National Institute for Health and Care Excellence

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Intrapartum care

Evidence tables for review M: Uterotonics for the prevention of postpartum haemorrhage

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Evidence tables

D1 – Participant and study characteristics

Table 1: Participant and study characteristics

Study	Methods	Participants	Interventions	Outcomes	Notes
Abdel-Aleem 1993	2-arm active-controlled randomised trial	150 parturients were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with risk factors for postpartum haemorrhage: duration of labour less than 2hrs or prolonged labour more than 24 hrs, MgSO4 for pre-eclampsia, chorioamnionitis, multiple pregnancy, previous PPH, APH and episiotomy.	200 mcg of Ergometrine administered by an intravenous bolus versus 250 mcg of Carboprost administered intramuscularly	The study recorded the following outcomes: Blood loss (ml). Third stage duration (min). Diarrhoea. Nausea. Vomiting. Abdominal pain.	Contact with study authors for additional information: No. Additional data from authors: No
Abdel-Aleem 2010	3-arm controlled randomised trial	1964 parturients were randomised in a hospital setting in Egypt and South Africa. The population comprised women of any parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with medical complications such as hypertension and diabetes, previous caesarean section, or an abdominal wall that was not thin enough to allow easy palpation of the uterus after delivery.	10 IU of Oxytocin administered intramuscularly versus no treatment	The study recorded the following outcomes: PPH at 500. PPH at 1000. Severe maternal morbidity: Intensive care admissions. Additional Uterotonics. Transfusion. Manual removal of placenta.	Contact with study authors for additional information: No. Additional data from authors: No
Acharya 2001	2-arm active-controlled	60 parturients were randomised in a hospital setting in UK. The population comprised women of both nulliparous and multiparous, either singleton or multiple pregnancy, at high risk for PPH, who	10 IU of Oxytocin administered by	The study recorded the following	Contact with study authors for additional

Study	Methods	Participants	Interventions	Outcomes	Notes
	randomised trial	delivered by elective caesarean section. Exclusion criteria were not specified.	an intravenous bolus versus 400 mcg of Misoprostol administered orally	outcomes: PPH at 1000. Additional Uterotonics. Transfusion. Blood loss (ml). Change in Haemoglobin. Vomiting. Shivering.	information: No. Additional data from authors: No
Adanikin 2012	2-arm active-controlled double-dummy randomised trial	218 parturients were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised parturients with altered serum electrolytes, peritonitis, sepsis, previous bowel surgery, thyroid disease, inflammatory bowel disease, or chronic constipation.	25 IU of Oxytocin administered by an intravenous bolus + infusion versus 600 mcg plus 5 IU of Misoprostol plus Oxytocin administered rectally plus by an intravenous bolus	The study recorded the following outcomes: PPH at 500. PPH at 1000. Nausea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Adanikin 2013	2-arm active-controlled double-dummy randomised trial	50 parturients were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with asthma or with hypersensitivity to prostaglandins.	600 mcg of Misoprostol administered rectally versus 20 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: Nausea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Afolabi 2010	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in Nigeria. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing induction of	10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH	Contact with study authors for additional information: No.

Study	Methods	Participants	Interventions	Outcomes	Notes
		labour or caesarean section, or those with haematocrit of less than 30%, preeclampsia/eclampsia, grand multiparity (five or more), multiple pregnancy, coagulopathy, or medical disorders.	versus 400 mcg of Misoprostol administered orally	at 500. PPH at 1000. Severe maternal morbidity: Intensive care admissions. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). Nausea. Vomiting. Fever. Shivering.	Additional data from authors: No
Ahmed 2014	2-arm active-controlled randomised trial	80 parturients were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised parturients with risk factors for excessive blood loss e.g., those with placenta praevia or placental abruption.	100 mcg of Carbetocin administered by an intravenous bolus versus 10 IU of Oxytocin administered by an intravenous bolus	The study recorded the following outcomes: Blood loss (ml).	Contact with study authors for additional information: Yes. Additional data from authors: No
Al-Sawaf 2013	3-arm controlled randomised trial	120 parturients were randomised in a hospital setting in Egypt. The population comprised women of parity 4 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing induction of labour or instrumental delivery, or those with previous caesarean section, extensive perineal, vaginal or cervical lacerations,	no treatment versus 200 mcg of Misoprostol administered sublingually versus 5 IU of	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional	Contact with study authors for additional information: Yes. Additional

Study	Methods	Participants	Interventions	Outcomes	Notes
		bleeding disorders, haemoglobin less than 100 g/l, uterine malformations, grand multiparity, multiple pregnancy, polyhydramnios, intrauterine fetal death, medical problems such as pre-eclampsia, diabetes, cardiopulmonary problems, bowel disease, or allergy to prostaglandins.	Oxytocin administered intramuscularly	Uterotonics. Transfusion. Blood loss (ml). Change in Haemoglobin.	data from authors: Yes
Alwani 2014	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of parity 3 or less, either singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria were not specified.	600 mcg of Misoprostol administered rectally versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: Additional Uterotonics. Transfusion. Death. Change in Haemoglobin. Nausea. Vomiting. Hypertension. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Al Zubaidi 2022	2-arm active-controlled randomised trial	300 pregnant women were randomised in a hospital setting in Iran. Population comprised of women of any parity with a singleton pregnancy. Women were at high risk for PPH as they had an established need for an emergency caesarean section. Exclusion criteria: uterine fibroids, longitudinal uterine incision, suspected placental pathology (accreta, previa, placental abruption), any history of coagulopathy, allergy to carbetocin, oxytocin homologues or excipients, a history of medical diseases such as: cardiac, hypertension, liver, renal or endocrine diseases.	Oxytocin (10 units, IV bolus) versus carbetocin (100mcg, IV bolus)	The study reported the following outcomes: Use of additional uterotonics with first 24 hours of surgery (extra dose of oxytocin, methylergometrine and misoprostol). Blood loss within first 24 hours after surgery (equal	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				or more than 1000ml). Blood transfusion within first 24 hours after surgery (as a result of significant Hb reduction).	
Amant 1999	2-arm active-controlled double-dummy randomised trial	213 parturients were randomised in a hospital setting in Belgium. The population comprised women of both nulliparous and multiparous, either singleton or multiple pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with hypertensive disorders, gestational age less than 32 weeks, intrauterine fetal death, uterine malformations, inflammatory bowel disease, obliterative vascular or coronary disease, sepsis, allergy to prostaglandins or alkaloids.	600 mcg of Misoprostol administered orally versus 200 mcg of Ergometrine administered by an intravenous bolus	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. diarrhoea. Nausea. Vomiting. Headache. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Amin 2014	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in Pakistan. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with traumatic PPH, bleeding disorders, prolonged labour, placenta praevia, placental abruption, multiple pregnancy, BMI more than 30, or previous PPH.	5 IU of Oxytocin administered by an intravenous bolus versus 800 mcg of Misoprostol administered rectally	The study recorded the following outcomes: PPH at 500. Severe maternal morbidity: Intensive care admissions. Manual removal of placenta.	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
				Death. Blood loss (ml). Third stage duration (min). diarrhoea. Vomiting. Fever. Shivering.	
Amornpetch akul 2018	2-arm active-controlled randomised trial	359 pregnant women were randomised in a hospital setting in Thailand. Population comprised of women of any parity with a singleton pregnancy. Women were at high risk for PPH as they had pregnancy complications predisposing to a higher risk of atonic PPH. Women gave birth via normal vaginal delivery or instrumental vaginal delivery. Exclusions were active labour when at admission; underlying medical disease including bleeding disorders; thrombocytopenia; cardiovascular diseases, liver and renal diseases, asthma, epilepsy, migraine; oxytocin or carbetocin allergy; obstetric complications such as preeclampsia or abnormal placentation; emergency caesarean delivery; non-atonic PPH.	Carbetocin (100mcg IV) versus oxytocin (5 units IV)	The study reported the following outcomes: Primary blood loss >1000ml; Additional uterotonics; blood transfusion; mean volumes of blood loss (ml).	Contact with study authors for additional information: No. Additional data from authors: No
Anupama 2021	2-arm placebo-controlled randomised trial	90 pregnant women were randomised in a hospital setting in India. Population comprised of women with a singleton pregnancy. Parity not reported. Women were high risk PPH without co-morbidities or pregnancy complications predisposing them to higher risk PPH. Women had an elective caesarean section. Exclusion criteria: multiple pregnancy; polyhydramnios; fetal macrosomia; antepartum haemorrhage obstructed labour; haemoglobin <8gm%; severe preeclampsia and coagulopathy; previous history of caesarean delivery or intraabdominal surgery; active thromboembolic disease such as deep vein thrombosis or intrinsic risk for thrombosis; cardiovascular, renal or liver disorders.	Misoprostol (400ug sublingual) versus placebo	The study reported the following outcomes: Additional uterotonics; Mean volumes of blood loss (ml) (from placental delivery to the end of caesarean section, and from end of	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				caesarean section to 2 hours post-partum)	
Askar 2011	2-arm active-controlled double-blinded randomised trial	240 parturients were randomised in a hospital setting in Kuwait. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients less than 18 years old and those with known or suspected coagulopathy, grand multiparity (5 or more), uterine fibroids, polyhydramnios, multiple pregnancy, fetal macrosomia, severe anaemia, cervical tears or who required prophylactic oxytocin infusion. The presence of contraindications for the use of either syntometrine or carbetocin that include pre-existing hypertension, pre-eclampsia, asthma, cardiac, renal or liver diseases, epilepsy, or history of hypersensitivity to syntometrine or carbetocin.	100 mcg of Carbetocin administered intramuscularly versus 500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Change in Haemoglobin. Nausea. Vomiting. Hypertension. Headache. Abdominal pain.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Asmat 2017	2-arm active-controlled randomised trial	1678 parturients were randomised in a hospital setting in Pakistan. The population comprised women of any parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with malpresentations such as breech, compound or transverse presentation, multiple pregnancy, placenta praevia type III, IV, placenta accreta, placental abruption, uterine rupture, myomectomy (uterine cavity opened), coagulation disorders, DIC, cardiac diseases, diabetes, and anaemia.	800 mcg of Misoprostol administered rectally versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. Blood loss (ml).	Contact with study authors for additional information: No. Additional data from authors: No
Attilakos 2010	2-arm active-controlled double-blinded	377 parturients were randomised in a hospital setting in UK. The population comprised women of both nulliparous and multiparous, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised parturients undergoing caesarean section with general anaesthesia,	100 mcg of Carbetocin administered by an intravenous bolus versus 5	The study recorded the following outcomes: PPH at 1000. Severe	Contact with study authors for additional information: Yes. Additional

Study	Methods	Participants	Interventions	Outcomes	Notes
	randomised trial	gestational age less than 37 weeks performed for fetal or maternal distress where, due to time constraints, it was not possible to recruit or randomise, or those with multiple pregnancy, placenta praevia or placental abruption.	IU of Oxytocin administered by an intravenous bolus	maternal morbidity: Intensive care admissions. Additional Uterotonics. Transfusion. Death. Blood loss (ml). Change in Haemoglobin. Nausea. Vomiting. Headache. Tachycardia. Hypotension. Shivering. Abdominal pain.	data from authors: Yes
Atukunda 2014	2-arm active-controlled double-dummy randomised trial	1140 parturients were randomised in a hospital setting in Uganda. The population comprised women of both nulliparous and multiparous, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing induction or augmentation of labour or elective caesarean section, or those with intrauterine fetal death, heart disease, severe malaria or acute bacterial infection, multiple pregnancy, antepartum haemorrhage, altered cognitive status or reported hypersensitivity to prostaglandins.	10 IU of Oxytocin administered intramuscularly versus 600 mcg of Misoprostol administered sublingually	The study recorded the following outcomes: PPH at 500. PPH at 1000. Severe maternal morbidity: Intensive care admissions. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin.	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
				Third stage duration (min). diarrhoea. Nausea. Vomiting. Headache. Fever. Shivering. Abdominal pain.	
Badejoko 2012	2-arm active-controlled double-dummy randomised trial	264 parturients were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients in the second or third stage of labour, or those with cervical lacerations or coagulopathy.	30 IU of Oxytocin administered by an intravenous bolus + infusion versus 600 mcg plus 20 IU of Misoprostol plus Oxytocin administered rectally plus by an intravenous infusion	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Death. Blood loss (ml). Vomiting. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Bagheri 2022	2-arm active-controlled randomised trial	180 pregnant women were randomised in a hospital setting in Iran. Population comprised of women with a singleton pregnancy. Parity not reported. Women were high risk PPH without co-morbidities or pregnancy complications predisposing them to higher risk PPH. Women had an elective caesarean section. Exclusion criteria were history of PPH; placenta previa and accreta; liver or kidney disease; eclampsia and preeclampsia; epilepsy; height under 155cm; obesity; infant weight over 4kg; polyhydramnios; receiving anticoagulants; patients with heart and lung problems; underlying diseases such as diabetes, hypertension, chronic anaemia, coagulation disorders and immunodeficiency.	Misoprostol (200 mcg, sublingual) + misoprostol (200 mcg, rectal) + oxytocin (20 units) versus oxytocin (20 units)	The study reported the following outcomes: Blood transfusion; Mean volumes of blood loss (ml)	Contact with study authors for additional information: No. Additional data from authors: No
Balki 2008	2-arm active-controlled double-	48 parturients were randomised in a hospital setting in Canada. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by emergency caesarean section.	250 mcg plus 20 IU of Ergometrine	The study recorded the following	Contact with study authors for additional

Study	Methods	Participants	Interventions	Outcomes	Notes
	blinded randomised trial	Exclusion criteria comprised parturients requiring general anaesthesia, or those with cardiac disease, hypertension or any condition predisposing to uterine atony and PPH, such as placenta praevia, multiple pregnancy, pre-eclampsia, macrosomia, polyhydramnios, uterine fibroids, bleeding disorders, chorioamnionitis, previous uterine atony, previous PPH or allergy/hypersensitivity to oxytocin or ergot derivatives.	plus Oxytocin administered by an intravenous bolus versus 20 IU of Oxytocin administered by an intravenous bolus + infusion	outcomes: Additional Uterotonics. Transfusion. Blood loss (ml). Nausea. Vomiting. Hypertension. Tachycardia. Hypotension.	information: Yes. Additional data from authors: No
Balki 2021	2-arm active-controlled randomised trial	105 pregnant women were randomised in a hospital setting in Canada. Population comprised of women with a singleton pregnancy. Unspecified parity. Women were at high risk for PPH, without comorbidities or pregnancy factors predisposing them to high-risk PPH. Women had a caesarean birth. Exclusion criteria were allergy or hypersensitivity to study drugs; conversion to general anaesthesia, cardiovascular or respiratory diseases, any risk factor for PPH (such as placental factors; multiple gestation, preeclampsia, macrosomia, polyhydramnios, uterine fibroids, previous history of postpartum bleeding, bleeding diathesis, known infection).	Oxytocin (5 units IV) + ergonovine (0.25mg IV) + placebo (IM) versus oxytocin (5 units IV) + placebo (IM)	The study reported the following outcomes: Primary blood loss >=1000ml; additional uterotonics; mean volumes of blood loss (ml)	Contact with study authors for additional information: No. Additional data from authors: No
Bamigboye, Hofmeyr 1998	2-arm placebo-controlled randomised trial	550 parturients were randomised in a hospital setting in South Africa. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	400 mcg of Misoprostol administered rectally versus placebo	The study recorded the following outcomes: PPH at 1000. Additional Uterotonics. Manual removal of placenta. Third stage duration (min). diarrhoea. Vomiting. Shivering. Abdominal pain.	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
Bamigboye, Merrell 1998	2-arm active-controlled randomised trial	491 parturients were randomised in a hospital setting in South Africa. The population comprised women of any parity, unspecified whether singleton or multiple pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	400 mcg of Misoprostol administered rectally versus 500 mcg and 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Change in Haemoglobin. Third stage duration (min).	Contact with study authors for additional information: No. Additional data from authors: No
Barton 1996	2-arm placebo-controlled randomised trial	119 parturients were randomised in a hospital setting in USA. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria were not specified.	100 mcg of Carbetocin administered by an intravenous bolus versus placebo	The study recorded the following outcomes: Additional Uterotonics.	Contact with study authors for additional information: No. Additional data from authors: No
Baskett 2007	2-arm active-controlled double-dummy randomised trial	622 parturients were randomised in a hospital setting in Canada. The population comprised women of any parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with placenta previa, placental abruption, coagulopathy or unstable asthma.	5 IU of Oxytocin administered by an intravenous bolus versus 400 mcg of Misoprostol administered orally	The study recorded the following outcomes: PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Fever. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
Begley 1990	2-arm controlled	1429 parturients were randomised in a hospital setting in Ireland. The population comprised women of parity 5 or less, a singleton	500 mcg of Ergometrine	The study recorded the	Contact with study authors

Study	Methods	Participants	Interventions	Outcomes	Notes
	randomised trial	pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, vaginal breech or instrumental delivery, or those with hypertension, epidural anaesthesia, antepartum haemorrhage, placenta praevia, placental abruption, first stage of labour more than 15 hours, "quick" delivery or needing resuscitation.	administered Intravenous bolus versus no treatment	following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Third stage duration (min). Nausea. Vomiting. Hypertension. Headache. Abdominal pain.	for additional information: Yes. Additional data from authors: Yes
Begum 2015	2-arm active-controlled randomised trial	100 parturients were randomised in a hospital setting in Bangladesh. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by caesarean. Exclusion criteria were not specified.	400 mcg of Misoprostol administered sublingually versus 20 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes:(No Outcome Data Found)	Contact with study authors for additional information: No. Additional data from authors: No
Bellad 2012	2-arm active-controlled double-dummy randomised trial	652 parturients were randomised in a hospital setting in India. The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section or instrumental delivery, or those with medical disorders, in active labour with more than 4cm dilatation or stillbirths.	400 mcg of Misoprostol administered sublingually versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
				loss (ml). Third stage duration (min). diarrhoea. Nausea. Vomiting. Fever. Shivering. Abdominal pain.	
Benchimol 2001	3-arm controlled randomised trial	602 parturients were randomised in a hospital setting in France. The population comprised women of any parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with gestational age less than 32 weeks, previous PPH, intrauterine fetal death, previous uterine scar, multiple pregnancy or pre-eclampsia.	no treatment versus 2.5 IU of Oxytocin administered by an intravenous bolus versus 600 mcg of Misoprostol administered orally	The study recorded the following outcomes: PPH at 500. PPH at 1000. Blood loss (ml). Change in Haemoglobin. Vomiting. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Bhatti 2014	2-arm active-controlled randomised trial	120 parturients were randomised in a hospital setting in Pakistan. The population comprised women of parity 4 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with haemoglobin>10g/dl, medical disorders, multiple pregnancy, instrumental births, stillbirths and over 42 weeks.	400 mcg of Misoprostol administered sublingually versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Death. Blood loss (ml). Nausea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
Bhullar 2004	2-arm placebo-controlled randomised trial	756 parturients were randomised in a hospital setting in USA. The population comprised women of any parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with a bleeding disorder.	200 mcg plus 20 IU of Misoprostol plus Oxytocin administered sublingually plus by an intravenous infusion versus 20 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). Vomiting. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Biswas 2007	2-arm active-controlled randomised trial	100 parturients were randomised in a hospital setting in India. The population comprised women of gravida 3 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with heart, renal or liver disease, previous caesarean and severe hypertension.	125 mcg of Carboprost administered intramuscularly versus 200 mcg of Ergometrine administered intramuscularly	The study recorded the following outcomes: Transfusion. Manual removal of placenta. Nausea. Vomiting. Hypertension. Fever.	Contact with study authors for additional information: No. Additional data from authors: No
Borruto 2009	2-arm active-controlled randomised trial	104 parturients were randomised in a hospital setting in France, Italy. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised parturients with toxemia, eclampsia or epilepsy.	100 mcg of Carbetocin administered by an intravenous bolus versus 10 IU of Oxytocin administered by	The study recorded the following outcomes: PPH at 500. Additional Uterotonics.	Contact with study authors for additional information: Yes. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
			an intravenous infusion	Blood loss (ml). Vomiting. Headache. Hypotension. Shivering. Abdominal pain.	
Boucher 1998	2-arm active-controlled double-dummy randomised trial	60 parturients were randomised in a hospital setting in Canada. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised parturients with heart disease or cardiac arrhythmia , hypertension or liver/renal/endocrine disease.	100 mcg of Carbetocin administered by an intravenous bolus versus 32.5 IU of Oxytocin administered by an intravenous bolus + infusion	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Death. Blood loss (ml). Nausea. Vomiting. Headache. Fever. Shivering. Abdominal pain.	Contact with study authors for additional information: Yes. Additional data from authors: No
Boucher 2004	2-arm active-controlled double-dummy randomised trial	164 parturients were randomised in a hospital setting in Canada. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients younger than 18 years old, or those without known PPH risk, known or suspected coagulopathy, heart disease or cardiac arrhythmia, chronic liver/renal/endocrine disease or hypersensitivity to study drugs.	100 mcg of Carbetocin administered intramuscularly versus 10 IU of Oxytocin administered Intravenous infusion	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. Blood loss (ml). Change in Haemoglobin. Nausea. Vomiting. Headache.	Contact with study authors for additional information: Yes. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				Shivering. Abdominal pain.	
Bugalho 2001	2-arm active-controlled double-dummy randomised trial	700 parturients were randomised in a hospital setting in Mozambique. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing induction or augmentation of labour.	400 mcg of Misoprostol administered rectally versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Blood loss (ml). Third stage duration (min). diarrhoea. Vomiting. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Butwick 2010	5-arm placebo-controlled randomised trial	75 parturients were randomised in a hospital setting in USA. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised parturients with active labour, ruptured membranes , drug allergy, multiple pregnancy, significant obstetric disease, risk factors for PPH (abnormal placentation, fibroids, previous PPH, previous classical uterine incision), coagulopathy or thrombocytopenia.	placebo versus 5, 3, 1, or 0.5 IU of Oxytocin administered by an intravenous bolus	The study recorded the following outcomes: Additional Uterotonics. Transfusion. Blood loss (ml). Nausea. Vomiting. Tachycardia. Hypotension.	Contact with study authors for additional information: Yes. Additional data from authors: No
Caliskan 2002	4-arm active-controlled double-dummy randomised trial	1633 parturients were randomised in a hospital setting in Turkey. The population comprised women of any parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with gestational age less than 32 weeks or hypersensitivity to prostaglandins.	400 mcg plus 10 IU of Misoprostol plus Oxytocin administered rectally plus by an intravenous infusion versus	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion.	Contact with study authors for additional information: Yes. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
			400 mcg of Misoprostol administered rectally versus 10 IU of Oxytocin administered by an intravenous infusion versus 200 mcg plus 10 IU of Ergometrine plus Oxytocin administered intramuscularly plus by an intravenous infusion	Change in Haemoglobin. Third stage duration (min). diarrhoea. Vomiting. Fever. Shivering.	
Caliskan 2003	4-arm active-controlled double-dummy randomised trial	1800 parturients were randomised in a hospital setting in Turkey. The population comprised women of any parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with gestational age less than 32 weeks or hypersensitivity to prostaglandins.	400 mcg plus 10 IU of Misoprostol plus Oxytocin administered orally plus by an intravenous infusion versus 400 mcg of Misoprostol administered orally versus 10 IU of Oxytocin administered by an intravenous infusion versus 200 mcg plus 10 IU of Ergometrine	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
			plus Oxytocin administered intramuscularly plus by an intravenous infusion		
Carbonell i Esteve 2009	2-arm active-controlled randomised trial	1410 parturients were randomised in a hospital setting in Spain. The population comprised women of parity 4 or less, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section or instrumental delivery, or those with gestational age less than 32 weeks, coagulopathy, haemoglobin less than 80 g/L, liver or kidney disorder, grand multiparity (five or more), hypersensitivity or any contraindication for use of prostaglandins.	400 mcg and 200 mcg plus 10 IU of Misoprostol plus Oxytocin administered sublingually and rectally plus intramuscularly versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Severe maternal morbidity: Intensive care admissions. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). NNU admissions. diarrhoea. Nausea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
Carillo-Gaucin 2016	2-arm active-controlled	120 parturients were randomised in a hospital setting in Mexico. The population comprised women of unspecified parity, either singleton or	unspecified dose of	The study recorded the	Contact with study authors

Study	Methods	Participants	Interventions	Outcomes	Notes
	randomised trial	multiple pregnancy, at high risk for PPH, who delivered by emergency caesarean section. Exclusion criteria comprised women with allergies to oxytocin or carbetocin or previous coagulation disorder.	Carbetocin administered by an unspecified route versus unspecified dose of Oxytocin administered by an unspecified route	following outcomes: Additional Uterotonics. Transfusion. Blood loss (ml).	for additional information: No. Additional data from authors: No
Cayan 2010	4-arm controlled randomised trial	160 parturients were randomised in a hospital setting in Turkey. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised parturients with thyroid disorder, inflammatory bowel disease or other bowel diseases, previous bariatric surgery or hypersensitivity to prostaglandins.	200, 400, or 600 mcg of Misoprostol plus Oxytocin administered rectally plus by an intravenous infusion versus 10 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: Fever. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
Chalermpolp rapa 2010	2-arm placebo-controlled randomised trial	120 parturients were randomised in a hospital setting in Thailand. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by caesareans. Exclusion criteria were not specified.	Unspecified dose of Misoprostol plus Oxytocin administered by an unspecified route versus Unspecified dose of Oxytocin administered by an unspecified route	The study recorded the following outcomes:(No Outcome Data Found)	Contact with study authors for additional information: Yes. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
Chandhiok 2006	2-arm cluster controlled randomised trial	1200 parturients were randomised in a community setting in India. The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with multiple pregnancy, known systemic disease or previous uterine surgery, or who were designated as high risk and scheduled for transfer to an advanced care facility at the time of labour.	600 mcg of Misoprostol administered orally versus 200 mcg of Ergometrine administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Third stage duration (min). Nausea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Chaudhuri 2010	2-arm active-controlled double-dummy randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised parturients undergoing caesarean section for cord prolapse or bradycardia, or those with cardiovascular, respiratory, liver or haematological disorders or known hypersensitivity to prostaglandins.	800 mcg of Misoprostol administered rectally versus 40 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: PPH at 500. PPH at 1000. Severe maternal morbidity: Intensive care admissions. Additional Uterotonics. Transfusion. Death. Blood loss (ml). Change in Haemoglobin. Vomiting.	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				Fever. Shivering.	
Chaudhuri 2012	2-arm active-controlled double-dummy randomised trial	530 parturients were randomised in a hospital setting in India. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing augmentation of labour, caesarean section or instrumental delivery, or those with risk factors for PPH, including BMI more than 30, grand multiparity (five or more), polyhydramnios, fetal macrosomia, antepartum haemorrhage, prolonged labour, previous PPH, haemoglobin less than 80 g/L, severe pre-eclampsia, asthma or coagulopathy.	400 mcg of Misoprostol administered sublingually versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Nausea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Chaudhuri 2015	2-arm active-controlled double-dummy randomised trial	396 parturients were randomised in a hospital setting in India. The population comprised women of parity 5 or less, either singleton or multiple pregnancy, at high risk for PPH, who delivered by emergency caesarean section. Exclusion criteria comprised parturients requiring conversion to general anaesthesia, or those with cardiovascular, hepatic, or haematologic disorders or any contraindication for the use of misoprostol or oxytocin.	400 mcg plus 20 IU of Misoprostol plus Oxytocin administered sublingually plus by an intramuscular bolus and intravenous infusion versus 20 IU of Oxytocin	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Death. Blood loss (ml). Change in Haemoglobin. diarrhoea.	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
			administered Intramuscular bolus plus an intravenous infusion	Fever. Shivering.	
Chaudhuri 2016	2-arm placebo-controlled randomised trial	288 parturients were randomised in a hospital setting in India. The population comprised women of parity 5 or less, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women who had caesareans or instrumental birth, known hypersensitivity to misoprostol and/or oxytocin, major cardiovascular, hepatic, or hematologic disorders or intrauterine fetal death or stillbirth.	400 mcg plus 10 IU of Misoprostol plus Oxytocin administered sublingually plus intramuscularly versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. diarrhoea. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Chhabra 2008	3-arm active-controlled randomised trial	300 parturients were randomised in a hospital setting in India. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing augmentation of labour, caesarean section or instrumental delivery, or those with grand multiparity (more than five), multiple pregnancy, pregnancy-induced hypertension, antepartum haemorrhage, previous caesarean, haemoglobin less than 80 g/L, other obstetric problems or known hypersensitivity to prostaglandins.	100 or 200 mcg of Misoprostol administered sublingually versus 200 mcg of Ergometrine administered by an intravenous bolus	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min).	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
				Nausea. Vomiting. Headache. Fever. Shivering.	
Choy 2002	2-arm active-controlled randomised trial	991 parturients were randomised in a hospital setting in Hong Kong. The population comprised women of parity 3 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with medical conditions that precluded the use of ergometrine, such as pre-eclampsia, cardiac disease or conditions that required prophylactic oxytocin infusion after delivery such as grand multiparity (four or more) or presence of uterine fibroids.	500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly versus 10 IU of Oxytocin administered by an intravenous bolus	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Change in Haemoglobin. Nausea. Vomiting. Hypertension. Headache.	Contact with study authors for additional information: Yes. Additional data from authors: No
Chua 1995	2-arm active-controlled randomised trial	115 parturients were randomised in a hospital setting in Singapore. The population comprised women of unspecified parity, a singleton pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	125 mcg of Carboprost administered intramuscularly versus 500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: Additional Uterotonics. Manual removal of placenta. diarrhoea.	Contact with study authors for additional information: No. Additional data from authors: No
Cook 1999	3-arm active-controlled randomised trial	930 parturients were randomised in a hospital setting in Australia, Papua and China. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery.	400 mcg of Misoprostol administered orally versus	The study recorded the following outcomes: PPH	Contact with study authors for additional information:

Study	Methods	Participants	Interventions	Outcomes	Notes
		Exclusion criteria comprised parturients undergoing elective caesarean section, or those with coagulopathy, asthma, heart disease, severe renal disease, epilepsy or hypertension.	500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly versus 10 IU of Oxytocin administered intramuscularly	at 500. PPH at 1000. Additional Uterotonics. Transfusion. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea.	Yes. Additional data from authors: No
Dabbaghi Gale 2012	2-arm active-controlled randomised trial	269 parturients were randomised in a hospital setting in Iran. The population comprised women of parity less than 3, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with previous PPH, asthma, clotting disorders, placental abruption, PPH due to lacerations, or those requiring instrumental delivery or caesarean section.	400 mcg of Misoprostol administered orally versus 10 IU of Oxytocin administered by an intravenous bolus	The study recorded the following outcomes:(No Outcome Data Found)	Contact with study authors for additional information: No. Additional data from authors: No
Dansereau 1999	2-arm active-controlled double-blinded randomised trial	694 parturients were randomised in a hospital setting in Canada. The population comprised women of parity 5 or less, either singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised parturients undergoing general anaesthesia or requiring a classical uterine incision, or those with heart disease, chronic hypertension requiring treatment, liver, renal, or endocrine disorders, coagulopathy, placenta praevia or placental abruption.	100 mcg of Carbetocin administered by an intravenous bolus versus 25 IU of Oxytocin administered by an intravenous bolus + infusion	The study recorded the following outcomes: Additional Uterotonics. Transfusion. Change in Haemoglobin. Nausea. Vomiting. Headache. Shivering. Abdominal pain.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Dasuki 2002	2-arm active-controlled randomised trial	196 parturients were randomised in a hospital setting in Indonesia. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at unspecified risk for PPH,	600 mcg of Misoprostol administered orally versus 10	The study recorded the following outcomes:	Contact with study authors for additional information:

Study	Methods	Participants	Interventions	Outcomes	Notes
		who delivered by vaginal delivery. Exclusion criteria were not specified.	IU of Oxytocin administered intramuscularly	Blood loss (ml). Third stage duration (min). Shivering.	Yes. Additional data from authors: No
de Groot 1996	3-arm placebo-controlled randomised trial	371 parturients were randomised in a hospital and community setting in the Netherlands. The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing induction or augmentation of labour or instrumental delivery, requiring tocolysis or those who refuse to take part or with cardiac disease, multiple pregnancy, non-cephalic presentation, polyhydramnios, coagulopathy, stillbirth, antepartum haemorrhage, Hb less than 4.8 mmol/L or previous complication in third stage.	placebo versus 5 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml).	Contact with study authors for additional information: No. Additional data from authors: No
Del Angel-Garcia 2006	2-arm active-controlled randomised trial	152 parturients were randomised in a hospital setting in Mexico. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by unspecified. Exclusion criteria were not specified.	unspecified dose of Oxytocin administered by an unspecified route versus unspecified dose of Carbetocin administered by an unspecified route	The study recorded the following outcomes:(No Outcome Data Found)	Contact with study authors for additional information: No. Additional data from authors: No
Derman 2006	2-arm placebo-controlled randomised trial	1620 parturients were randomised in a community setting in India. The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients at high risk and inappropriate for home or community births according to India's ministry of health guidelines including those undergoing elective caesarean section or breech vaginal delivery, or those previous caesarean section, haemoglobin less than 80 g/L, antepartum haemorrhage,	600 mcg of Misoprostol administered orally versus placebo	The study recorded the following outcomes: PPH at 500. PPH at 1000. Severe maternal morbidity:	Contact with study authors for additional information: Yes. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
		hypertension, multiple pregnancy, history of previous antepartum or PPH, retained placenta, uterine inversion, diabetes, heart disease, seizures, placenta praevia, asthma or contraindications to misoprostol.		Intensive care admissions. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). diarrhoea. Nausea. Vomiting. Fever. Shivering.	
Dhananjaya 2014	2-arm active-controlled randomised trial	100 parturients were randomised in a hospital setting in India. The population comprised women of parity 4 or less, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with grand multiparity (not defined), rhesus negative blood group, cardiac disease, diabetes, bleeding disorder, precipitated labour, overdistended uterus, traumatic PPH, PROM/Chorioamnionitis, intrauterine death, previous caesarean section/scar on uterus or inability to obtain the informed consent.	10 IU of Oxytocin administered intramuscularly versus 200 mcg of Ergometrine administered intramuscularly	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. Transfusion. Blood loss (ml). Third stage duration (min). diarrhoea. Nausea. Vomiting. Headache.	Contact with study authors for additional information: No. Additional data from authors: No
Diallo 2017	2-arm active-controlled randomised trial	304 parturients were randomised in a hospital setting in Senegal. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women who could not give their consent, those requiring a caesarean delivery and those with asthma allergy to misoprostol, pregnancies of less than 36 weeks, temperature above 38°C, chorioamnionitis, multiple	400 mcg of Misoprostol administered orally versus 5 IU of Oxytocin administered by	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics.	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
		pregnancy, severe cardiopathy, severe anaemia, clotting disorders, or complex perineal tear.	an intravenous bolus	Transfusion. Blood loss (ml). Change in Haemoglobin. diarrhoea. Nausea. Vomiting. Fever. Shivering.	
Diop 2016	2-arm active-controlled randomised trial	1820 parturients were randomised in a community setting in Senegal. The population comprised women of any parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with known allergies to prostaglandins or pregnancy complications.	600 mcg of Misoprostol administered orally versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: Death. Change in Haemoglobin. diarrhoea. Nausea. Vomiting. Fever. Shivering. Maternal satisfaction.	Contact with study authors for additional information: Yes. Additional data from authors: No
Docherty 1981	2-arm active-controlled randomised trial	50 parturients were randomised in a hospital setting in UK. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	10 IU of Oxytocin administered intramuscularly versus 500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: Blood loss (ml).	Contact with study authors for additional information: No. Additional data from authors: No
Dutta 2016	2-arm active-controlled randomised trial	400 parturients were randomised in a hospital setting in India. The population comprised women of parity 2 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women requiring caesarean section or	600 mcg of Misoprostol administered rectally versus	The study recorded the following outcomes: PPH	Contact with study authors for additional information: No.

Study	Methods	Participants	Interventions	Outcomes	Notes
		instrumental delivery, haemoglobin less than 8 g/dl, APH, severe pregnancy induced hypertension, pre-eclampsia or eclampsia, prolonged labour or precipitate labour, fetal weight >3.5kg, polyhydramnios, and medical disorders (cardiovascular disease, diabetes mellitus, thyroid disorders and other coagulation abnormalities.	10 IU of Oxytocin administered intramuscularly	at 500. Transfusion. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Nausea. Vomiting. Headache. Fever. Shivering. Abdominal pain.	Additional data from authors: No
Eftekhari 2009	2-arm active-controlled randomised trial	100 parturients were randomised in a hospital setting in Iran. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised parturients with multiple pregnancy, prolonged labour more than 12 h, two or more previous caesarean sections, previous uterine rupture, Hb less than 80 g/l, who had a history of heart, renal or liver disorders or had a coagulopathy.	400 mcg of Misoprostol administered sublingually versus 20 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: Additional Uterotonics. Blood loss (ml). Change in Haemoglobin.	Contact with study authors for additional information: Yes. Additional data from authors: No
El Behery 2015	2-arm active-controlled double-dummy randomised trial	180 parturients were randomised in a hospital setting in Egypt. The population comprised women of nulliparous, a singleton pregnancy, at high risk for PPH, who delivered by emergency caesarean section. Exclusion criteria comprised parturients undergoing elective caesarean section, vaginal delivery or general anaesthesia, or those who are multigravida, or with malpresentation, fetal anomalies, placenta praevia, diabetes, hypertension, pre-eclampsia or cardiac disease.	100 mcg of Carbetocin administered by an intravenous bolus versus 20 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Death. Blood loss (ml). Change in Haemoglobin.	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
				Headache. Fever.	
El Tahan 2012	2-arm placebo-controlled randomised trial	382 parturients were randomised in a hospital setting in Egypt. The population comprised women of parity 3 or less, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised parturients with asthma, anaemia, bleeding disorders, cardiac disease, inflammatory disease, bowel disease, multiple pregnancy, pre-eclampsia, placenta praevia, placental abruption, previous APH, previous PPH, grand multiparity (not defined), fibroids, growth restriction, fetal malformations or allergy to prostaglandins.	400 mcg plus 10 IU of Misoprostol plus Oxytocin administered sublingually plus by an intravenous bolus versus 10 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: Severe maternal morbidity: Intensive care admissions. Additional Uterotonics. Transfusion. Death. Blood loss (ml). diarrhoea. Vomiting. Fever. Shivering. Abdominal pain.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Elbohoty 2016	3-arm active-controlled triple-dummy randomised trial	270 parturients were randomised in a hospital setting in Egypt. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with hypersensitivity to oxytocin, carbetocin, or prostaglandins; contraindication to treatment with prostaglandins (e.g., glaucoma); history of significant heart disease; severe asthma; epilepsy; history or evidence of liver, renal, or vascular disease; history of coagulopathy, thrombocytopenia, or anticoagulant therapy; HELLP syndrome or eclampsia; placental abruption; or contraindication to spinal anaesthesia.	100 mcg of Carbetocin administered by an intravenous bolus versus 400 mcg of Misoprostol administered sublingually versus 30 IU of Oxytocin administered by an intravenous bolus + infusion	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Death. Nausea. Vomiting. Headache. Fever. Shivering. Abdominal pain.	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
Elgafor el Sharkwy 2013	2-arm active-controlled double-dummy randomised trial	380 parturients were randomised in a hospital setting in Egypt. The population comprised women of any parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised parturients undergoing general anaesthesia, or those with coagulopathy, coronary artery disease, hypertension, PPH due to causes other than uterine atony or hypersensitivity to carbetocin.	400 mcg plus 20 IU of Misoprostol plus Oxytocin administered sublingually plus by an intravenous infusion versus 100 mcg of Carbetocin administered by an intravenous bolus	The study recorded the following outcomes: Additional Uterotonics. Transfusion. Death. Change in Haemoglobin. Nausea. Vomiting. Headache. Hypotension. Fever. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
El-Refaey 2000	2-arm active-controlled randomised trial	1000 parturients were randomised in a hospital setting in UK. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section or water birth, or those with severe asthma.	500 mcg of Misoprostol administered orally versus 500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Nausea. Vomiting. Headache. Fever.	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				Shivering. Abdominal pain.	
Elsedeek 2012	2-arm placebo-controlled randomised trial	400 parturients were randomised in a hospital setting in Egypt. The population comprised women of parity 4 or less, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised parturients undergoing their first elective caesarean section, or those unsure of gestation or with hypertension, diabetes, oligohydramnios, abnormal placenta or abnormal laboratory investigations.	400 mcg plus 10 IU of Misoprostol plus Oxytocin administered rectally plus by an intravenous infusion versus 10 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: PPH at 1000. Additional Uterotonics. Transfusion. Blood loss (ml). Change in Haemoglobin. NNU admissions. Fever. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
Enakpene 2007	2-arm active-controlled randomised trial	864 parturients were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, a singleton pregnancy, at Low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with pre-eclampsia, hypertension, cardiac disease, severe anaemia, asthma, renal/hepatic disorders, gran multiparity (not defined), multiple pregnancy, polyhydramnios, previous PPH, fibroids or contraindications to misoprostol or ergometrine.	400 mcg of Misoprostol administered orally versus 500 mcg of Ergometrine administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Severe maternal morbidity: Intensive care admissions. Additional Uterotonics. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
				duration (min). diarrhoea. Nausea. Vomiting. Headache. Fever. Shivering.	
Ezeama 2014	2-arm active-controlled double-dummy randomised trial	300 parturients were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with premature labour (less than 28 weeks), multiple pregnancy, antepartum haemorrhage, hypertension in pregnancy, severe anaemia or haemoglobinopathy.	10 IU of Oxytocin administered intramuscularly versus 500 mcg of Ergometrine administered intramuscularly	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Third stage duration (min). Nausea. Vomiting. Hypertension. Headache.	Contact with study authors for additional information: Yes. Additional data from authors: No
Fahmy 2015	4-arm active-controlled double-dummy randomised trial	200 parturients were randomised in a hospital setting in Egypt. The population comprised women of parity 4 or less, unspecified whether singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with coagulopathy, thrombocytopenia, fibroids, placenta praevia, history of previous obstetric haemorrhage more than 1 litre, and women who received anticoagulant and antiplatelets therapy.	10 IU of Oxytocin administered by an intravenous bolus versus 100 mcg of Carbetocin administered by an intravenous bolus	The study recorded the following outcomes: Additional Uterotonics. Transfusion. Blood loss (ml).	Contact with study authors for additional information: No. Additional data from authors: No
Fahmy 2016	2-arm active-controlled	60 parturients were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, a twin pregnancy,	100 mcg of Carbetocin	The study recorded the	Contact with study authors

Study	Methods	Participants	Interventions	Outcomes	Notes
	randomised trial	at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with hypertension, pre-eclampsia, cardiac, respiratory, renal or liver disease, pre-existing bleeding disorder such as haemophilia and women taking therapeutic anticoagulants, hypersensitivity to carbetocin or oxytocin. Patients with haemoglobin less than 9.5 gm% and those who are pregnant with more than two babies.	administered by an intravenous bolus versus 20 IU of Oxytocin administered by an intravenous bolus	following outcomes: Additional Uterotonics. Transfusion. Blood loss (ml).	for additional information: No. Additional data from authors: No
Fakour 2013	2-arm active-controlled double-dummy randomised trial	200 parturients were randomised in a hospital setting in Iran. The population comprised women of nulliparous, unspecified whether singleton or multiple pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	400 mcg of Misoprostol administered sublingually versus 20 IU of Oxytocin administered intravenously	The study recorded the following outcomes:(No Outcome Data Found)	Contact with study authors for additional information: No. Additional data from authors: No
Fararjeh 2003	2-arm active-controlled randomised trial	97 parturients were randomised in a hospital setting in Turkey. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing elective caesarean section or instrumental delivery, or those with premature labour (less than 37 weeks), post maturity (more than 43 weeks), grand multiparity (more than four), twin pregnancy, growth restriction, macrosomia, Hb less than 100 g/l, systemic disorder, prolonged third stage, manual removal of placenta or additional lacerations due to episiotomy or where it took longer than 30 min to repair lacerations after episiotomy.	400 mcg of Misoprostol administered rectally versus 200 mcg plus 10 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Blood loss (ml). Change in Haemoglobin.	Contact with study authors for additional information: No. Additional data from authors: No
Fawole 2011	2-arm placebo-controlled randomised trial.	1345 parturients were randomised in a hospital setting in Nigeria. The population comprised multiparous women, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised severe allergic conditions or asthma, age below 18 years, pyrexia above 38°C, or abortion of the pregnancy.	400 mcg of misoprostol administered sublingually plus 10 IU of oxytocin or 250 mcg to 500 mcg of ergometrine administered intramuscularly	Could not include in the analysis as could not separate out the patients that received oxytocin from those who	Contact with study authors for additional information: Yes. Additional data from authors: Yes, but data not provided separate for

Study	Methods	Participants	Interventions	Outcomes	Notes
			or by an intravenous bolus (n = 658) or intravenous bolus versus 10 IU of Oxytocin or 250 mcg to 500 mcg of ergometrine administered intramuscularly or intravenously (n = 660).	received ergometrine.	each drug used and could not be included in the meta-analysis.
Fawzy 2012	3-arm active-controlled randomised trial	300 parturients were randomised in a hospital setting in Egypt, Libya. The population comprised women of nulliparous, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women at high risk for PPH such as multiple pregnancy, polyhydramnios, placenta praevia, diabetes mellitus, renal disorders.	500 mcg of Ergometrine administered by an intravenous bolus versus 200 mcg of Misoprostol administered sublingually or rectally	The study recorded the following outcomes: Death. Blood loss (ml). Third stage duration (min). Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
Fazel 2013	2-arm active-controlled randomised trial	100 parturients were randomised in a hospital setting in Iran. The population comprised women of parity 3 or less, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised parturients with twin pregnancy, fetal distress, pregnancy-induced hypertension, oligohydramnios, polyhydramnios, macrosomia, grand multiparity (4 or more), HELLP syndrome, coagulopathy, asthma, heart/lung/liver disease, previous more than one caesarean section, previous myomectomy, previous other abdominal operations, febrile diseases or sensitivity to prostaglandins.	400 mcg of Misoprostol administered rectally versus 10 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: Transfusion. Blood loss (ml). Nausea. Vomiting. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
Fekih 2009	2-arm active-controlled	250 parturients were randomised in a hospital setting in Tunisia. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or	200 mcg plus 20 IU of Misoprostol plus	The study recorded the following	Contact with study authors for additional

Study	Methods	Participants	Interventions	Outcomes	Notes
	randomised trial	emergency caesarean. Exclusion criteria comprised parturients undergoing caesarean section with general anaesthesia, or those with placenta praevia, retroplacental clot, multiple pregnancy, premature labour (less than 32 weeks), intra-uterine death, Hb less than 80 g/l, coagulopathy, HELLP syndrome, antepartum haemorrhage, ruptured uterus, previous more than 2 caesareans or other uterine scar, prolonged labour (more than 12 hours) or pyrexia.	Oxytocin administered sublingually plus by an intravenous bolus and infusion versus 20 IU of Oxytocin administered by an intravenous bolus + infusion	outcomes: PPH at 1000. Transfusion. Blood loss (ml). Change in Haemoglobin. Nausea. Vomiting. Headache. Fever. Shivering.	information: No. Additional data from authors: No
Fenix 2012	2-arm active-controlled double-dummy randomised trial	75 parturients were randomised in a hospital setting in Philippines. The population comprised women of any parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with pre-existing hypertension, pre-eclampsia, diabetes, asthma, cardiac/renal diseases, coagulopathy, abnormal laboratory tests or allergy to the study medication.	100 mcg of Carbetocin administered by an intravenous bolus versus 10 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Blood loss (ml). Change in Haemoglobin. Nausea. Vomiting. Headache. Tachycardia. Abdominal pain.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Fu 2003	2-arm controlled randomised trial	156 parturients were randomised in a hospital setting in China. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	400 mcg of Misoprostol administered orally versus no treatment	The study recorded the following outcomes: PPH at 500. Blood loss (ml).	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
Fuks 2014	2-arm active-controlled double-blinded randomised trial	143 parturients were randomised in a hospital setting in Jamaica. The population comprised women of parity 4 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with multiple pregnancy, gran multiparous, intrauterine fetal demise, preeclampsia, polyhydramnios, third- or fourth-degree laceration, and caesarean delivery.	600 mcg plus 10 IU of Misoprostol plus Oxytocin administered rectally plus intramuscularly versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes:(No Outcome Data Found)	Contact with study authors for additional information: No. Additional data from authors: No
Garg 2005	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of nulliparous, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	600 mcg of Misoprostol administered orally versus 200 mcg of Ergometrine administered by an intravenous bolus	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. Manual removal of placenta. Third stage duration (min). diarrhoea. Nausea. Vomiting. Headache. Fever. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
Gavilanes 2015	2-arm active-controlled randomised trial	100 parturients were randomised in a hospital setting in Ecuador. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised parturients with Hb less than 80 g/l, multiple pregnancy, polyhydramnios, previous uterine rupture, bleeding disorders, intrauterine death or hyperthermia (more than 38.5C).	400 mcg of Misoprostol administered sublingually versus 10 IU of Oxytocin administered by	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Blood loss (ml).	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
			an intravenous infusion	Nausea. Vomiting. Headache. Shivering.	
Gerstenfeld 2001	2-arm placebo-controlled randomised trial	400 parturients were randomised in a hospital setting in USA. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with multiple pregnancy, coagulopathy, Hb less than 70 g/L, indication for caesarean section or contraindication to prostaglandin or oxytocin use.	400 mcg of Misoprostol administered rectally versus 20 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. diarrhoea. Nausea. Vomiting. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
Gore 2017	2-arm active-controlled randomised trial	364 parturients were randomised in a hospital setting in India. The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women of gestational age less than 37 years, polyhydramnios, APH, pre-eclampsia, multiple pregnancy, intrauterine fetal distress, coagulation disorders, asthma, epilepsy, heart disease, kidney disease, severe anaemia with haemoglobin less than 7g/dl, complicated or eventful first and second stage of labour.	400 mcg of Misoprostol administered orally versus 200 mcg of Ergometrine administered by an intravenous bolus	The study recorded the following outcomes: Change in Haemoglobin. Third stage duration (min).	Contact with study authors for additional information: No. Additional data from authors: No
Gulmezoglu 2001	2-arm active-controlled double-blinded randomised trial	18530 parturients were randomised in a hospital setting in Argentina, China, Egypt, Ireland, Nigeria, South Africa, Switzerland, Thailand and Vietnam Nigeria, South Africa, Switzerland, Thailand, and Vietnam. The population comprised women of both nulliparous and multiparous, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing elective or emergency caesarean section after randomisation, or those with asthma, severe chronic allergic conditions, abortion, pyrexia (more than 38°C) or inability to give consent.	600 mcg of Misoprostol administered orally versus 10 IU of Oxytocin administered intramuscularly or by an intravenous bolus	The study recorded the following outcomes: PPH at 500. PPH at 1000. Severe maternal morbidity: Intensive care admissions. Additional	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
				Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Third stage duration (min). diarrhoea. Nausea. Vomiting. Fever. Shivering.	
Gupta 2006	2-arm active-controlled double-blinded randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at Both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	600 mcg of Misoprostol administered rectally versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). Nausea. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Hamm 2005	2-arm placebo-controlled randomised trial	352 parturients were randomised in a hospital setting in USA. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria were not specified.	200 mcg plus 20 IU of Misoprostol plus Oxytocin administered sublingually	The study recorded the following outcomes: PPH at 1000. Additional	Contact with study authors for additional information: Yes. Additional

Study	Methods	Participants	Interventions	Outcomes	Notes
			plus by an intravenous infusion versus 20 IU of Oxytocin administered by an intravenous infusion	Uterotonics. Transfusion. Blood loss (ml). Change in Haemoglobin.	data from authors: No
Harriott 2009	2-arm active-controlled randomised trial	140 parturients were randomised in a hospital setting in West Indies. The population comprised women of both nulliparous and multiparous, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with previous PPH, hypertension, previous caesarean, intrauterine death, sepsis/pyrexia (more than 38°C), antepartum haemorrhage or Hb less than 80 g/L.	500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly versus 400 mcg of Misoprostol administered rectally	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Nausea. Vomiting. Hypertension. Fever. Shivering. Maternal satisfaction.	Contact with study authors for additional information: No. Additional data from authors: No
Hernandez-Castro 2016	2-arm placebo-controlled	123 parturients were randomised in a hospital setting in Mexico. The population comprised women of any parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised	400 mcg plus 20 IU of Misoprostol plus Oxytocin	The study recorded the following outcomes: PPH	Contact with study authors for additional information: No.

Study	Methods	Participants	Interventions	Outcomes	Notes
	randomised trial	women with hypersensitivity to prostaglandins, hyperthermia, coagulation defects, or history of vaginal bleeding (placental abruption or placenta praevia) and those who required general anaesthesia.	administered sublingually plus by an intravenous infusion versus 20 IU of Oxytocin administered by an intravenous infusion	at 1000. Additional Uterotonics. Transfusion.	Additional data from authors: No
Hofmeyr 1998	2-arm placebo-controlled randomised trial	500 parturients were randomised in a hospital setting in South Africa. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing augmentation of labour, or those with hypertension, diabetes or previous caesarean.	400 mcg of Misoprostol administered orally versus placebo	The study recorded the following outcomes: PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Shivering. Abdominal pain.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Hofmeyr 2001	2-arm placebo-controlled randomised trial	600 parturients were randomised in a hospital setting in South Africa. The population comprised women of any parity, unspecified whether singleton or multiple pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	600 mcg of Misoprostol administered orally versus placebo	The study recorded the following outcomes: PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. diarrhoea. Nausea. Vomiting. Fever.	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				Shivering. Abdominal pain.	
Hofmeyr 2011	2-arm placebo-controlled randomised trial	1103 parturients were randomised in a hospital setting in South Africa, Uganda, and Nigeria. The population comprised women of any parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section or instrumental delivery, or those who declined participation or were unable to consent, were too ill or distressed to participate or with a not viable pregnancy.	400 mcg plus 10 IU of Misoprostol plus Oxytocin administered sublingually plus intramuscularly versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Manual removal of placenta. Death. Blood loss (ml). Fever. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Hoj 2005	2-arm placebo-controlled randomised trial	661 parturients were randomised in a community setting in Guinea-Bissau. The population comprised women of parity 3 or less, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	600 mcg of Misoprostol administered sublingually versus placebo	The study recorded the following outcomes: PPH at 500. PPH at 1000. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Nausea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Hong 2007	2-arm placebo-controlled	214 parturients were randomised in a hospital setting in Korea. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at high risk for PPH, who	20 IU of Oxytocin administered by	The study recorded the following	Contact with study authors for additional

Study	Methods	Participants	Interventions	Outcomes	Notes
	randomised trial	delivered by caesarean (unspecified whether elective or emergency). Exclusion criteria were not specified.	an intravenous infusion versus 400 mcg plus 20 IU of Misoprostol plus Oxytocin administered rectally plus by an intravenous infusion	outcomes: Additional Uterotonics. Transfusion. Change in Haemoglobin. Fever. Shivering.	information: Yes. Additional data from authors: No
Humera 2016	2-arm active-controlled randomised trial	100 parturients were randomised in a hospital setting in India. The population comprised women of any parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with pre-eclampsia or eclampsia, previous caesarean, previous retained placenta, APH, coagulation disorder, cardiac diseases, diabetes, hypertension and epilepsy.	600 mcg of Misoprostol administered orally versus 200 mcg of Ergometrine administered by an intravenous bolus	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Third stage duration (min). Nausea. Vomiting. Hypertension. Headache. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Ibrahim 2017	2-arm active-controlled randomised trial	60 pregnant women were randomised in a hospital setting in Egypt. Population comprised of women of any parity with a singleton pregnancy. Women were at high risk for PPH, with severe preeclampsia. Vaginal birth. Exclusion criteria: HELLP syndrome, eclampsia, abruptioplacentae, polyhydramnios, uterine scar, chorioamnionitis, malpresentation and multiple pregnancies.	Carbetocin (100 ug IV bolus) versus misoprostol (600 ug sublingually)	The study reported the following outcomes: Need for ICU admission; need for	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				additional uterotonics; blood transfusion; mean volumes of blood loss (ml)	
Ibrahim 2020	2-arm active-controlled randomised trial	160 pregnant women were randomised in a hospital setting in Egypt. Population comprised of women of any gravidity. Parity not reported. Women at high risk for PPH as they had a hypertensive disorder in pregnancy and scheduled elective caesarean. Exclusion criteria: history of risk factors for excessive blood loss during surgery such as placenta previa, twin pregnancy, presence of uterine fibroid; thromboembolic disorder history; chronic medical diseases such as cardiac, hepatic or renal; maternal request for a caesarean section; caesarean section performed under general anaesthesia.	Carbetocin (100 ug, IV injection) versus Oxytocin (10 IU infusion)	The study reported the following outcomes: Need for additional uterotonics; blood transfusions; mean volumes of blood loss (ml)	Contact with study authors for additional information: No. Additional data from authors: No
Is 2012	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	400 mcg of Misoprostol administered rectally versus unspecified of Ergometrine administered intramuscularly	The study recorded the following outcomes: Third stage duration (min). Nausea. Vomiting. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Jago 2007	2-arm active-controlled randomised trial	510 parturients were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing induction or augmentation of labour or instrumental delivery, or those requiring epidural analgesia or with hypertension in pregnancy, existing hypertension, chronic renal disease, diabetes, vascular diseases, cardiac disease, anticoagulation therapy or allergy to ergometrine or oxytocin.	500 mcg of Ergometrine administered intramuscularly versus 10 IU of Oxytocin administered by an intravenous bolus	The study recorded the following outcomes: PPH at 500. PPH at 1000. Blood loss (ml). Hypertension.	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
Jain 2019	3-arm active-controlled randomised trial	75 pregnant women were randomised in a hospital setting in India. Population comprised of women of any parity with a singleton pregnancy. Women were at low risk of PPH, delivering vaginally. Exclusion criteria were haemoglobin <7g/dL; previous history of PPH; pregnancy-induced hypertension; mal-presentation; coagulation abnormality; antepartum haemorrhage; intrauterine demise; previous caesarean section; medical disorders such as diabetes, heart disease, stroke, peripheral vascular disorders, epilepsy, asthma; liver and kidney disorders; uterine rupture; scar dehiscence.	Methylergometrine (0.2mg, IM) versus Misoprostol (400 mcg, rectal) versus Oxytocin (5 IU, IV)	The study reported the following outcomes: Mean volumes of blood loss (ml)	Contact with study authors for additional information: No. Additional data from authors: No
Jangsten 2011	2-arm controlled randomised trial	1802 parturients were randomised in a hospital setting in Sweden. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing elective caesarean section, or those who were non-Swedish speaking or with previous PPH, pre-eclampsia, grand multiparity (more than four) or intrauterine death.	10 IU of Oxytocin administered by an intravenous bolus versus no treatment	The study recorded the following outcomes: PPH at 1000. Transfusion. Manual removal of placenta. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). Maternal satisfaction.	Contact with study authors for additional information: Yes. Additional data from authors: No
Jans 2016	2-arm controlled randomised trial	1704 parturients were randomised in a community setting in Netherlands. The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with indications for a prophylactic approach to the third stage management in primary midwifery care and women with poor command of the Dutch language.	5 IU of Oxytocin administered intramuscularly versus no treatment	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Third stage duration (min). Breastfeeding. Nausea.	Contact with study authors for additional information: Yes. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				Vomiting. Headache. Abdominal pain. Maternal sense of wellbeing.	
Jerbi 2007	2-arm controlled randomised trial	130 parturients were randomised in a hospital setting in Tunisia. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with placenta praevia, antepartum haemorrhage, non-cephalic presentation, intrauterine death, grand multiparity, (more than five), fibroids, anticoagulation therapy, previous PPH or previous caesarean.	5 IU of Oxytocin administered by an intravenous bolus versus no treatment	The study recorded the following outcomes: PPH at 1000. Transfusion. Manual removal of placenta. Death. Change in Haemoglobin. Third stage duration (min).	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Jirakulsawas 2000	2-arm active-controlled randomised trial	140 parturients were randomised in a hospital setting in Thailand. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	600 mcg of Misoprostol administered orally versus 200 mcg of Ergometrine administered intramuscularly	The study recorded the following outcomes: PPH at 500. Blood loss (ml).	Contact with study authors for additional information: No. Additional data from authors: No
Kabir 2015	2-arm active-controlled randomised trial	110 parturients were randomised in a hospital setting in Bangladesh. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with placenta praevia, multiple pregnancy, placental abruption, hypertensive disorders, preeclampsia, cardiac/renal/liver disorders, epilepsy, moderate anaemia (Hb <9g/dl), intrauterine fetal death and unwilling to participate in the study.	100 mcg of Carbetocin administered by an intravenous bolus versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Blood loss (ml). Abdominal pain.	Contact with study authors for additional information: Yes. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
Kang 2022	2-arm active-controlled randomised trial	852 pregnant women were randomised in a hospital setting in China. Population comprised of women of any parity with a singleton pregnancy. Women were at high risk for PPH, as they had PPH risk factors and scheduled caesarean section. PPH risk factors: scarred uterus, uterine fibroid, breech presentation, 35 years or over. Exclusion criteria: age less than 18; multiple pregnancy; placenta praevia; suspected placenta accreta; systematic disease such as liver or kidney dysfunction, heart disease, hypertension, endocrine disease except gestational diabetes; abnormal coagulation; hypersensitive to carbetocin or oxytocin.	Carbetocin (100 ug , IV injection) versus Oxytocin (10 IU plus 20 IU, uterine injection and intravenous infusion)	The study reported the following outcomes: Primary PPH >=1000ml; additional uterotonics; blood transfusions; mean volume of blood loss (ml)	Contact with study authors for additional information: No. Additional data from authors: No
Karkanis 2002	2-arm active-controlled randomised trial	238 parturients were randomised in a hospital setting in Canada. The population comprised women of parity 5 or less, unspecified whether singleton or multiple pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with coagulopathy, anticoagulation therapy, previous PPH or previous caesarean.	400 mcg of Misoprostol administered rectally versus 5 IU of Oxytocin administered by an intravenous bolus or intramuscularly	The study recorded the following outcomes: Additional Uterotonics. Transfusion. Manual removal of placenta. Change in Haemoglobin. Third stage duration (min). Nausea. Vomiting. Headache. Fever. Shivering. Abdominal pain.	Contact with study authors for additional information: Yes. Additional data from authors: No
Kerekes 1979	3-arm controlled randomised trial	140 parturients were randomised in a hospital setting in Hungary. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	200 mcg of Ergometrine administered Intravenous	The study recorded the following outcomes: Third	Contact with study authors for additional information: Yes. Additional

Study	Methods	Participants	Interventions	Outcomes	Notes
			bolus versus no treatment	stage duration (min).	data from authors: No
Khan 1995	2-arm active-controlled double-blinded randomised trial	2040 parturients were randomised in a hospital setting in United Arab Emirates. The population comprised women of any parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing induction or augmentation of labour, caesarean section or instrumental delivery, or requiring general anaesthesia, epidural or diazepam, or those with antenatal hypertension (160/100 mmHg or more), hypertension on antihypertensive drugs, multiple pregnancy, cardiac disease or Hb of 90 g/L or less.	10 IU of Oxytocin administered intramuscularly versus 500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Transfusion. Manual removal of placenta. Vomiting. Headache.	Contact with study authors for additional information: Yes. Additional data from authors: No
Khurshid 2010	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of any parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with hypertension, cardiac disease, renal disease, gastro-intestinal disorders, respiratory disease, endocrinal problems, coagulation disorder and sensitivity to prostaglandin or methergine.	125 mcg of Carboprost administered intramuscularly versus 200 mcg of Ergometrine administered by an intravenous bolus	The study recorded the following outcomes: Additional Uterotonics. Manual removal of placenta. Blood loss (ml). Third stage duration (min).	Contact with study authors for additional information: No. Additional data from authors: No
Koen 2016	2-arm active-controlled double-dummy randomised trial	540 parturients were randomised in a hospital setting in South Africa. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women not willing or not able to provide consent, previous classic CS, <18 years of age, pre-eclampsia, eclampsia, uncontrolled hypertension, cardiac/liver/renal disorders, hypersensitivity to oxytocin or oxytocin + ergometrine, occlusive vascular disease, autoimmune vasculitis.	12.5 IU of Oxytocin administered by an intravenous bolus + infusion versus 500 mcg plus 15 IU of Ergometrine plus Oxytocin administered intramuscularly plus by an	The study recorded the following outcomes: Additional Uterotonics. Transfusion. Blood loss (ml). Nausea. Vomiting. Headache.	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
			intravenous infusion		
Kumar 2016	2-arm active-controlled randomised trial	201 parturients were randomised in a hospital setting in India. The population comprised women of any parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesareans, with hypersensitivity to drugs, asthma, cardiac diseases, epilepsy, psychiatric disorders, liver and renal diseases.	125 mcg of Carboprost administered intramuscularly versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. Transfusion. Death. Blood loss (ml). Third stage duration (min). diarrhoea. Nausea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Kumar 2021	2-arm active-controlled randomised trial	80 pregnant women were randomised in a hospital setting in India. Population comprised of women of any parity with a singleton pregnancy. Women were at a low risk of PPH delivering by vaginal birth. Exclusion criteria: elective and emergency caesarean section, severe anaemia, multiple gestation, antepartum haemorrhage, malpresentation/malposition, polyhydramnios, prolonged labour or obstructed labour, history of previous rupture uterus, grand multipara, macrosomic baby, fibroid uterus, severe pre-eclampsia, known hypersensitivity to prostaglandins and induction of labour with oxytocin or prostaglandins.	Misoprostol (600 ug rectally) versus oxytocin (10 IU IM)	The study reported the following outcomes: Mean volumes of blood loss (ml)	Contact with study authors for additional information: No. Additional data from authors: No
Kumru 2005	2-arm active-controlled randomised trial	55 parturients were randomised in a hospital setting in Turkey. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised parturients with multiple pregnancy, hypertension or vascular diseases.	10 IU of Oxytocin administered by an intravenous bolus + infusion versus 200 mcg plus 10 IU of	The study recorded the following outcomes: Blood loss (ml).	Contact with study authors for additional information: Yes. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
			Ergometrine plus Oxytocin administered by an intravenous bolus plus by intravenous bolus plus infusion		
Kundodyiwa 2001	2-arm placebo-controlled randomised trial	500 parturients were randomised in a hospital setting in Zimbabwe. The population comprised women of unspecified parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing instrumental delivery, or those with previous PPH, antepartum haemorrhage, coagulopathy, multiple pregnancy, asthma or allergies to prostaglandins or oxytocin.	400 mcg of Misoprostol administered orally versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Severe maternal morbidity: Intensive care admissions. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Third stage duration (min). diarrhoea. Nausea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
Kushtagi 2006	2-arm active-controlled randomised trial	215 parturients were randomised in a hospital setting in India. The population comprised women of any parity, unspecified whether singleton or multiple pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	200 mcg of Ergometrine administered by an intravenous	The study recorded the following outcomes: PPH	Contact with study authors for additional information: No.

Study	Methods	Participants	Interventions	Outcomes	Notes
			bolus versus 125 mcg of Carboprost administered intramuscularly	at 500. Blood loss (ml). Third stage duration (min). Hypertension.	Additional data from authors: No
Lam 2004	2-arm active-controlled randomised trial	60 parturients were randomised in a hospital setting in China (Hong Kong SAR). The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing induction or augmentation of labour, or those with antepartum haemorrhage, anaemia, two or more surgical terminations, previous manual removal of placenta, previous PPH or previous third stage complications.	500 mcg plus 5 IU of Ergometrine plus Oxytocin administered by an intravenous bolus versus 600 mcg of Misoprostol administered sublingually	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Manual removal of placenta. Death. Fever.	Contact with study authors for additional information: Yes. Additional data from authors: No
Lamont 2001	2-arm active-controlled randomised trial	529 parturients were randomised in a hospital setting in United Kingdom. The population comprised women of both nulliparous and multiparous, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by both caesarean and vaginal delivery. Exclusion criteria comprised women with known sensitivity to either prostaglandins, ergometrine or oxytocin, had a history of asthma, glaucoma, raised intraocular pressure or were known to have cardiac, pulmonary, renal or hepatic disease, hypertension, sepsis or obliterative vascular disorders. Women were excluded if they were currently taking anticoagulant treatment or participating in other clinical trials.	250 mcg of Carboprost administered intramuscularly versus 500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Manual removal of placenta. Blood loss (ml). diarrhoea. Nausea. Vomiting.	Contact with study authors for additional information: No. Additional data from authors: No
Lapaire 2006	2-arm active-controlled double-blinded randomised trial	56 parturients were randomised in a hospital setting in Switzerland. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised parturients undergoing emergency caesarean section, or those with fetal distress, fetal malformations, pre-eclampsia, HELLP syndrome, coagulopathy, severe systemic disorders, an American Society of Anesthesiologists physical status of 3 or greater, severe asthma,	25 IU of Oxytocin administered by an intravenous bolus + infusion versus 800 mcg plus 5 IU of Misoprostol plus	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion.	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
		previous myomectomy, pyrexia (more than 38.5C) or hypersensitivity to prostaglandins.	Oxytocin administered orally plus by an intravenous bolus	Death. Blood loss (ml). Nausea. Headache. Shivering.	
Leung 2006	2-arm active-controlled double-dummy randomised trial	329 parturients were randomised in a hospital setting in Hong Kong. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients requiring prophylactic oxytocin infusion, or those with pre-existing hypertension, pre-eclampsia, asthma, cardiac/renal/liver diseases, grand multiparity or fibroids.	100 mcg of Carbetocin administered intramuscularly versus 500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). Nausea. Vomiting. Hypertension. Headache. Tachycardia. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
Liu 2020	2-arm active-controlled randomised trial	636 pregnant women were randomised in a hospital setting in China. Population comprised of women of any parity with either singleton or twin pregnancy. Expected vaginal delivery. 2.2% Carbetocin arm had twin pregnancy, and 2.9% of oxytocin arm had twin pregnancy. Women were at high risk PPH as they had a least one risk factor for uterine atony (macrosomia; amnion fluid index>=250mm; twin pregnancy; intrapartum fever' prolonged labour >12 hours; labour induction or augmentation; epidural analgesia; tocolysis utility; precipitate delivery; operative vaginal delivery; antepartum haemorrhage including marginal placental previa and placental	Carbetocin (100 ug, IV infusion) versus oxytocin (10 IU oxytocin, IV infusion)	The study reported the following outcomes: Primary PPH >=1000ml; additional uterotonics; blood transfusions;	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
		abruption; pregnancy complications such as hypertension or gestational diabetes. Exclusion criteria were serious cardiovascular disorders; serious hepatic or renal disease; epilepsy; known allergies to oxytocin or carbetocin; those without risk factors for uterine atony.		mean volume of blood loss (ml)	
Lokugamage 2001	2-arm active-controlled randomised trial	40 parturients were randomised in a hospital setting in UK. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised parturients with two or more previous caesarean sections or previous uterine rupture.	10 IU of Oxytocin administered by an intravenous bolus versus 500 mcg of Misoprostol administered orally	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Blood loss (ml). Change in Haemoglobin. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Lumbiganon 1999	3-arm active-controlled double-dummy randomised trial	597 parturients were randomised in a hospital setting in South Africa and Thailand. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing elective caesarean section or abortion, or those with asthma, other severe chronic allergic conditions a contraindication to use of misoprostol or if they were not willing or able to give informed consent.	600 or 400 mcg of Misoprostol administered orally versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). diarrhoea. Nausea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Maged 2016	2-arm active-controlled	200 parturients were randomised in a hospital setting in Egypt. The population comprised women of any parity, either singleton or	100 mcg of Carbetocin	The study recorded the	Contact with study authors

Study	Methods	Participants	Interventions	Outcomes	Notes
	double-blinded randomised trial	multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with placenta praevia, coagulopathy, pre-eclampsia, cardiac/renal/liver disorders, epilepsy or known hypersensitivity to oxytocin or carbetocin.	administered intramuscularly versus 5 IU of Oxytocin administered intramuscularly	following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). Nausea. Vomiting. Headache. Tachycardia. Shivering.	for additional information: No. Additional data from authors: No
Maged 2017	2-arm active-controlled double-blinded randomised trial	300 parturients were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women with placenta previa, coagulopathy, preeclamptic or known sensitivity to oxytocin or methergine.	100 mcg of Carbetocin administered by an intravenous bolus versus 200 mcg plus 5 IU of Ergometrine plus Oxytocin administered by an intravenous bolus	The study recorded the following outcomes: PPH at 1000. Additional Uterotonics. Blood loss (ml). Change in Haemoglobin. Nausea. Vomiting. Headache. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Maged 2020	2-arm active-controlled randomised trial	150 pregnant women were randomised in a hospital setting in Egypt. Population comprised of women of any parity with a singleton pregnancy. Women were at low risk for PPH, admitted for vaginal delivery. Exclusion criteria: women with a history of PPH in previous delivery; uterine fibroids; previous caesarean; medical disorders such	Carbetocin (100ug/ml, IV infusion) versus misoprostol (800 ug, rectal)	The study reported the following outcomes: additional	Contact with study authors for additional information: No. Additional data

Study	Methods	Participants	Interventions	Outcomes	Notes
		as diabetes, anaemia, coagulation disorders, cardiac, hepatic or renal disease; prepartum haemorrhage.		uterotonics; blood loss (ml)	from authors: No
Malik 2018	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with anaemia, pregnancy induced hypertension, placental abruption/placenta praevia, multiple pregnancy, gran multiparous, malpresentation, polyhydramnios, previous uterine scar, chorioamnionitis, prolonged labour, intrauterine fetal death, coagulation disorder, asthma/epilepsy/heart/renal disorder.	125 mcg of Carboprost administered intramuscularly versus 200 mcg of Ergometrine administered by an intravenous bolus	The study recorded the following outcomes:Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Nausea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Mannaerts 2018	2-arm active-controlled double-blinded randomised trial	68 parturients were randomised in a hospital setting in Belgium. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with medical conditions potentially influencing outcome measures (nausea, vomitus, and hypotension): diabetes, pre-existing hypertension, preeclampsia, gestational hypertension, and known gastrointestinal diseases.	15 IU of Oxytocin administered by an intravenous bolus + infusion versus 100 mcg of Carbetocin administered by an intravenous bolus	The study recorded the following outcomes: Additional Uterotonics. Change in Haemoglobin. Nausea.	Contact with study authors for additional information: No. Additional data from authors: No
Masse 2022	2-arm active-controlled randomised trial	160 pregnant women were randomised in a hospital setting in the United States. Population comprised of women of any parity with a singleton pregnancy. Women were at high risk for PPH as they were undergoing a caesarean birth. Exclusion criteria: Placental or uterine anomalies including placenta accreta; contraindications to methylergonovine; history of chronic or pregnancy induced hypertension; coronary artery disease; human immunodeficiency; taking a protease inhibitor; known hypersensitivity to methylergonovine.	Oxytocin plus methylergonovine (300ml/min plus 0.2mg, IM plus IM) versus oxytocin plus placebo (300ml/min, IV plus IM)	The study reported the following outcomes: Primary PPH >=1000ml; additional uterotonics; blood transfusions;	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				mean volume of blood loss (ml)	
McDonagh 2022	4-arm active-controlled randomised trial	Total N randomised = 280; setting (hospital); Canada; Mixed Parity; singleton pregnancy; PPH risk: low (see def below); birth type CB elective; exclusion criteria: refusal to give written informed consent; allergy or hypersensitivity to oxytocin or carbetocin; active labour; requirement for general anaesthesia; BMI ≥40 kg.m-2; and conditions predisposing to uterine atony and PPH (placenta praevia; multiple gestation; pre- eclampsia; eclampsia; macrosomia; polyhydramnios; uterine fibroids; previous history of uterine atony and PPH; bleeding diathesis; and hepatic, renal or cardiovascular disease)	carbetocin 20 ug + placebo infusion versus carbetocin 100 ug + placebo infusion versus oxytocin 0.5 IU bolus + infusion of 40 mIU.min-1 versus oxytocin 5 IU bolus + infusion of 40 mIU.min-1	The study recorded the following outcomes: Primary PPH ≥ 1000ml, Additional uterotonics in the operating theatre, Additional uterotonics in the first 24hours postoperatively and median volumes of blood loss	Contact with study authors for additional information: No. Additional data from authors: No. Blood loss median data was converted to mean + SE
McDonald 1993	2-arm active-controlled double-blinded randomised trial	3497 parturients were randomised in a hospital setting in Australia. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing emergency or elective caesarean section, or requiring general anaesthetic for instrumental delivery, or those with hypertension in labour (more than 150/100 mm Hg), antenatal hypertension, maternal distress, advanced stage in labour, language barrier, fetal abnormality, intrauterine death or medical disorder.	500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. NNU admissions. Breastfeeding. Nausea. Vomiting.	Contact with study authors for additional information: Yes. Additional data from authors: No
Mitchell 1993	2-arm active-controlled	461 parturients were randomised in a hospital setting in United Kingdom. The population comprised women of unspecified parity,	500 mcg plus 5 IU of	The study recorded the	Contact with study authors

Study	Methods	Participants	Interventions	Outcomes	Notes
	double-blinded randomised trial	either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing elective caesarean section, or those with significant hypertension or cardiac disease.	Ergometrine plus Oxytocin administered intramuscularly versus 5 IU of Oxytocin administered intramuscularly	following outcomes: PPH at 500. PPH at 1000. Manual removal of placenta. Blood loss (ml). Third stage duration (min).	for additional information: Yes. Additional data from authors: No
Mobeen 2011	2-arm placebo-controlled randomised trial	1119 parturients were randomised in a community setting in Pakistan. The population comprised women of unspecified parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with hypertension, non-cephalic presentation, polyhydramnios, previous caesarean, multiple pregnancy, intrauterine death, antepartum haemorrhage or Hb less than 80 g/l.	600 mcg of Misoprostol administered orally versus placebo	The study recorded the following outcomes: PPH at 500. PPH at 1000. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Nausea. Vomiting. Headache. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Modi 2014	4-arm active-controlled randomised trial	100 parturients were randomised in a hospital setting in India. The population comprised women of parity 3 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with gestations less than 37 or more than 42 weeks, intrauterine death, fetal growth restriction, hypertensive or cardiac or renal disorders, multiple pregnancies, placenta praevia, placenta abruption, gran multiparous, coagulation	10 IU of Oxytocin administered intramuscularly versus 200 mcg of Ergometrine administered by	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics.	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
		disorders, anaemia (<8g/dl), tachycardia or hypotension, malpresentations, chorioamnionitis, or known allergy to prostaglandins.	an intravenous bolus versus 125 mcg of Carboprost administered intramuscularly versus 600 mcg of Misoprostol administered rectally	Transfusion. Blood loss (ml). Third stage duration (min).	
Moertl 2011	2-arm active-controlled double-blinded randomised trial	84 parturients were randomised in a hospital setting in Austria. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised parturients requiring general anaesthesia, or those with placenta praevia, placental abruption, multiple pregnancy, pre-eclampsia, gestational diabetes, pre-existing insulin-dependent diabetes, cardiovascular/renal disorders, hypo-/hyperthyroidism or women on cardiovascular system medications.	100 mcg of Carbetocin administered by an intravenous bolus versus 5 IU of Oxytocin administered by an intravenous bolus	The study recorded the following outcomes: Additional Uterotonics. Change in Haemoglobin. Nausea. Headache.	Contact with study authors for additional information: Yes. Additional data from authors: No
Mohamed 2015	2-arm active-controlled randomised trial	172 parturients were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with medical disorder as hypertension, diabetes or on an anticoagulant, severe polyhydramnios, multiple pregnancy, placenta praevia or placental abruption, previous uterine scar other than lower segment caesarean section or who had more than one previous section.	5 IU of Oxytocin administered by an intravenous bolus versus 100 mcg of Carbetocin administered by an intravenous bolus	The study recorded the following outcomes:Blood loss (ml).	Contact with study authors for additional information: No. Additional data from authors: No
Moir 1979	2-arm active-controlled randomised trial	88 parturients were randomised in a hospital setting in UK. The population comprised women of primigravidas, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	500 mcg of Ergometrine administered by an intravenous bolus versus 10 IU of Oxytocin administered by	The study recorded the following outcomes: PPH at 500. PPH at 1000. Blood	Contact with study authors for additional information: Yes. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
			an intravenous bolus	loss (ml). Nausea.	
Moodie 1976	2-arm active-controlled randomised trial	148 parturients were randomised in a hospital setting in UK. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	500 mcg of Ergometrine administered by an intravenous bolus versus 5 IU of Oxytocin administered by an intravenous bolus	The study recorded the following outcomes: PPH at 500. Blood loss (ml). Nausea.	Contact with study authors for additional information: No. Additional data from authors: No
Mukta 2013	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of any parity, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing emergency or elective caesarean section, or those with eclampsia, asthma, epilepsy, cardiac/kidney disorder or coagulopathy.	600 mcg of Misoprostol administered orally versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. diarrhoea. Nausea. Vomiting. Fever. Shivering. Abdominal pain.	Contact with study authors for additional information: Yes. Additional data from authors: No
Musa 2015	2-arm active-controlled double-dummy randomised trial	235 parturients were randomised in a hospital setting in Nigeria. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing planned instrumental, or those who received oxytocin and/or misoprostol other than in the third stage of labour, or those with grand multiparity (more than four), multiple pregnancy, fibroids, polyhydramnios, pre-eclampsia, eclampsia, hypertension, cardiac disorder, asthma, antepartum haemorrhage, previous PPH, prolonged rupture of membranes or Hb less than 100 g/L).	600 mcg of Misoprostol administered orally versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. Severe maternal morbidity: Intensive care admissions. Additional Uterotonics. Manual removal	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
				of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Nausea. Vomiting. Fever. Shivering.	
Nahaer 2020	2-arm active-controlled randomised trial	Total N randomised= 100; setting (hospital); Bangladesh. Parity: nulliparous; singleton pregnancy; PPH risk: both low and high (see def below); birth type CB (elective, emergency); exclusion criteria: placenta previa, multiple gestation, placental abruption (determined by history and ultrasound report) hypertensive disorders in pregnancy, preeclampsia, and known case of cardiac, renal, liver diseases, epilepsy, moderate anaemia and unwilling to participate in the study	Carbetocin100 µg I/V as a single dose versus 10 IU of oxytocin	The study recorded the following outcomes: Additional uterotonics and blood transfusion	Contact with study authors for additional information: No. Additional data from authors: No
Nankaly 2016	3-arm active-controlled randomised trial	185 parturients were randomised in a hospital setting in Iran. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women with anaemia, multiple pregnancy, polyhydramnios, prolonged labour, premature rupture of membranes, placenta praevia, placental abruption, vaginal bleeding, diabetes, blood pressure, kidney disease, cardiovascular disease and coagulation disorders or other underlying disease.	20 IU of Oxytocin administered by an intravenous infusion versus 400 mcg or 200 mcg of Misoprostol administered sublingually	The study recorded the following outcomes: Additional Uterotonics. Transfusion. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Nasr 2009	2-arm active-controlled double-dummy randomised trial	514 parturients were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with antepartum haemorrhage, coagulopathy, hypertension in pregnancy or the need for anticoagulants.	800 mcg of Misoprostol administered rectally versus 5 IU of Oxytocin administered by	The study recorded the following outcomes: PPH at 500. PPH at 1000. Severe	Contact with study authors for additional information: Yes. Additional

