Reviewer's report

Title: Misoprostol for postpartum hemorrhage prevention at home birth: An integrative review of global implementation experience to date

Version: 1 Date: 19 November 2012

Reviewer: Andrew Weeks

Reviewer's report:

This is a timely and important paper, and the authors are to be congratulated on a detailed analysis of the data available. However, the authors have not been able to simplify the complex data sets for the reader, and I think that most readers will be unable to analyse the mass of data presented. It would be helpful to strip away some of the excess to leave the key important data.

Major Compulsory Revisions

1. The manuscript is currently very complex to read. There is no single factor here, but a combination of wordiness, confusing terms and excessive data. I would have liked to see the five research questions more tightly defined so that the results can be stripped down to provide those 5 answers. Currently there is so much data provided (much of it surplus to requirements) that the key outcomes are hidden. The multiple suggested changes needed have been placed in the ‘minor essential’ section below.

2. My understanding is that the type of follow-up varied in the studies reported. If this is true, then I would like to see some transparency about this with the studies categorised as (for example) 'personal follow-up of each woman', 'telephone follow-up', 'report-back from community workers' and 'assessment of need for treatment only'. This could be added to one of the tables.

3. Figure 1 needs to be formatted according to the MOOSE guidelines (JAMA 2000; 283(15):2008-2012) and a checklist completed.

4. Tables 3 and 6 need to report the actual combined data rather than the range of reported rates. I would suggest that the actual figure is calculated by adding together the numerator and denominators from the studies, and then reporting it as a percentage. [For example if the rates were 0/10, 9/10, 9/10, 9/10, and 9/10, this is currently reported as 0-90% whereas it should be 36/50 = 72%]

Minor Essential Revisions

1. I found table 1 very difficult to follow. I would suggest that the home birth rate is condensed into just a single column, the number of districts column removed, and a column added for ‘Who administered the misoprostol?’ i.e. self, TBA or trained health worker (maybe using the codes from table 2). The number of women enrolled column needs explaining (I still don’t understand why some were enrolled but didn’t get the misoprostol, others have ‘intervention’ in brackets (did some in that column not have the intervention?), and some had just a postpartum
sample). I would suggest that the key data is included and the rest removed for clarity rather than trying to include everything. I would also like to see an asterix beside those studies that were not peer reviewed before publication.

2. In table 2, presumably all subgroups could have more than one allocation in the table. Thus it is currently missing under the ‘administration method’ subgroup. But if it is in all 3, then it might be simpler to place the explanation in the title rather than as footnotes.

3. In table 3 I would suggest that the explanations of how the distribution rates and coverage rates are calculated are placed in the title for the table rather than within the first column.

4. If the distribution rate is the number of women receiving misoprostol divided by the total women enrolled, why are the data in tables 1 and 4 not identical? For example in the Afghanistan study the distribution rate from table 1 should be 1350/2039 – but it is reported in table 4 as 96.6%.

5. It is unclear why only 10 studies are included in table 4 and not all 17. Since the distribution data should be the same as in table 1, it need not be repeated. Then the coverage rate could be placed in table 1 and then this table could be used just to show the change in facility births – and then only 4 studies need to be included.

6. In table 4, why is skilled birth attendance referred to when the column is all about facility birth?

7. The use of a forward slash between studies/programmes is very confusing when the same symbol is being used to separate numerator and denominator.

8. The whole text is very wordy. The background could for example be reduced to a couple of paragraphs rather than providing a full review of maternal mortality secondary to PPH and attempts to prevent deaths.

9. The description of the Mozambique study is confusing in both table and text as it provides 2 alternatives - one of which is a ‘distributing cadre’ and the other is distribution timing’. I believe that they should use the same categorisation as in tables 3 and 6.

10. Tables 3 and 6 would benefit from some statistical analysis, especially so as to qualify the text where it says about table 5 that ‘…this was more commonly reported when the drug was distributed…’.

Discretionary revisions

1. I don’t understand why the authors have given such prominence to the issue of who distributes the misoprostol. To me, the main issue is whether the misoprostol is administered by health workers or self-administered – who hands it out and trains the woman is less important. I would therefore remove ‘distributing cadre’ from tables 3 and 6 and maybe place the data in the text only. The data for self administered versus health worker administered could also be added into the abstract for both coverage and adverse effects.

Level of interest: An article of importance in its field
Quality of written English: Needs some language corrections before being published

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests.