection after cesarean section. Supporting evidence was also reported from Egypt, India and Australia [31, 37, 39].

The other finding from this systematic review and meta-analysis also indicated mothers who had history of labor duration more than 24hrs had increased risk of developing SSI than mothers whose labor duration was ≤24hrs. Supportive finding was also reported from different country wide studies from India, China, Brazil and Nigeria [31, 33, 40, 41]. Hence, maternal early postpartum complication including infections (SSI) and exposure time where infection can be acquired increased as duration of labor increased. Beyond this, it is also the fact that prolonged labor along with increased number of vaginal examinations also increased the risk of SSI [42]. Labor pain is the severe form of pain causing maternal fatigue and dehydration as well as prolonged vascular diminishing to reproductive tract tissue by the presenting part which make favorable condition for microbes and infection even after the procedure.

Sectional having this evidences, this systematic review and meta-analysis also identified that chorioamnionitis another risk of SSI. Mothers who were diagnosed positive for chorioamnionitis had increased risk of SSI following cesarean section than mothers who don't diagnosed for chorioamnionitis. Consistent finding was also reported from Canada, Australia and Estonia [30, 39, 43]. Chorioamnionitis is the inflammation of feto-placental membrane that can increase the chance of ascending or iatrogenic infection. This ascending infection can be complicated to sepsis for the both neonate and mother. This infection will affect or migrate to the sterile organs and tissues breached during cesarean section.

Moreover, anemia was also identified as medical factor which exacerbated SSI after cesarean section. Mothers who were diagnosed for anemia had increased risk of developing SSI after cesarean section than mothers who don't diagnosed for anemia. This finding was consistent with a study conducted in Australia [39]. Anemia is one of the hematologic disorders that negatively affect mothers’ body infection protection mechanism or immune system. Iron is essential element for proper functioning of the host immune system. In
addition, low hemoglobin level causes lower oxygen saturation at peripheral tissue [44]. Delay in wound healing and low infection prevention finally leads to high risk of developing post procedure infection; SSI after cesarean section.

Once more, having history of vertical skin incision increases the risk of SSI. Mothers with history of vertical skin incision after cesarean section had increased risk of developing SSI than mothers with horizontal skin incision. Comparable finding was also reported from Nepal[45]. The potential reason may be that, having vertical skin incision is associated with involving more areas, delayed wound healing, higher risk of wound dehiscence, that will put the mothers for risk of developing SSI following the procedure[46, 47].

Limitation Of The Study
This systematic review and meta-analysis included only articles reporting in English language, which may restrict our findings. The majority of the articles use small sample size, might be affect the prevalence estimation. All included studies were cross sectional study design in which the result might potentially affected by confounding variables. In addition the meta-analysis didn’t include all regions and administrative city which only includes four regions and one administrative city of the country. Therefore further country based studies to assess other confounding factors related to health service factors, health policy factors and health care giver related factors for the prevalent SSI in Ethiopia is recommended.

Conclusions
The prevalence of surgical site infection after cesarean section in Ethiopia was high compared with the sphere standards of CDC guidelines for SSI after caesarian section. Therefore, Ministry of Health with its stake holders should give special emphasis on community and institution based programs in manner to prevent prolonged labor, PROM, chorioamnionitis and anemia which will also have synergistic impact on caesarian section site infection. Moreover, there is also a call to health professionals not to use vertical incision as primary option of caesarian section to reduce the risk of surgical site infection among mothers.

Abbreviations
AA—Addis Ababa, CDC—Center of Disease Control, HAI—Health Care-Associated Infections, PPROM—
Premature Rapture of Membrane, SNNPR—South Nation and Nationality peoples Region, SSI — Surgical Site Infection

Declarations

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Availability of data and materials

Data will be available from the corresponding author upon reasonable request.

Authors’ contributions

TG developed the protocol and involved in the design, selection of study, data extraction, statistical analysis and developing the initial drafts of the manuscript. AN and GD involved in quality assessment. TG, AN and GD prepared and revising subsequent drafts as well as prepared the final draft of the manuscript. All authors read and approved the final draft of the manuscript.

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Competing interests

The authors have declared that there are no competing interests.

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**Figures**

**Figure 1**

PRISMA flow diagram of included studies to estimate the pooled prevalence of SSI and its associated factors after cesarean section in Ethiopia 2009-2018
Figure 2

Forest plot of the pooled prevalence of SSI after cesarean section in Ethiopia 2009-2018
Figure 3

Meta funnel presentation of the prevalence of SSI after cesarean section, 2009–2018, Ethiopia.
Figure 4

Forest plots which describe factors associated with SSI after cesarean section in Ethiopia 2009-2018

Supplementary Files

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