Study	Methods	Participants	Interventions	Outcomes	Notes
			an intravenous infusion	maternal morbidity: Intensive care admissions. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Third stage duration (min). diarrhoea. Nausea. Vomiting. Fever. Shivering.	data from authors: Yes
Nayak 2017	2-arm placebo-controlled randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women having severe medical and surgical complications including the heart, liver, kidney, brain disease and blood disorders, any contraindication to misoprostol including mitral stenosis, glaucoma and diastolic blood pressure over 100 mmHg and known allergic to prostaglandins, history of thromboembolic disorders, abnormal placentation such as placenta praevia, placental abruption and placental adhesions caused by repeated artificial abortions, pregnancy complications such as severe pre-eclampsia, multiple pregnancies, macrosomia and polyhydramnios, complication with myoma and with any blood dyscrasia.	400 mcg plus 10 IU of Misoprostol plus Oxytocin administered sublingually plus by an intravenous infusion versus 10 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. Transfusion. Blood loss (ml). Change in Haemoglobin.	Contact with study authors for additional information: No. Additional data from authors: No
Nellore 2006	2-arm active-controlled randomised trial	120 parturients were randomised in a hospital setting in India. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women requiring oxytocin induction or augmentation of labour, caesarean delivery, or	400 mcg of Misoprostol administered rectally versus 125 mcg of	The study recorded the following outcomes: PPH at 500. PPH at	Contact with study authors for additional information: No. Additional data

Study	Methods	Participants	Interventions	Outcomes	Notes
		those with gestational age less than 37 weeks, multiple pregnancy, haemoglobin concentration less than 8 g/dL, and known allergy to prostaglandins.	Carboprost administered intramuscularly	1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). Shivering.	from authors: No
Ng 2001	2-arm active-controlled randomised trial	2058 parturients were randomised in a hospital setting in Hong Kong. The population comprised women of parity 3 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients requiring oxytocin infusion in the third stage, or those with pre-eclampsia, cardiac disorder, asthma, grand multiparity (more than three), fibroids or contraindications for the use of either misoprostol or syntometrine.	600 mcg of Misoprostol administered orally versus 500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Nausea. Vomiting. Hypertension. Headache. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Ng 2004	2-arm active-controlled double-dummy	298 parturients were randomised in an unspecified setting in Hong Kong. The population comprised women of unspecified parity, a singleton pregnancy, at unspecified risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with multiple pregnancy or non-vaginal delivery.	400 mcg of Misoprostol administered orally versus 1 ml of Oxytocin	The study recorded the following outcomes:(No	Contact with study authors for additional information: No. Additional data

Study	Methods	Participants	Interventions	Outcomes	Notes
	randomised trial		administered by an intravenous bolus	Outcome Data Found)	from authors: No
Ng 2007	2-arm active-controlled double-dummy randomised trial	360 parturients were randomised in a hospital setting in Hong Kong. The population comprised women of parity 3 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients requiring oxytocin infusion in the third stage, or those with pre-eclampsia, cardiac disorder, asthma, grand multiparity (more than three), fibroids or contraindications for the use of either misoprostol or syntometrine.	400 mcg of Misoprostol administered orally versus 500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Change in Haemoglobin. diarrhoea. Nausea. Vomiting. Hypertension. Headache. Fever. Shivering. Maternal satisfaction.	Contact with study authors for additional information: No. Additional data from authors: No
Nihar 2022	2-arm active-controlled randomised trial	Total N randomised = 100; setting (hospital); India. Parity: mixed; singleton pregnancy; PPH risk: both low and high (see def below); birth type CB (elective, emergency); exclusion criteria: Multifetal gestation; Duration of surgery > 2 hours; Previous antepartum haemorrhage, Postpartum haemorrhage, bleeding disorders; BMI>30; known sensitivity to oxytocin and methergine; Not giving consent; absolute contraindications to methergine - heart disease, Rh negative pregnancy hypertensive disorder ,pre-eclampsia and peripheral vascular diseases	10 units intravenous Oxytocin versus 0.2 mg intramuscular methergine (ergometrine)	The study recorded the following outcomes: Need for additional uterotonics, blood loss (ml) and need for blood transfusion	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
Nirmala 2009	2-arm active-controlled randomised trial	120 parturients were randomised in a hospital setting in Malaysia. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients younger than 18 years old, or those with cardiac disorder, hypertension requiring treatment, liver/renal/vascular/endocrine disorder (excluding gestational diabetes) or hypersensitivity to oxytocin or carbetocin.	100 mcg of Carbetocin administered intramuscularly versus 500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. Severe maternal morbidity: Intensive care admissions. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Nausea. Vomiting. Hypertension. Headache. Shivering. Abdominal pain.	Contact with study authors for additional information: No. Additional data from authors: No
Nordstrom 1997	2-arm placebo-controlled randomised trial	1000 parturients were randomised in a hospital setting in Sweden. The population comprised women of any parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	10 IU of Oxytocin administered by an intravenous bolus versus placebo	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml).	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
Nuamsiri 2016	2-arm placebo-controlled randomised trial	323 parturients were randomised in a hospital setting in Thailand. The population comprised women of parity 4 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with multiple pregnancy, polyhydramnios, uterine fibroids, previous postpartum haemorrhage, antepartum haemorrhage, parity greater than four, previous caesarean section, severe anaemia (haemoglobin level of ≤ 8 g/dL), coagulopathy, contraindications to the use of ergometrine, estimated fetal birth weight > 4,000 g. and inability to obtain written informed consent. Women who ended up having a caesarean section or instrumental delivery were also excluded from this study.	200 mcg plus 20 IU of Ergometrine plus Oxytocin administered by an intravenous bolus + infusion versus 20 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). Nausea. Hypertension.	Contact with study authors for additional information: No. Additional data from authors: No
Oboro 2003	2-arm active-controlled double-dummy randomised trial	496 parturients were randomised in a hospital setting in Nigeria. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing induction or augmentation of labour, or those with previous caesarean, Hb less than 80 g/l, previous PPH, grand multiparity (not defined), multiple pregnancy, polyhydramnios, fibroids or precipitate labour.	10 IU of Oxytocin administered intramuscularly versus 600 mcg of Misoprostol administered orally	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Nausea. Vomiting.	Contact with study authors for additional information: Yes. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				Fever. Shivering.	
Ogunbode 1979	3-arm active-controlled randomised trial	144 parturients were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing instrumental delivery, or those with previous PPH, multiple pregnancy, polyhydramnios or vaginal lacerations.	200 mcg or 500 mcg of Ergometrine administered intramuscularly versus 500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. Manual removal of placenta. Blood loss (ml).	Contact with study authors for additional information: Yes. Additional data from authors: No
Orji 2008	2-arm active-controlled randomised trial	600 parturients were randomised in a hospital setting in Nigeria. The population comprised women of parity 6 or less, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with hypertension in pregnancy, packed cell volume less than 30%, previous PPH, haemoglobinopathy or cardiac disorder.	10 IU of Oxytocin administered by an intravenous bolus versus 250 mcg of Ergometrine administered by an intravenous bolus	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Manual removal of placenta. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). Nausea. Vomiting. Hypertension. Headache.	Contact with study authors for additional information: No. Additional data from authors: No
Ortiz-Gomez 2013	3-arm active-controlled randomised trial	156 parturients were randomised in a hospital setting in Spain. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised parturients with comorbidities, refractory	100 mcg of Carbetocin administered by an intravenous bolus versus 61	The study recorded the following outcomes: Additional	Contact with study authors for additional information: Yes. Additional

Study	Methods	Participants	Interventions	Outcomes	Notes
		hypotension due to neuraxial blockage, vasoactive drugs needed to control hemodynamic issues or multiple pregnancy.	IU of Oxytocin administered by an intravenous bolus + infusion	Uterotonics. Nausea. Vomiting. Headache. Shivering.	data from authors: Yes
Othman 2016	2-arm active-controlled randomised trial	120 parturients were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with anaemia (haemoglobin < 8 g), multiple pregnancy, placental abnormality (e.g., placenta praevia, placenta abruption), polyhydramnios, two or more previous caesarean deliveries, current or previous history of heart disease, liver, renal disorders or known coagulopathy.	400 mcg of Misoprostol administered sublingually versus 20 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: Additional Uterotonics. Blood loss (ml). Vomiting. Headache. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Otoide 2020	2-arm active-controlled randomised trial	Total N randomised = 300; setting (hospital); Nigeria. Parity: mixed; singleton and multiple pregnancy; PPH risk: mixed (see def below); birth type (VB, AVB (forceps, vacuum/ventouse/assisted breech), exclusion criteria elevated blood pressure at the antenatal clinic or in labour (diastolic blood pressure >100 mmHg); planned caesarean section, unwilling/unable to give informed consent	400 ug misoprostol and a placebo injection versus 2 ml of 0.5 mg ergometrine intravenously and oral placebo	The study recorded the following outcomes: Primary PPH ≥ 1000ml, Additional uterotonics and need for blood transfusion	Contact with study authors for additional information: No. Additional data from authors: No
Ottun 2021	2-arm active-controlled randomised trial	Total N randomised = 1036; setting (hospital); Nigeria. Parity: mixed; singleton pregnancy; PPH risk: low (see def below); birth type (VB type not reported); exclusion criteria: multiple pregnancies, antepartum haemorrhage, sickle cell disease, asthma, delivery below 28 weeks, planned caesarean section, fever (>38 C), unable to consent. women who had an emergency Caesarean Section after randomisation were excluded from analysis	10 IU of intramuscular oxytocin plus placebo versus 400ug sublingual misoprostol plus 10 IU of intramuscular oxytocin	The study recorded the following outcomes: Mean blood loss (ml), Need for blood transfusion and need for	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				additional uterotonics	
Owonikoko 2011	2-arm active-controlled randomised trial	100 parturients were randomised in a hospital setting in Nigeria. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised parturients requiring general anaesthesia, or those with multiple pregnancy, placenta praevia, antepartum haemorrhage, cardiac/renal/liver disorders, coagulopathy, asthma, glaucoma, pre-eclampsia, eclampsia, prolonged labour or contraindications to administration of prostaglandins.	20 IU of Oxytocin administered by an intravenous infusion versus 400 mcg of Misoprostol administered sublingually	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Blood loss (ml). Nausea. Vomiting. Headache. Hypotension. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Pakniat 2015	3-arm active-controlled double-dummy randomised trial	150 parturients were randomised in a hospital setting in Iran. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised women with any risk factor of postpartum haemorrhage i.e., anaemia (Hb <8 g/dl), multiple pregnancy, antepartum haemorrhage, polyhydramnios, two or more previous caesarean sections and/or a history of previous uterine rupture, cardiac/liver/renal disorders, or known coagulopathy.	400 mcg of Misoprostol administered sublingually versus 200 mcg plus 5 IU of Misoprostol plus Oxytocin administered sublingually plus by an intravenous bolus versus 20 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: Additional Uterotonics. Change in Haemoglobin. Nausea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Parsons 2006	2-arm active-controlled	450 parturients were randomised in a hospital setting in Ghana. The population comprised women of both nulliparous and multiparous, either singleton or multiple pregnancy, at both high and low risk for	10 IU of Oxytocin administered	The study recorded the following	Contact with study authors for additional

Study	Methods	Participants	Interventions	Outcomes	Notes
	randomised trial	PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with asthma, epilepsy or contraindications to prostaglandins.	intramuscularly versus 800 mcg of Misoprostol administered orally	outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Nausea. Vomiting. Hypertension. Fever. Shivering.	information: Yes. Additional data from authors: Yes
Parsons 2007	2-arm active-controlled randomised trial	450 parturients were randomised in a hospital setting in Ghana. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with asthma, epilepsy or contraindications to prostaglandins.	10 IU of Oxytocin administered intramuscularly versus 800 mcg of Misoprostol administered rectally	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). Nausea. Vomiting.	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
				Hypertension. Fever. Shivering.	
Patil 2013	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with haemoglobin level less than 7 g/dl, antepartum haemorrhage, multiple pregnancy, non-cephalic presentations, pregnancy induced hypertension, previous LSCS, induced labour, instrumental delivery, cervical tear and third-degree perineal tear, body temperature > 38o C on admission, cardiac disease, hepatic disorders & known hypersensitivity to prostaglandins.	600 mcg of Misoprostol administered orally versus 200 mcg of Ergometrine administered by an intravenous bolus	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Blood loss (ml). diarrhoea. Nausea. Vomiting. Headache. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Patil 2016	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of parity 4 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with hypersensitivity to drugs, respiratory diseases, cardiac disease, renal, liver disorder, epilepsy, psychiatric disorders, preeclampsia, severe anaemia, multiple pregnancy, poly/oligohydramnios, previous PPH, gran multiparous.	10 IU of Oxytocin administered intramuscularly versus 125 mcg of Carboprost administered intramuscularly	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. Blood loss (ml). Third stage duration (min). diarrhoea. Nausea. Vomiting. Headache. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Penaranda 2002	3-arm active-controlled	78 parturients were randomised in a hospital setting in Colombia. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by	50 mcg of Misoprostol administered	The study recorded the following	Contact with study authors for additional

Study	Methods	Participants	Interventions	Outcomes	Notes
	randomised trial	vaginal delivery. Exclusion criteria comprised parturients with asthma, multiple pregnancy, intrauterine death, coagulopathy, cervical tear or water in the blood collector.	sublingually versus 16mIU/min of Oxytocin administered by an intravenous infusion versus 200 mcg of Ergometrine administered intramuscularly	outcomes: PPH at 500. PPH at 1000. Blood loss (ml). Third stage duration (min). Vomiting. Shivering.	information: No. Additional data from authors: No
Perez-Rumbos 2017	2-arm active-controlled randomised trial	500 parturients were randomised in a hospital setting in Venezuela. The population comprised women of parity 4 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women undergoing caesareans, gran multiparous (>=5), multiple pregnancy, previous caesareans, precipitate labour, anaemia (< 6 g/dL), chorioamnionitis, previous PPH, polyhydramnios, intrauterine fetal death, APH, asthma and hypersensitivity in any of the agents, clotting disorders, renal/liver disorders, epilepsy, hypertension, or those who did not consent to the study.	600 mcg of Misoprostol administered rectally versus 20 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Nausea. Vomiting. Headache. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Poeschman n 1991	3-arm controlled randomised trial	77 parturients were randomised in a hospital setting in the Netherlands. The population comprised women of unspecified parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women if they had a Hobel Score of more than 10.	5 IU of Oxytocin administered intramuscularly versus 500 mcg of Sulprostone	The study recorded the following outcomes: PPH at 500. PPH at	Contact with study authors for additional information: No. Additional data

Study	Methods	Participants	Interventions	Outcomes	Notes
			administered intramuscularly versus placebo	1000. Additional Uterotonics. Manual removal of placenta. Blood loss (ml). Third stage duration (min). Nausea.	from authors: No
Prendiville 1988	2-arm controlled randomised trial	1695 parturients were randomised in a hospital setting in UK. The population comprised women of both nulliparous and multiparous, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with cardiac disorder, antepartum haemorrhage, non-cephalic presentation, multiple pregnancy, intrauterine death but after change in the protocol multiple other exclusion criteria were introduced.	500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly versus no treatment	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Change in Haemoglobin. NNU admissions. Breastfeeding. Vomiting. Headache.	Contact with study authors for additional information: No. Additional data from authors: No
Quibel 2016	2-arm placebo-controlled randomised trial	1721 parturients were randomised in a hospital setting in France. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with multiple pregnancies, known hypersensitivity to prostaglandins, caesarean delivery, or participation in any other treatment trial.	400 mcg plus 10 IU of Misoprostol plus Oxytocin administered orally plus by an intravenous bolus versus 10 IU of Oxytocin administered by	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml).	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
			an intravenous bolus	Change in Haemoglobin. diarrhoea. Nausea. Vomiting. Fever. Shivering.	
Rajaei 2014	2-arm active-controlled double-dummy randomised trial	400 parturients were randomised in a hospital setting in Iran. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with placenta praevia, placental abruption, coagulopathy, previous caesarean, macrosomia (more than 4kg), polyhydramnios or uncontrolled asthma.	20 IU of Oxytocin administered by an intravenous infusion versus 400 mcg of Misoprostol administered orally	The study recorded the following outcomes: Additional Uterotonics. Transfusion. Blood loss (ml). Change in Haemoglobin. Hypotension. Fever. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
Ramirez 2001	3-arm active-controlled randomised trial	An unspecified number of parturients were randomised in a hospital setting in Spain. The population comprised women of nulliparous, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised multiparous women, severe anaemia, hypertensive disorders.	5 IU of Oxytocin administered by an intravenous bolus versus 200 mcg of Ergometrine administered by an intravenous bolus versus no treatment	The study recorded the following outcomes:(No Outcome Data Found)	Contact with study authors for additional information: No. Additional data from authors: No
Rashid 2009	2-arm active-controlled randomised trial	686 parturients were randomised in a hospital setting in Saudi Arabia. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section or requiring oxytocin infusion in the third stage, or those with pre-eclampsia, cardiac disorder, hypertension on	500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional	Contact with study authors for additional information: No. Additional data

Study	Methods	Participants	Interventions	Outcomes	Notes
		treatment, antepartum haemorrhage, pre-term labour (less than 37 weeks), post maturity (more than 42 weeks) or Hb less or equal to 90 g/l.	versus 10 IU of Oxytocin administered by an intravenous infusion	Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Third stage duration (min). Nausea. Vomiting. Headache.	from authors: No
Ray 2001	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing elective caesarean section, or those with pre-term labour (less than 32 weeks), prolonged labour, antepartum haemorrhage, pre-eclampsia, intrauterine death, multiple pregnancy, epilepsy, asthma, cardiac/kidney disorder, coagulopathy or anaemia.	400 mcg of Misoprostol administered orally versus unspecified dose of Ergometrine administered by an unspecified route	The study recorded the following outcomes: Additional Uterotonics. Transfusion. Manual removal of placenta. Hypertension.	Contact with study authors for additional information: Yes. Additional data from authors: No
Reddy 2001	3-arm active-controlled randomised trial	120 parturients were randomised in a hospital setting in India. The population comprised women of any parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with heart, liver or renal disease, asthma, epilepsy, Rh negative, traumatic PPH, severe anaemia (<6g/dL) or hypertension.	200 mcg of Ergometrine administered by an intravenous bolus versus 250 mcg of Carboprost administered intramuscularly	The study recorded the following outcomes:Blood loss (ml). Third stage duration (min). diarrhoea. Headache.	Contact with study authors for additional information: No. Additional data from authors: No
Reyes 2011	2-arm active-controlled randomised trial	144 parturients were randomised in a hospital setting in Panama. The population comprised women of parity 5 or more, a singleton pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing emergency caesarean section, or those with coagulopathy, unknown parity or known allergy to carbetocin.	100 mcg of Carbetocin administered by an intravenous bolus versus 20 IU of Oxytocin administered by	The study recorded the following outcomes: Additional Uterotonics. Transfusion.	Contact with study authors for additional information: Yes. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
			an intravenous infusion	Manual removal of placenta. Breastfeeding. Nausea. Vomiting. Headache. Shivering. Abdominal pain.	
Reyes, Gonzalez 2011	2-arm active-controlled double-dummy randomised trial	57 parturients were randomised in a hospital setting in Panama. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both caesarean and vaginal delivery. Exclusion criteria comprised parturients with HELLP syndrome, blood dyscrasia or multiple pregnancy.	100 mcg of Carbetocin administered by an intravenous bolus versus 10 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: Additional Uterotonics. Transfusion. Change in Haemoglobin. Third stage duration (min). Breastfeeding. Vomiting. Headache. Fever.	Contact with study authors for additional information: Yes. Additional data from authors: No
Rogers 1998	2-arm controlled randomised trial	1512 parturients were randomised in a hospital setting in UK. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing augmentation of labour or instrumental delivery or requiring epidural analgesia, or those with placenta praevia, previous PPH, antepartum haemorrhage, Hb less than 100 g/L or mean corpuscular volume less than 75 fL, non-cephalic presentation, multiple pregnancy, intrauterine death, grand multiparity (more than five), fibroids, anticoagulation therapy, pre-term labour (less than 32 weeks) or contraindications to any of the drugs.	unspecified of Ergometrine plus Oxytocin administered intramuscularly versus no treatment	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Third stage duration (min).	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				NNU admissions. Breastfeeding. Nausea. Vomiting. Headache. Maternal satisfaction.	
Rosseland 2013	3-arm placebo-controlled randomised trial	76 parturients were randomised in a hospital setting in Norway. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised parturients with pre-eclampsia, placenta praevia, placenta accreta, von Willebrand disease or other bleeding disorder or preoperative systolic arterial pressure less than 90mmHg.	5 IU of Oxytocin administered Intravenous bolus versus 100 mcg of Carbetocin administered Intravenous bolus versus placebo	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Blood loss (ml). Change in Haemoglobin. Headache.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Sadiq 2011	2-arm active-controlled randomised trial	1865 parturients were randomised in a hospital setting in Nigeria. The population comprised women of parity 6 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing instrumental delivery, or those with diabetes, non-cephalic presentation, anaemia, antepartum haemorrhage, multiple pregnancy, grand multiparity (more than six) or known allergy.	10 IU of Oxytocin administered by an intravenous bolus versus 600 mcg of Misoprostol administered orally	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Blood loss (ml). Change in Haemoglobin.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Samimi 2013	2-arm active-controlled double-blinded randomised trial	216 parturients were randomised in a hospital setting in Iran. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with hypertension, pre-eclampsia, uterine rupture, cervical tear, asthma,	100 mcg of Carbetocin administered intramuscularly versus 200 mcg plus 5 IU of	The study recorded the following outcomes: Severe maternal	Contact with study authors for additional information: Yes. Additional

Study	Methods	Participants	Interventions	Outcomes	Notes
		cardiovascular/renal/liver disorders, grand multiparity (not defined), fibroids or previous PPH.	Ergometrine plus Oxytocin administered intramuscularly	morbidity: Intensive care admissions. Additional Uterotonics. Death. Change in Haemoglobin. Nausea. Vomiting. Tachycardia. Hypotension. Shivering. Abdominal pain.	data from authors: Yes
Shady 2017	3-arm active-controlled randomised trial	360 parturients were randomised in a hospital setting in Egypt. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with medical disorders as cardiac, hepatic, renal, neurologic disorders, thromboembolic disease, blood disorders, diabetes, gestational hypertension and preeclampsia, gran multiparous (>5), multiple pregnancy, polyhydramnios, macrosomia, APH, prolonged and obstructed labour, scarred uterus or previous instrumental delivery and those suffering from hypersensitivity to tranexamic acid.	10 IU of Oxytocin administered by an intravenous bolus versus 600 mcg of Misoprostol administered sublingually	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. Transfusion. diarrhoea. Nausea. Vomiting.	Contact with study authors for additional information: No. Additional data from authors: No
Shady 2019	2-arm active-controlled randomised trial	Total N randomised = 240; setting (hospital); Egypt. Parity: mixed; singleton pregnancy; PPH risk: both low and high (see def below); birth type (VB, AVB (forceps, vacuum), CB (elective, emergency); exclusion criteria: medical disorders: cardiac, hepatic, renal, neurologic disorders thromboembolic disease, blood disorders, diabetes, gestational hypertension, and pre-eclampsia, women with scarred uterus or previous instrumental delivery. Women at risk for PPH (grand multipara (parity >5), multiple pregnancy, polyhydramnios, fetal macrosomia, antepartum haemorrhage, prolonged, and obstructed labour).	10 IU oxytocin IV versus 600 ug buccal misoprostol	The study recorded the following outcomes: mean blood loss (ml), Need for blood transfusion and need for additional uterotonics	Contact with study authors for additional information: No. Additional data from authors: No. Blood loss median data was converted to mean + SE

Study	Methods	Participants	Interventions	Outcomes	Notes
Shaheen 2019	2-arm active-controlled randomised trial	Total N randomised= 240; setting (hospital); Pakistan. Parity: mixed; singleton pregnancy; PPH risk low (see def below); birth type (VB, AVB (forceps, vacuum); exclusion criteria: Placenta previa, placental abruption, pervious LSCS, macrosomia (fetal weight >4kg) polyhydramnios and asthma.	10 IU intramuscular oxytocin versus 666 ug sublingual misoprostol	The study recorded the following outcomes: mean blood loss (ml), blood transfusion and PPH > 1000	Contact with study authors for additional information: No. Additional data from authors: No
Shrestha 2011	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in Nepal. The population comprised women of any parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with polyhydramnios, chorioamnionitis, preterm labour, previous caesarean, asthma, cardiac disorder or contraindication/hypersensitivity to the use of prostaglandin and uterotonics.	1000 mcg of Misoprostol administered rectally versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. Severe maternal morbidity: Intensive care admissions. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). Fever. Abdominal pain.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Singh 2009	4-arm active-controlled double-dummy randomised trial	300 parturients were randomised in a hospital setting in India. The population comprised women of unspecified parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing augmentation of labour, or those with intrauterine death, antepartum haemorrhage, multiple pregnancy, malpresentation, cardiac disorder, Rhesus-negative mother, hypertension, Hb less than 70 g/L or hypersensitivity/contraindication to prostaglandins.	400 or 600 mcg of Misoprostol administered sublingually versus 5 IU of Oxytocin administered by an intravenous bolus versus 200 mcg of Ergometrine	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml).	Contact with study authors for additional information: Yes. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
			administered by an intravenous bolus	Third stage duration (min). Fever. Shivering.	
Sitaula 2017	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in Nepal. The population comprised women of parity 4 or less, a singleton pregnancy, at high risk for PPH, who delivered by elective caesarean section. Exclusion criteria comprised women with polyhydramnios, uncontrolled diabetes mellitus, previous 2 or more caesarean deliveries, severe pre-eclampsia, multiple pregnancy, grand multipara, known coagulation disorder, caesarean delivery under GA, previous myomectomy, previous uterine rupture, abnormal placentation, sensitivity to misoprostol.	400 mcg plus 20 IU of Misoprostol plus Oxytocin administered rectally plus by an intravenous infusion versus 20 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: PPH at 1000. Transfusion. Blood loss (ml). Change in Haemoglobin.	Contact with study authors for additional information: No. Additional data from authors: No
Soltan 2007	4-arm active-controlled randomised trial	1228 parturients were randomised in a hospital setting in Egypt. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with traumatic PPH, blood disorders, chorioamnionitis, placenta praevia or placental abruption.	200 mcg of Ergometrine administered intramuscularly versus 600-1000 mcg of Misoprostol administered sublingually	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Vomiting.	Contact with study authors for additional information: Yes. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				Fever. Shivering.	
Sood 2012	2-arm placebo-controlled randomised trial	174 parturients were randomised in a hospital setting in India. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria were not specified.	400 mcg plus 20 IU of Misoprostol plus Oxytocin administered sublingually plus by an intravenous infusion versus 20 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Blood loss (ml). Change in Haemoglobin. Nausea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: No. Additional data from authors: No
Stanton 2013	2-arm cluster controlled randomised trial	1586 parturients were randomised in a community setting in Ghana. The population comprised women of unspecified parity, either singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	10 IU of Oxytocin administered intramuscularly versus no treatment	The study recorded the following outcomes: PPH at 500. PPH at 1000. Death.	Contact with study authors for additional information: No. Additional data from authors: No
Su 2009	2-arm active-controlled double-blinded randomised trial	370 parturients were randomised in a hospital setting in Singapore. The population comprised women of unspecified parity, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing elective caesarean section, or those with multiple pregnancy, previous PPH, coagulopathy, coronary artery disease, hypertension or hypersensitivity/contraindications for the use of syntometrine or carbetocin.	100 mcg of Carbetocin administered intramuscularly versus 500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Third stage	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				duration (min). Nausea. Vomiting. Headache. Shivering. Abdominal pain.	
Sultana 2007	2-arm active-controlled randomised trial	400 parturients were randomised in a hospital setting in Bangladesh. The population comprised women of both nulliparous and multiparous, unspecified whether singleton or multiple pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with previous caesarean.	400 mcg of Misoprostol administered orally versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Shivering. Abdominal pain.	Contact with study authors for additional information: No. Additional data from authors: No
Supe 2016	4-arm controlled randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of any parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with medical disorders like pregnancy-induced hypertension, cardiac disease, sensitivity to prostaglandins, and history of previous caesarean section.	800 mcg of Misoprostol administered rectally versus 200 mcg of Ergometrine administered intramuscularly versus 125 mcg of Carboprost administered intramuscularly versus no treatment	The study recorded the following outcomes: Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Nausea. Vomiting.	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				Fever. Shivering. Abdominal pain.	
Surbeck 1999	2-arm placebo-controlled randomised trial	65 parturients were randomised in a hospital setting in Switzerland. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with multiple pregnancy, pre-eclampsia, previous PPH or antepartum haemorrhage.	600 mcg of Misoprostol administered orally versus placebo	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. Blood loss (ml). Third stage duration (min). NNU admissions. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
Sweed 2018	2-arm active-controlled randomised trial	Total N randomised= 636; setting (hospital); Egypt. Parity: mixed; singleton/multiple pregnancy; PPH risk high (see def below); birth type CB (elective); exclusion criteria fetal distress, primigravida, blood dyscrasia, large fibroids, high-order pregnancy, over distended uterus such as hydramnios and fetal macrosomia, preeclampsia, eclampsia, previous history of postpartum haemorrhage, contraindications to prostaglandin therapy such as history of severe bronchial asthma or allergy to misoprostol, abnormal placentation, previous myomectomy, previous two or more CD, have any contraindication to spinal anaesthesia	400 ug misoprostol sublingually or retally and 5 IU Oxytocin intravenously versus Placebo rectally and sublingually and 5 IU Oxytocin intravenously. Placebo was identical to the misoprostol tablets	Intraoperative blood loss, severe postpartum haemorrhage (>1000 ml), need for blood transfusion, need for further oxytocin	Contact with study authors for additional information: No. Additional data from authors: No
Taheripanah 2017	2-arm active-controlled randomised trial	220 parturients were randomised in a hospital setting in Iran. The population comprised women of nulliparous and multiparous, a singleton pregnancy, at high risk for PPH, who delivered by emergency caesarean section. Exclusion criteria comprised women	100 mcg of Carbetocin administered by an intravenous bolus versus 30	The study recorded the following outcomes: Additional	Contact with study authors for additional information: No. Additional data

Study	Methods	Participants	Interventions	Outcomes	Notes
		refusing to cooperate, major therapeutic side effects, history of cardiac and renal diseases, preeclampsia, and twin pregnancy.	IU of Oxytocin administered by an intravenous infusion	Uterotonics. Transfusion. Blood loss (ml). Change in Haemoglobin. Nausea. Vomiting. Headache.	from authors: No
Tewatia 2014	2-arm active-controlled randomised trial	100 parturients were randomised in a hospital setting in India. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with grand multiparity (more than four), anaemia, malpresentation, polyhydramnios, antepartum haemorrhage, liver/renal disorder, previous caesarean, previous PPH, uterine anomaly, traumatic PPH or contraindications to use misoprostol or oxytocin.	10 IU of Oxytocin administered by an intravenous infusion versus 600 mcg of Misoprostol administered sublingually	The study recorded the following outcomes: PPH at 500. PPH at 1000. Severe maternal morbidity: Intensive care admissions. Additional Uterotonics. Transfusion. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Nausea. Vomiting. Fever. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Thilaganathan 1993	2-arm controlled randomised trial	193 parturients were randomised in a hospital setting in UK. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing induction or	no treatment versus 500 mcg plus 5 IU of Ergometrine	The study recorded the following outcomes:	Contact with study authors for additional information:

Study	Methods	Participants	Interventions	Outcomes	Notes
		augmentation of labour or instrumental delivery, or those with grand multiparity (not defined), malpresentation, multiple pregnancy, previous caesarean, previous PPH, antepartum haemorrhage, hypertension in pregnancy, intrauterine death, preterm rupture of membranes, cervical lacerations or third-degree perineal tears.	plus Oxytocin administered intramuscularly	Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Change in Haemoglobin. Third stage duration (min).	Yes. Additional data from authors: No
Tripti 2006	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of nulliparous and multiparous, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with hypertension, cardiac disease, renal disease, gastrointestinal disorders, respiratory disease, endocrinal problems, coagulation disorder, and sensitivity to prostaglandin or methergine.	125 mcg of Carboprost administered intramuscularly versus 200 mcg of Ergometrine administered by an intravenous bolus	The study recorded the following outcomes: Additional Uterotonics. Manual removal of placenta. Blood loss (ml). Third stage duration (min).	Contact with study authors for additional information: No. Additional data from authors: No
Ugwu 2014	2-arm active-controlled randomised trial	120 parturients were randomised in a hospital setting in Nigeria. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised parturients requiring general anaesthesia, or those with multiple pregnancy, placenta praevia, pre-eclampsia, eclampsia, undiagnosed vaginal bleeding, prolonged labour, prolonged obstructed labour, cardiac/renal/liver disorders or fever.	400 mcg plus 20 IU of Misoprostol plus Oxytocin administered sublingually plus by an intravenous infusion versus 20 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: PPH at 500. PPH at 1000. Severe maternal morbidity: Intensive care admissions. Additional Uterotonics. Transfusion. Death. Blood	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
				loss (ml). Fever. Shivering.	
Un Nisa 2012	2-arm active-controlled randomised trial	100 parturients were randomised in a hospital setting in India. The population comprised women of parity 2 to 4, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with previous PPH, multiple pregnancy, previous caesarean, macrosomia, pre-eclampsia, diabetes, cardiac/lung/bleeding/clotting disorders or taking anticoagulants.	10 IU of Oxytocin administered by an intravenous bolus versus 500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500.	Contact with study authors for additional information: Yes. Additional data from authors: No
Uncu 2015	5-arm controlled randomised trial	248 parturients were randomised in a hospital setting in Turkey. The population comprised women of parity 5 or less, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with placenta praevia, previous PPH, antepartum haemorrhage, non-cephalic presentation, multiple pregnancy, intrauterine death, grand multiparity (more than five), fibroids, pre-eclampsia or anticoagulation therapy.	no treatment versus 400-800 mcg of Misoprostol administered orally, vaginally or rectally	The study recorded the following outcomes: Additional Uterotonics. Transfusion. Third stage duration (min). diarrhoea. Shivering. Abdominal pain.	Contact with study authors for additional information: Yes. Additional data from authors: No
Vagge 2014	2-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with cardiac disorder in pregnancy, uterine tumour in pregnancy, secondary PPH, grand multiparity (not defined), multiple pregnancy, polyhydramnios, anaemia, coagulopathy, antepartum haemorrhage, previous PPH, prolonged labour, precipitate labour or known allergic or hypersensitivity reaction to prostaglandins.	10 IU of Oxytocin administered by an intravenous infusion versus 800 mcg of Misoprostol administered rectally	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Blood loss (ml). diarrhoea.	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				Nausea. Fever. Shivering.	
Vaid 2009	3-arm active-controlled randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of parity 4 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients with grand multiparity (more than four), multiple pregnancy, preterm labour (less than 32 weeks), HELLP syndrome, polyhydramnios, coagulopathy, asthma, cardiac/renal disorder, epilepsy, hypertension, Hb less than 80 g/l or known drug allergy.	400 mcg of Misoprostol administered sublingually versus 200 mcg of Ergometrine administered intramuscularly versus 125 mcg of Carboprost administered intramuscularly	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. Transfusion. Manual removal of placenta. diarrhoea. Nausea. Vomiting. Fever. Shivering. Abdominal pain.	Contact with study authors for additional information: Yes. Additional data from authors: No
Van Der Nelson 2021	3-arm active-controlled randomised trial	Total N randomised = 5929; setting (hospital); England. Parity: mixed; singleton pregnancy; PPH risk low (see def below); birth type (VB, AVB (forceps, vacuum); exclusion criteria: hypertension, antepartum haemorrhage, suspected placental abruption, maternal coagulation disorder, women who would decline blood products, epilepsy, and contraindication to any of the study drugs	(10 IU oxytocin intramuscularly, 500 µg/5 IU Syntometrine intramuscularly or 100 µg carbetocin intramuscularly	proportion of women receiving additional uterotonics, PPH >1000 transfusion of blood products	Contact with study authors for additional information: No. Additional data from authors: No. Blood loss median data was converted to mean + SE
van Selm 1995	2-arm active-controlled double-dummy randomised trial	81 parturients were randomised in a hospital setting in Netherlands. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women with coagulation disorder, anticoagulant medication, multiple pregnancy, fibroids, hypertension, induction of labour.	200 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly versus 500 mcg of Sulprostone	The study recorded the following outcomes: PPH at 500. PPH at 1000. Transfusion. Manual removal	Contact with study authors for additional information: No. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
			administered intramuscularly	of placenta. Blood loss (ml). Third stage duration (min).	
Verma 2006	2-arm active-controlled double-dummy randomised trial	200 parturients were randomised in a hospital setting in India. The population comprised women of unspecified parity, unspecified whether singleton or multiple pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria were not specified.	400 mcg of Misoprostol administered sublingually versus 200 mcg of Ergometrine administered intramuscularly	The study recorded the following outcomes: PPH at 500. Additional Uterotonics. Manual removal of placenta. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). Nausea. Fever. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
Vimala 2004	2-arm active-controlled randomised trial	120 parturients were randomised in a hospital setting in India. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing induction or augmentation of labour or caesarean section, or those with preterm labour (less than 37 weeks), grand multiparity (more than five), multiple pregnancy, hypertension in pregnancy, Hb less than 80 g/L or known hypersensitivity to prostaglandins.	400 mcg of Misoprostol administered sublingually versus 200 mcg of Ergometrine administered by an intravenous bolus	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). Nausea.	Contact with study authors for additional information: Yes. Additional data from authors: No

Study	Methods	Participants	Interventions	Outcomes	Notes
				Vomiting. Headache. Fever. Shivering.	
Vimala 2006	2-arm active-controlled randomised trial	100 parturients were randomised in a hospital setting in India. The population comprised women of unspecified parity, a singleton pregnancy, at high risk for PPH, who delivered by both elective or emergency caesarean. Exclusion criteria comprised parturients with multiple pregnancy, antepartum haemorrhage, polyhydramnios, prolonged labour (more than 12 hours), previous more than one caesarean, previous uterine rupture, cardiac/liver/renal disorder, coagulopathy or Hb less than 80 g/l.	400 mcg of Misoprostol administered sublingually versus 20 IU of Oxytocin administered by an intravenous infusion	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Blood loss (ml). Change in Haemoglobin. Vomiting. Headache. Fever. Shivering.	Contact with study authors for additional information: Yes. Additional data from authors: No
Walley 2000	2-arm active-controlled double-dummy randomised trial	401 parturients were randomised in a hospital setting in Ghana. The population comprised women of parity 5 or less, a singleton pregnancy, at low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing induction or augmentation of labour or caesarean section, or those with grand multiparity (more than five), multiple pregnancy, preterm labour (less than 32 weeks), hypertension in pregnancy, HELLP syndrome, polyhydramnios, previous PPH, coagulopathy, precipitate labour, chorioamnionitis, Hb less than 80 g/L or a known hypersensitivity to prostaglandins.	400 mcg of Misoprostol administered orally versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in Haemoglobin. Third stage duration (min). diarrhoea. Nausea.	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
				Vomiting. Fever. Shivering.	
Whigham 2016	2-arm active-controlled double-blinded randomised trial	122 parturients were randomised in a hospital setting in Australia. The population comprised women of any parity, a singleton pregnancy, at high risk for PPH, who delivered by emergency caesarean section. Exclusion criteria comprised parturients undergoing elective caesarean section or requiring general anaesthesia, or those with vascular/liver/renal disorders, preterm labour (less than 37 weeks), multiple pregnancy, placenta praevia, placental abruption, previous more than two caesareans or an adverse reaction to carbetocin/oxytocin.	100 mcg of Carbetocin administered by an intravenous bolus versus 5 IU of Oxytocin administered by an intravenous bolus	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Blood loss (ml). Change in Haemoglobin.	Contact with study authors for additional information: Yes. Additional data from authors: Yes
Widmer 2018	2-arm active-controlled double-blinded randomised trial	29645 parturients were randomised in a hospital setting in Argentina, Egypt, India, Kenya, Nigeria, Singapore, South Africa, Thailand, Uganda and the United Kingdom. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised women in an advanced stage of labour (cervical dilatation >6 cm) or who were too distressed to give informed consent, who had known allergies to carbetocin, oxytocin homologues or excipients, who had serious cardiovascular disorders, serious hepatic or renal disease, or who had epilepsy.	100 mcg of Carbetocin administered intramuscularly versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Severe maternal morbidity: Intensive care admissions. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Vomiting. Abdominal pain.	Contact with study authors for additional information: No. Additional data from authors: No
Yesmin 2022	2-arm active-controlled randomised trial	Total N randomised= 64; setting (hospital); Bangladesh. Parity: mixed; singleton/multiple pregnancy; PPH risk high (see def below); birth type, CB (elective, emergency); exclusion criteria: hypertension, preeclampsia, eclampsia, placenta previa, gestational age less than	100 µg of carbetocin intravenously versus 10 IU of	estimated blood loss, blood transfusion, use of additional	Contact with study authors for additional information: No.

Study	Methods	Participants	Interventions	Outcomes	Notes
		37 weeks, cardiac, renal or liver diseases, epilepsy and general anaesthesia, as well as women with history of hypersensitivity to carbetocin or oxytocin	oxytocin intravenously	oxytocic, PHH >1000	Additional data from authors: No
Yuen 1995	2-arm active-controlled double-blinded randomised trial	1000 parturients were randomised in a hospital setting in Hong Kong. The population comprised women of unspecified parity, a singleton pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients requiring oxytocin infusion in the third stage, or those with pre-eclampsia or cardiac disorder.	500 mcg plus 5 IU of Ergometrine plus Oxytocin administered intramuscularly versus 10 IU of Oxytocin administered intramuscularly	The study recorded the following outcomes: PPH at 500. PPH at 1000. Severe maternal morbidity: Intensive care admissions. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Change in Haemoglobin. Nausea. Vomiting. Headache.	Contact with study authors for additional information: Yes. Additional data from authors: No
Zachariah 2006	3-arm active-controlled randomised trial	2023 parturients were randomised in a hospital setting in India. The population comprised women of both nulliparous and multiparous, unspecified whether singleton or multiple pregnancy, at both high and low risk for PPH, who delivered by vaginal delivery. Exclusion criteria comprised parturients undergoing caesarean section, or those with asthma, cardiac disorder, rhesus factor incompatibility or hypertension.	400 mcg of Misoprostol administered orally versus 10 IU of Oxytocin administered intramuscularly versus 200 mcg of Ergometrine administered by an intravenous bolus	The study recorded the following outcomes: PPH at 500. PPH at 1000. Additional Uterotonics. Transfusion. Manual removal of placenta. Death. Blood loss (ml). Change in	Contact with study authors for additional information: Yes. Additional data from authors: Yes

Study	Methods	Participants	Interventions	Outcomes	Notes
				Haemoglobin. Third stage duration (min). diarrhoea. Nausea. Vomiting. Headache. Fever. Shivering.	
Zgaya 2020	2-arm placebo-controlled randomised trial	Total N randomised= 211; setting (hospital); Tunisia. Parity: mixed; singleton pregnancy; PPH risk low (see def below); birth type (VB, AVB (forceps, vacuum); exclusion criteria: patients at high risk for postpartum haemorrhage: coagulation disorders, a placenta Previa, a placental retro hematoma, a HELLP syndrome, in utero fetal death, maternal fever (≥38°C), prolonged labour (> 12 hours) and need for caesarean delivery. Patients with hypertensive diseases in pregnancy, anaemia (hb < 8), prepartum haemorrhage, previous history of uterine rupture, or conditions requiring prophylactic oxytocin infusion after delivery (e.g., multiple pregnancy, previous history of PPH)	400 ug sublingual misoprostol versus 400 ug of placebo	estimation of blood loss, blood transfusion and need for additional dose of oxytocin.	Contact with study authors for additional information: No. Additional data from authors: No

D2 – Risk of bias assessment for included studies

Table 2: Risk of bias assessment

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
Abdel-Aleem 1993	Table of random numbers was used.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Blood was collected in a tray and measured. Sterile pads were placed over the vulva and were before and after use for a period of 4 hours.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Carboprost kindly supplied by Prof. S. Bergstrom, Sweden but source(s) of funding for the study were not reported.
Abdel-Aleem 2010	Allocated to 1 of 3 groups by selecting the next number in a computer-generated random number sequence	The allocated group was noted inside opaque sealed envelopes	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	In Assiut, investigators appraised blood loss by collection with a calibrated plastic drape placed under the mother within 30 minutes of delivery. At the East London Hospital Complex, investigators appraised blood loss by collection with a low-profile plastic “fracture” bedpan placed under the mother.	Investigators were unable to collect outcome data from 14 randomised study participants.	The study protocol was registered retrospectively (ACTRN: 12609000372280).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the institution of the authors, or conducted without external funding.
Achary a 2001	Sequence generation was not reported.	Randomisation was performed using sealed opaque envelopes	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised intra-operative blood loss by the estimation of attending physicians, and by measurement of preoperative and postoperative haemoglobin concentration and haematocrit.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Adaniki n 2012	Allocation sequence developed by 1 researcher (O.O.) using a computer-	Used sealed opaque envelopes	"The same researcher administered the drugs intra-operation and set up the infusions in the operating	Assessors were blinded to treatment allocations.	Methods of appraising blood loss were not reported.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	generated table of random numbers with varied permutated blocks		room; he was the only person who was not blind to the drug allocation, and he did not take any further part in the active running of the study".						
Adaniki n 2013	1:1 computer-generated randomisatio n	The pharmacy department provided the study drugs and placebos in unidentifiabl e form but the resident doctor was responsible for the patient's allocation according to the randomisatio n table.	Study participants and caregivers were blinded to treatment allocations.	Outcome assessors were blinded.	Investigators weighted the pads 4 hours postpartum for assessment of blood loss.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Afolabi 2010	Randomised into two groups, A and B, by blocked (restrictive) double blind randomisatio n using random table generated numbers	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised blood loss at delivery by collection with a large kidney dish, for measurement in a graduated measuring jar.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
Ahmed 2014	Sequence generation was not reported.	Allocation concealment was not reported.	The study was "single-blind" but the identity of those blinded, and the method of blinding were not reported.	Assessor blinding was not reported.	Methods of appraising blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Al-Sawaf 2013	Sequence generation was not reported.	Used closed envelopes.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised blood loss by collection with sterile packs weighed beforehand and afterwards.	"Following randomisation, 16 study participants were excluded from our analysis. Of these, 14 patients received intrapartum oxytocin, one patient experienced extensive vaginal laceration, and another experienced a cervical laceration".	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.
Alwani 2014	The patients were randomized in two groups using random number table generated online (http://www.graphpad.co	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Methods of evaluating blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	No funding was sought for this study.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	m/quickcalcs/randomize1/).								
Al Zubaidi 2022	Sequence generation was not reported.	Allocation concealment was not reported.	Operating obstetricians, care givers, and investigators were blinded. Ampules, trial packs and dispensers were identical in shape and size and weight.	Outcome assessors were blinded.	Blood was collected using suction and weighed. Blood soak drapes and swabs were also collected and weighed.	The study authors did not mention any incomplete outcome data	Study reported outcomes as reported in the protocol.	Intention to treat not specified but assumed.	Source(s) of funding for the study were not reported
Amant 1999	Allocation by a computer-generated list and randomisation in blocks	The study box contained either two capsules of misoprostol and an ampoule containing placebo, or two capsules with placebo and an ampoule containing methylergometrine. The study boxes and capsules were indistinguishable in the two groups	Study participants and caregivers were blinded to treatment allocations.	Assessors were blinded to treatment allocations.	Methods of appraising blood loss were not reported.	"213 women were enrolled in the study, but the data for 13 were excluded because a caesarean section was performed after randomisation (n = 3), or because no predelivery (n = 3) or postpartum (n = 7, short hospital stay) blood sample was taken".	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.
Amin 2014	Sequence generation	Allocation concealment	Blinding (of study participants and	Assessor blinding was not reported.	Investigators appraised blood loss by collection with special drapes placed under the	The study authors did not mention any	The protocol of the study was	The authors did not specify whether all those who were	Source(s) of funding for the

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	was not reported.	was not reported.	caregivers) was not reported.		mother until 1 hour postpartum and weighed beforehand and afterwards. Blood was also collected in graduated plastic bags.	incomplete outcome data.	unavailable for verification.	enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	study were not reported.
Amornpetchakul 2018	Computer generated randomisation.	Allocation concealment was not reported.	Study participants and caregivers were blinded. Drugs were prepared in unlabelled syringes by the research assistant and after preparation were both colourless and identical.	The statistician who analysed the data was blinded to the drug administered and the group allocation.	Blood loss was measured using a postpartum drape with a calibrated bag.	9 participants were excluded post-randomised due to not receiving allocated intervention.	Study reported outcomes as reported in the protocol.	Intention to treat not specified but assumed.	Study was funded by the Siriraj Research Development Fund
Anupama 2021	Computer generated sequence.	Allocation concealed by sequentially numbered opaque sealed envelopes.	Study participants and investigators were blinded to the assignment.	Investigators were blinded to the assignment.	Blood loss was measured using a suction bottle (changed after delivery of placenta to avoid measuring amniotic fluid), and also using the weight of soaked operation sheets, gauze pieces and mops.	Data were collected completely from all randomised study participants	Study did not report blood transfusion as specified in their methods.	Intention to treat not specified but assumed.	Source(s) of funding for the study were not reported
Askar 2011	Allocation by a computer-generated code prepared before the recruitment.	Used sealed, consecutively numbered, opaque envelopes	Study participants and caregivers were blinded to treatment allocations.	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by collection with a new plastic sheet placed under the mother following delivery of the placenta, and weighed (together with any gauzes, tampons and pads applied during the delivery) beforehand and 2 hours afterwards. A digital scale was used for weight measurement.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Asmat 2017	A lottery method was used.	Allocation concealment was not reported but	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	"Pads soaked were used to assess the amount of blood loss." Methods of evaluating	The study authors did not mention any	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
		unlikely to have been implemented with a lottery method of randomisation.			blood loss were not reported in sufficient detail.	incomplete outcome data.		allocated to treatment were included in the analysis, in the groups to which they were randomised.	
Attilakos 2010	The randomisation sequence (1:1 ratio—blocks of ten, no stratification) was generated by computer	The preparation of the ampoules was undertaken by DHP Ltd. (Powys, UK) which provided sequentially numbered and labelled boxes each containing a 1-ml ampoule of the study drug. All boxes and ampoules were identically labelled, with the study number being the only differentiating feature between different drug packs. the random	Study participants and caregivers were blinded to treatment allocations.	Assessors were blinded to treatment allocations.	Blood loss was estimated by the attending surgeon "in the usual way (visual estimation, number of used swabs and amount of aspirated blood)".	Data were collected completely from all randomised study participants.	The study report matches the study protocol that was registered prospectively (EudraCT 2005-002812-94).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Ferring Pharmaceuticals funded the cost of preparation of blinded medication ampoules. No other external funding was required for the study.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
		allocation sequence was not known to the investigators until the study had finished and the analysis was started							
Atukunda 2014	A study biostatistician generated a randomization list with a block size of ten	The study clinical pharmacist prepared the study drugs and placebos. The midwife research assistants received opaque envelopes with affixed study codes, containing both an injection (1 ml of oxytocin 10 IU or its placebo) and three pills (misoprostol 600 mg or its placebo)	"To achieve blinding of the participants and assessors, both inactive agents were manufactured and packaged to resemble actual study medicines in terms of shape, size, and colour".	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by collection with a clean plastic sheet placed under the mother during and after the third stage of labour. The sheet was specifically designed and piloted for the purpose. Blood was then drained into a calibrated container to improve accuracy in blood loss measurement. Furthermore, "mothers were given pre-weighed standard sanitary pads to place in the perineum at all times. These pads were changed and weighed hourly for the first 6 hours, and then every 6 hours until 24 hours postpartum. Blood loss was estimated as 1 mL per g of weight of the pad after subtracting the dry pad weight". Investigators added the estimated blood loss in pads, to the volume of blood already collected with the plastic sheet. To improve consistency in the estimation of blood loss, standardised electronic scales were used to weigh soiled sanitary pads.	Data were collected completely from all randomised study participants.	The study report matches the study protocol that was registered (ClinicalTrials.gov NCT01866241).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by scholarship funding from the Father Bash Foundation (public funding).

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
Badejoko 2012	The randomisation code produced by an independent statistician using a computer-generated random number sequence	Used sequentially numbered sealed packets made of identical opaque brown-paper envelopes prepared by the hospital pharmacy	Study participants and caregivers were blinded to treatment allocations.	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by collection with a BRASS-V calibrated drape "which is a sterile intrapartum blood collection mat with a calibrated receptacle" placed under the mother after the delivery of the baby and immediate clamping of the umbilical cord. The drape included ribbons tied around the abdomen of the mother to optimise blood collection.	"6 women from the misoprostol group and 3 from the oxytocin group were excluded from statistical analysis. 5 of these women in the misoprostol group and all 3 in the oxytocin group were excluded because of the occurrence of cervical lacerations in them. T	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	The study was conducted without external funding.
Bagheri 2022	Sequence generation was not reported.	Allocation concealment was not reported.	Study reported 'single-blind', no further details	Assessor blinding was not reported. The nature of intervention administration would not have allowed for blinding.	Blood loss measured by the amount of blood in the suction, the weight of blood absorbed by gauzes, and volume of clots expelled from the vagina.	Data were collected completely from all randomised study participants.	Study reported outcomes as reported in the protocol.	Intention to treat not specified but assumed	Study was taken from a university master's thesis, no further information provided.
Balki 2008	Computer-generated list of numbers	Used consecutively numbered opaque sealed packets or envelopes	Study participants and caregivers were blinded to treatment allocations.	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by measurement of haematocrit preoperatively and 48 hours postoperatively.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the institution of the authors.
Balki 2021	Computer generated table of random	Allocation was concealed using sealed	Participants and clinical teams were masked to study drug	Investigators were blinded to the assignment.	Blood loss was calculated through the difference between haematocrit values	5 participants did not received the allocated intervention and	Study reported outcomes as reported in the protocol	Intention to treat not specified but assumed	Source(s) of funding for the study were not reported

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	numbers in blocks of 6.	opaque envelopes.	allocation. IM placebo given to ensure blinding.		before and 24 hours after caesarean delivery.	were excluded post-randomisation.			
Bamigboye, Hofmeyr 1998	Computer-generated random sequence	Allocation concealment was by means of sealed, opaque containers containing 400 mg misoprostol or placebo tablets	"The placebo tablets were similar in size and colour but were not identical in shape to the misoprostol tablets. Blinding of the midwife administering the tablets was therefore not possible".	Assessor blinding was not reported.	Investigators appraised blood loss by collection with an absorbent plastic-backed linen saver and a low-profile plastic “fracture” bedpan placed under the mother. Blood collection in the plastic bedpan continued until 1 hour after delivery of the baby. At 1 hour after delivery, all the blood on the linen saver was scooped into the bedpan with the blood already collected there, and "the total blood was carefully measured". All the used linen savers and vaginal pads were weighed, and the known dry weights of these materials were subtracted from the measured total weight.	"Records of 4 of the 550 allocations (all from the placebo group) could not be traced".	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Bamigboye, Merrell 1998	Computer-generated random sequence	Allocation concealment was by means of sealed opaque envelopes	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised blood loss by the estimation of attending physicians.	"About halfway through enrolment it was discovered that a small number of women had been excluded from the syntometrine [ergometrine plus oxytocin] group because of hypertension detected after enrolment (thus contraindicating the use of syntometrine [ergo	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the South African Medical Research Council (public funding).

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
Barton 1996	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Methods of appraising blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Basket t 2007	Computer-generated randomisation cards	Used sealed, opaque, sequentially numbered envelopes	"The packages were prepared by the hospital pharmacy and their active drug unknown to the physicians and nurses".	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by a combination of the visual estimation of attending physicians and measurement of blood volume in a kidney dish placed under the mother during the third stage of labour.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the Nova Scotia Health Research Foundation (public funding).
Begley 1990	Random number tables were used. The first number was selected from the table and the numbers were then allocated in blocks of 100, following in sequence	Used numbered, sealed envelopes	Study participants and caregivers were not blinded to treatment allocations.	Assessors were not blinded to treatment allocations.	A sterile receiver was placed against the perineum to collect the blood lost and was measured.	No losses but dropouts for change in haemoglobin.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by public funding or conducted without external funding.
Begum 2015	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Methods of evaluating blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
								to which they were randomised.	
Bellad 2012	Subjects were assigned to treatment with a 1 : 1 ratio using computer-generated simple randomisation	The study medications and placebos were packaged in appropriately coded envelopes by administrative staff from the department of clinical pharmacy	Study participants and caregivers were blinded to treatment allocations.	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by collection with a BRASS-V calibrated drape placed under the mother before delivery of the baby. "The calibrated blood collection receptacle was opened after delivery and drainage of amniotic fluid. The blood collected in the drape was transferred to a measuring jar with 10-mL calibrations for accuracy. Blood-soaked swabs were weighed in g, and the known dry weight of the swabs was subtracted; this volume was added to the measured blood volume from the drape (assuming an equivalence of 1 g and 1 mL)". Blood loss was measured at 1 and 2 hours after delivery of the baby.	Data were collected completely from all randomised study participants.	The study protocol was registered retrospectively (ClinicalTrials.gov NCT01373359).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from Jawaharlal Nehru Medical College (the institution of the authors). Study medications were donated by Cipla (misoprostol) and AstraZeneca (oxytocin).
Benchimol 2001	Slips with the words “control,” “Syntocinon,” and “Cytotec” were placed into envelopes which were then drawn at random upon admission into the delivery room to	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised blood loss by weighing (methods of collecting blood were not reported).	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	determine to which group the woman would belong								
Bhatti 2014	1:1 simple randomisation but the sequence generation was not reported in sufficient detail.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Visual assessment of blood loss.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Bhullar 2004	Agent vials were coded with a number, which had been assigned using a random number table	Used opaque vials containing either a 200 mcg misoprostol tablet or a placebo	"The placebo tablets were similar in size and colour, but not identical in shape to the misoprostol tablet".	"The placebo tablets were similar in size and colour, but not identical in shape to the misoprostol tablet".	Investigators appraised blood loss by the estimation of attending physicians.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Biswas 2007	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Weighed blood clots and vaginal pads before and after use.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Borruto 2009	Sequence generation was not reported.	Allocation concealment was not reported.	"The patients were divided in two groups with blinding to the study medication". Blinding of	Assessor blinding was not reported.	Investigators appraised blood loss by "a sensitive colorimetric method".	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups	The authors "do not have a financial relationship with the organisation that sponsored the research".

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
			caregivers was unconfirmed.					to which they were randomised.	No other source(s) of funding for the study were reported.
Boucher 1998	Sequence generation was not reported.	Allocation concealment was not reported.	Study participants and caregivers were blinded to treatment allocations.	Double blinded.	Investigators appraised blood loss by a sensitive colorimetric measurement of the haemoglobin concentration of blood loss collected "by means of aspiration from the operative field [that] began immediately after administration of the study drug and ceased at the time of skin closure. All gauzes used during this timeframe were placed in 15% Lyse solution. All aspirated blood, gauzes, and the reference blood sample were sent to the laboratory for quantification of total blood volume. Blood on gauzes was extracted with Lyse solution, and haemoglobin content was determined with a sensitive colorimetric method adapted to the Cobas FARA analyser. Haemoglobin concentration is proportional to the absorbance of a hydrogen peroxide-activated aminophenazone-phenol mixture measured at a wavelength of 500 nm. The inter-assay coefficient of variation averaged 3.3%, and the limit of detection of the assay was 14 mg/dL. The amount of blood collected in gauzes was calculated with the following formula: blood	"3 patients who received general instead of epidural anaesthesia were excluded from the study and did not receive the study medication" but the study report did not specify whether these exclusions occurred before or after randomisation.	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	The study was supported by funding from Ferring Pharmaceuticals.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
					loss in dL = amount of haemoglobin in surgical gauzes in mg / haemoglobin concentration in mg/dL before caesarean section. Total blood loss was calculated by means of summing the volumes of blood aspirated and collected with gauzes".				
Boucher 2004	Computer-generated randomisation codes using a block size of 4	Used consecutively numbered sealed envelopes	The study was "double-blind": "for each study subject, kits containing both the study medication and a placebo were prepared in the hospital pharmacy according to the randomisation schedule, to assure blinding of the clinical staff".	Assessors were blinded to treatment allocations.	Methods of appraising blood loss were not reported.	164 women were randomised in the study, but 4 were excluded because they did not receive the study medication (3 oxytocin and 1 carbetocin) after randomisation.	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	The study was supported by funding from Ferring Pharmaceuticals.
Bugalho 2001	Sequence generation was not reported.	Allocation concealment was not reported.	"Neither the investigators nor the nurses participating in the study had access to the codes until the completion of the study".	Assessor blinding was not reported.	Investigators appraised blood loss with a metallic collector placed under the mother, from immediately after delivery of the baby until the mother was removed from the delivery room.	"A few subjects were excluded after randomisation for emergency caesarean section or incomplete data collection".	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of retained placenta were omitted).	Those who withdrew from the study after randomisation were not included in the analysis.	This study was financed by the Maputo Central Hospital (the institution of the authors) and the Special Program on Research and Research Training in Human Reproduction of the WHO (public funding).

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Butwick 2010	Randomised using Microsoft Excel-generated random number allocations	Used opaque envelopes containing group assignments	"The obstetrician and anaesthetist involved in each case were blinded to the oxytocin dose assignments".	Assessor blinding was not reported.	Investigators appraised blood loss "by estimating blood collected by suction and by calculating the weight of blood on surgical swabs".	"75 patients were enrolled, and 74 patients completed the study; 1 patient was excluded due to protocol violation (obstetrician request for supplemental oxytocin despite adequate uterine tone)".	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	The study was supported by funding from the Department of Anesthesia of the Stanford University School of Medicine (the institution of the authors).
Caliskan 2002	The randomisation was based on a table of computer-generated blocks of random numbers	Used sealed consecutively-numbered opaque envelopes	"To overcome the limitation of the shape of the placebo, all medications were applied by midwives, but residents who treat the birth and the third stage of labour were blinded to the identity of medication. Only the midwife who applied the medication opened the envelope once to read the code and then transferred the randomisation code into another identical envelope. The identities of the placebo and active medication were also	"To overcome the limitation of the shape of the placebo, all medications were applied by midwives, but residents who treat the birth and the third stage of labour were blinded to the identity of medication. Only the midwife who applied the medication opened the envelope once to read the code and then	Investigators appraised blood loss by collection with a sterile steel bedpan and plastic bed linen. Gauzes and pads were also collected and weighed until 1 hour after delivery of the placenta.	"The study enrolled 1633 women, but the data for 27 women were excluded because of lack of predelivery (n = 13) or postpartum (n = 14, short hospital stay) haemoglobin concentrations".	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.

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			concealed from caregivers and residents who followed up the patient for the next 24 hours. The randomisation code was not broken until study completion."	transferred the randomisation code into another identical envelope. The identities of the placebo and active medication were also concealed from caregivers and residents who followed up the patient for the next 24 hours. The randomisation code was not broken until study completion."					
Caliskan 2003	Computer-generated without any blocking or stratification.	Used sealed, consecutively-numbered opaque envelopes.	"The placebo tablets were similar in size and colour but were not identical in shape to the misoprostol tablets. To minimise this limitation, the preparation and administration of the medication	"The placebo tablets were similar in size and colour but were not identical in shape to the misoprostol tablets. To minimise this	Investigators appraised blood loss by collection with a sterile steel bedpan and plastic bed linen from immediately after delivery. Gauzes and pads were also collected 1 hour after delivery of the placenta and weighed.	"The data for 226 patients were excluded because of caesarean deliveries performed after randomisation (n = 206) and the lack of predelivery (n = 6) or postpartum (n = 14, short	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
			were carried out by a midwife who had not been involved in the management of the patient except for drug administration.	limitation, the preparation and administration of the medication were carried out by a midwife who had not been involved in the management of the patient except for drug administration.		hospital stay) haemoglobin concentrations.			
Carbonell i Esteve 2009	Random assignments generated by computer	Used sequentially-numbered, opaque, sealed envelopes prepared by people not related to the study. This process was supervised by an analyst. Every morning a secretary received the sealed envelopes	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	After delivery of the baby, investigators appraised blood loss by collection with a sterile waterproof cloth placed under the mother, to channel blood into a bottle with capacity of 2 L: the volume reading was collected once beyond the third stage of labour.	1410 women were randomised in the study, but 10 were excluded because they did not receive the allocated agents (3 in the misoprostol plus oxytocin group and 7 in the oxytocin group) after randomisation.	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	The study was supported by the Science and Ethics Committee of the Hospital Eusebio Hernandez in Habana, Cuba in conjunction with the Clinica Mediterranean Medica in Valencia, Spain (the institutions of the authors).

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		for distribution and this process was monitored by someone working on the study							
Carillo-Gaucin 2016	Simple randomisation but sequence generation was not reported in sufficient detail.	Allocation concealment was not reported.	It is mentioned that the study was double blinded but blinding methods (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Methods of evaluating blood loss were not reported.	There were 3 losses to follow up.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Cayan 2010	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Methods of appraising blood loss were not reported.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Chalermpolprapa 2010	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Methods of evaluating blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Chandhiok 2006	Randomisation process not explained in sufficient detail.	Randomisation process not explained in sufficient detail but lack of allocation	Not applicable.	Not applicable.	Immediately after the cord was clamped and cut, the paramedical worker in both groups placed a calibrated blood collection drape (BRASS-V drape) under the women's buttocks for quantification of blood loss.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	This ICMR Task Force study was funded in part by the WHO Country Office, New Delhi; Cipla Pharmaceuticals provided the

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		concealment usually not an issue in cluster trials.			This consists of a plastic sheet to which a funnelled pouch is attached. The volume of blood collected in the first hour was recorded. In the event of persistent bleeding, another measurement was made at the end of 2 h.				misoprostol tablets.
Chaudhuri 2010	Randomised using computer-generated random numbers in a 1:1 ratio	The packets containing the two drugs were sealed and opaque, and could not be identified by the surgeons and anaesthetists	"The packets containing the 2 types of drug were sealed and opaque, and could not be identified by the surgeons and anaesthetist".	Assessors were blinded to treatment allocations.	Investigators appraised intraoperative blood loss by collection with a suction bottle for volumetric measurement, combined with linen savers and mops weighed before and after delivery. They added the approximate volume of the contents of the suction bottle (a) to the difference in weight between dry (b) and soaked (c) linen savers and mops (1 g equivalent to 1 mL). Amniotic fluid volume (d) was calculated by multiplying amniotic fluid index by 30 mL. Finally, intraoperative blood loss was determined by subtracting amniotic fluid volume from approximate blood loss ((a + (c - b)) - d). Furthermore, investigators appraised postoperative bleeding over the next 8 hours by weighing soaked pads and subtracting the dry weight.	"4 women in group 1 [misoprostol] and 6 women in group 2 [oxytocin] were excluded from the analysis: 4 women required conversion to general anaesthesia, 5 women had traumatic intraoperative bleeding (extension of lower segment incision or broad ligament h	The study report matches the study protocol that was registered (CTRI 2009/091/000075).	Those who withdrew from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.
Chaudhuri 2012	Computer-generated random number sequence	Used pre-prepared sealed and opaque packet	"The misoprostol and placebo tablets were similar in size, shape, and colour. The ampoules of oxytocin and placebo were also	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by collection with specially designed, pre-weighed absorbent thick cotton pads with plastic lining, placed under the mother. Blood clots, if any, were expressed from the vagina into	"2 women in the study group and 1 woman in the control group refused sublingual administration of the drug".	The study report matches the study protocol that was registered (CTRI 2009/091/000672).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
			similar. Selection, enrolment, and randomisation were done by the resident doctors, whereas preparation of packets and confidential record maintenance was done by the labour room nursing staff in charge."		a polythene bag. Any episiotomy wound was repaired immediately, and the swabs used for the purpose of episiotomy were not included in blood loss assessment. If necessary, pads were replaced during the observational hour after delivery. Then the soaked pad(s) and the blood clots were weighed. "The specific gravity of blood being 1.08, the amount of blood lost in mL was approximately equal to the weight in g".				
Chaudhuri 2015	Randomisation was done using a computer-generated random number sequence and blocks of size eight.	Assignments were contained in sealed, opaque and sequentially-numbered packets.	"Randomisation and confidential record maintenance were performed by residents who were not involved in the trial, and the operation theatre midwife prepared the sealed packets and allocated and administered the drugs. Thus, clinicians, investigators, data analysts, and participants were masked to the treatment allocation."	Assessors were blinded to treatment allocations.	Investigators appraised intraoperative blood loss from after delivery of the placenta. Blood was collected with a suction bottle, linen savers and mops: the dry weights of these materials were subtracted from the soaked weights, and the total volume of intraoperative blood loss calculated on the basis that 1 g is equivalent to 1 mL. Investigators also appraised postoperative blood loss by weighing soaked pads.	Data were collected completely from all randomised study participants.	The study report matches the study protocol that was registered (CTRI 2013/05/003645).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Chaudhuri 2016	Used a computer-generated random number	Used sealed, opaque, and sequentially	Participants, investigators, and data analysts were masked to group assignment.	Participants, investigators, and data analysts were	Linens soaked with amniotic fluid were removed soon after delivery of the newborn, and a pre-weighed thick cotton pad with plastic lining was placed	Data were collected completely from all randomised	Registered with Clinical Trial Registry India (Registration No.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups	Source(s) of funding for the study were not reported.

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	sequence and block randomisation (blocks of 6–8).	numbered packets.		masked to group assignment.	under the buttocks. All blood clots were removed from the vagina and kept in a plastic bag. The pad was replaced if completely soaked during the 1-hour observation period. Episiotomies were repaired immediately after complete delivery of the placenta, and cotton swabs used during this procedure were not included in the blood loss assessment. The difference in weight between the soaked and dry pad was added to the weight of blood clots to calculate the total blood loss (1mL was considered equal to 1 g given the specific gravity of blood of 1.08).	study participants.	CTRI/2014/03/004491).	to which they were randomised.	
Chhabra 2008	Used random number tables.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised blood loss by "measuring blood and blood clots collected in sponges".	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Choy 2002	Computer-generated random number	Used sealed consecutively-numbered opaque envelopes	"The preparation and administration of the medication was carried out by a second midwife who was not involved in the management of the patient except for the drug administration. The medical attendant who	Assessors were blinded to treatment allocations.	Investigators appraised blood loss "by measuring the amount of blood clots and weighing the towels and swabs used".	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
			delivered the baby was not informed of the type of oxytocics used."						
Chua 1995	Randomised by a random number table.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	All blood and blood clots lost in the first 2 hours after delivery were collected by mopping the blood and clots with absorbent paper, and collect the paper in a plastic bag. The bags were sent to the laboratory for processing within 2 hours of completion of blood collection.	115 women were randomised in the study, but 3 were excluded because they gave birth precipitously before preparing the bed for accurate collection of blood after randomisation.	The protocol of the study was unavailable for verification.	Those who were excluded from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.
Cook 1999	Randomisation was by random number list in blocks of 20 with a separate randomisation for each centre.	Used sequentially-numbered sealed security (opaque) envelopes containing the appropriate drug label for each centre.	Study participants and caregivers were not blinded to treatment allocations.	Assessors were not blinded to treatment allocations.	Investigators appraised blood loss by combining "estimated" and "measured" values according to the standard clinical practice of each study centre. The "estimated" blood loss was judged by the attending senior midwives and/or clinicians. The "measured" blood loss was calculated as the actual volume of blood collected in a calibrated measuring jug, combined with the difference in weight between dry and blood-stained undersheets and sanitary pads.	Data were not collected completely from 67 study participants: "the main reasons for exclusion prior to randomisation, and following randomisation but before treatment, were the need for caesarean section and development of hypertension, either before or during labour."	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.
Dabbaghi	Sequence generation	Allocation concealment	Blinding (of study participants and	Assessor blinding was not reported.	Methods of evaluating blood loss were not reported.	The study authors did not mention any	The protocol of the study was	The authors did not specify whether all those who were	Source(s) of funding for the

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Gale 2012	was not reported.	was not reported.	caregivers) was unclear.			incomplete outcome data.	unavailable for verification.	enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	study were not reported.
Danser eau 1999	Computer-generated randomisation code, stratified by center and with use of random blocks of 2.	Allocation concealment was not reported.	"All physicians and nurses involved, all investigators and their staff, and all sponsor representatives were kept blinded to the treatment codes at all times".	Assessors were blinded to treatment allocations.	Methods of appraising blood loss were not reported.	694 women were enrolled in the study, but 59 were excluded because of withdrawals (n=5) or protocol violations (n=54) after randomisation.	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	The study was supported by funding from Ferring Pharmaceuticals .
Dasuki 2002	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Methods of appraising blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
de Groot 1996	Computer-generated randomisation list.	Used identical study boxes. Care was taken that no difference could be seen or heard between the packages of the ergometrine/ placebo tablets and	The study made use of placebo tablets to minimise detection bias between the placebo and the oral ergometrine arm but also included an unblinded oxytocin arm and the comparison of oxytocin versus placebo was unblinded.	Assessor blinding was not reported.	Investigators appraised blood loss by collection with a "fresh" perineal pad placed under the mother from immediately after birth until 1 hour after the delivery of the placenta. The difference in the weight of the pad before and after delivery was calculated on the basis that 1 g is equivalent to 1 mL of blood. "During delivery some blood was usually spattered on the drapes and gowns of the attendants, although attempts were made to minimise such losses. This	"4 women with exclusion criteria were entered erroneously (3 forceps, 1 augmentation). They are considered as non-participants".	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
		the oxytocin ampoules.			gave a constant error of approximately 10%. In addition, the placental interstices contain maternal blood (about 9% of placental weight). As systematic overestimations (amniotic fluid) and underestimations (blood loss) are likely to be equally distributed among the groups, no corrections have been made for them".				
Del Angel-Garcia 2006	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Methods of evaluating blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Derman 2006	Generated randomisation list with a random block size by the data coordinating centre and was stratified by the midwife.	The envelopes were numbered and each envelope had a five-digit code number assigned to it. The first two digits were the auxiliary nurse midwife number, followed by a sequence number beginning	"The identical placebo was specifically manufactured for the study".	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by collection with a polyurethane blood collection drape placed under the mother from immediately after birth until 1 hour after delivery of the baby. The blood collection drape included a calibrated receptacle specifically developed for the study. In the event of persistent bleeding beyond 1 hour, the drape was removed at 1 hour, blood loss measured, and a new drape used with a second measurement made at 2 hours.	Data were collected completely from all randomised study participants.	The study report matches the study protocol that was registered (ClinicalTrials.gov NCT00097123).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the National Institute of Child Health and Human Development (public funding) and the Bill and Melinda Gates Foundation (public funding).

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		with 001 and ending with 100, assigned to the individual subject. Non-distinguishable envelopes in batches of 100 were distributed to each of the midwifes affiliated with the four selected primary-health centres.							
Dhananjaya 2014	Systematic random sampling method.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised blood loss by collection with drapes that were weighed together with mops and clots, and by measurement of haemoglobin concentration and haematocrit of a sample of venous blood before delivery and 24 hours after birth. A sample of venous blood before delivery and 24 hours after the birth was also collected, for haemoglobin and haematocrit measurement "as an objective index of blood loss".	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Diallo 2017	A computer-generated randomised sequence.	Cards assigning patients into groups were placed in	If an oxytocin drip was used during labour, it was continued for patients in the	"The patient was then attended by the midwife who was not	The blood lost was collected in a basin placed after the clamping of the umbilical cord and the removal of the amniotic fluid. Episiotomies	Authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment	No funding sought for this study.

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		envelopes which were then sealed and numbered as and when patients were included.	"oxytocin" group and replaced by a bottle of 5% glucose solution in the "misoprostol" group. The patient was then attended by the midwife who was not informed of the type of uterotonic administered.	informed of the type of uterotonic administered."	were repaired immediately after delivery. Blood loss was collected for up to 2 hours after delivery. This blood was transferred into a graduated jar to measure its exact volume.			were included in the analysis, in the groups to which they were randomised.	
Diop 2016	The computer-generated random allocation was overseen by Gynuity Health Projects, which also assigned clusters. Maternity huts with auxiliary midwives located 3–21 km from the closest referral centre were randomly assigned (1:1) by staff at Gynuity Health Projects to either oral misoprostol	Study drugs were packed into individually numbered single-dose envelopes by staff at Gynuity Health Projects and supplied to maternity huts by Child Fund Senegal.	Not blinded.	Not blinded.	The perceived amount of blood loss was documented as "normal", "moderate", or "significant".	There were 1820 recruited initially through the clusters but 1412 were included in the analysis and 1049 had data available for the study's primary outcome.	The study report matches the study protocol that was registered prospectively (ClinicalTrials.gov, number NCT01713153).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	This study was funded by the Bill & Melinda Gates Foundation.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	or oxytocin in Uniject, stratified by reported previous year clinic volume (deliveries) and geographical location (inland or coastal).								
Docherty 1981	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Methods of appraising blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Dutta 2016	Sequence generation was not reported.	Allocation concealment was not reported.	Study is stated to be double blinded but blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Any blood clot which expressed from the uterus was measured in the calibrated glass container.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Eftekhari 2009	By a simple randomisation method, patients were allocated into two equal groups.	Allocation concealment was not reported.	Study participants and caregivers were not blinded to treatment allocations.	Assessor blinding was not reported.	Investigators appraised blood loss by collection in a suction bottle, and with drapes and pads beneath the mother. Amniotic fluid was suctioned and measured, and then subtracted from the total volume of the suction bottle. Meanwhile the known dry weight(s) of drapes and pads	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

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					were subtracted from the soaked weights of these materials. Measurements of blood collected in the suction bottle and on drapes and pads were added together.		results in the study report (cases of transfusion were omitted).		
El Behery 2015	Computer-generated code	Used sealed, opaque envelopes	The study was "double-blinded": "a double dummy system for administration was used".	Assessors were blinded to treatment allocations.	Investigators appraised blood loss "in the usual way (visual estimation, number of used swabs and amount of aspirated blood)".	180 women were included in the study, but 100 were excluded because 4 had congenital fetal anomalies, 7 cases had placenta praevia, 5 cases were diabetic, 8 had hypertension, 9 had preeclampsia, 3 cases were cardiac, 28 cases needs general anaesthesia, 17 cases delivered vaginally and 19 cases delivered by elective caesarean section). It was unclear if these were excluded before or after randomisation.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
El Tahan 2012	Used a computer-generated randomisation code.	Used sequentially-numbered sealed	placebo and misoprostol tables "looked identical in size, colour, and packing".	Assessors were blinded to treatment allocations.	Investigators appraised intraoperative blood loss by collection in a suction bottle minus sonographically estimated amniotic fluid	"4 patients in the placebo group and 12 patients in the misoprostol	The study report matches the study protocol that was registered	Those who withdrew from the study after randomisation were not included in the analysis.	The study was supported by funding from Mansoura University (the

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
		opaque envelopes.			volume, together with visual estimates of the volume of blood on the floor and the weight differences between dry and used towels, linens, and swabs. Visual estimates were performed by obstetricians blinded to treatment allocation. Towels, linen and swabs were weighed with an electronic scale. Weights were added to volumetric values on the basis that 1 g is equivalent to 1 mL. Investigators appraised postoperative blood loss by weighing bed linen, gowns and perineal pads. Furthermore, blinded investigators estimated blood loss by multiplying maternal blood volume in mL by the difference between preoperative and postoperative haematocrit measurements, all divided by preoperative haematocrit measurements.	group were excluded from the study due to loss to follow-up or missed preoperative haematocrit data".	retrospectively (ClinicalTrials.gov NCT01466530).		institution of the authors).
Elbohoty 2016	Randomisation was performed in a 1:1:1 ratio using a computer-generated sequence.	Numbered, sealed envelopes were prepared, with each envelope containing one of the three study drugs and placebos for the other two drugs. The	Tablet placebos, containing hydrogenated castor oil, hypromellose, microcrystalline cellulose, and sodium starch glycolate were prepared to be identical in size, colour, shape, and packing to the tablet study drug. Intravenous	Consequently, patients, investigators, and data analysts were masked to group assignments and unmasking only occurred after data	Surgical towels were weighed with their wrapping before and after delivery using a highly accurate digital balance. The difference in mass between the dry and soaked towels was calculated. Operative blood loss was calculated using three parameters: (A) the volume of the suction bottle contents (mL), (B) the difference in towel mass (g), and © the amniotic fluid volume (mL). Intraoperative blood loss (mL) was calculated	270 women were randomised in the study, but 7 were excluded because they had general anaesthesia (n=4) or the drug ampoules were damaged after randomisation.	The study report matches the study protocol that was registered (ClinicalTrials.gov: NCT02053922).	Those who were excluded from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
		randomization protocol was concealed from the research team and the primary investigator contacted a central coordinating investigator to identify the envelope to be distributed to each patient.	placebo ampoules containing normal saline were prepared and were identical in shape and packing to the intravenous study drugs used. All envelopes were prepared by Sigma Pharmaceuticals and were already sealed when received by the research team.	analysis was completed.	as: Intraoperative blood loss = (A + B) −C .				
Elgafor el Shark wy 2013	Computer-generated random number sequence.	Drugs were in pre-prepared sealed and opaque packets.	Caesarean delivery was performed by four senior obstetricians who were blinded to the allocation.	Assessors were blinded to treatment allocations.	Investigators appraised blood loss "in the usual way (visual estimation, number of used swabs and amount of aspirated blood)".	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
El-Refaey 2000	Statistician using computer-generated block randomisation with varying block size	Used opaque, sequentially-numbered sealed envelopes	Study participants and caregivers were not blinded to treatment allocations.	Assessors were not blinded to treatment allocations.	Investigators appraised blood loss by the estimation of attending physicians.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Elsede ek 2012	Computer-generated tables.	Allocation was placed in sealed envelopes until the time of operation.	Attending obstetricians and other caregivers were blinded to treatment allocations.	Assessors were blinded to treatment allocations.	Investigators appraised blood loss from after uterine incision, by collection in 2 separate suction sets administered by a nurse, and by weighing surgical towels before and after each operation.	Data were collected completely from all randomised study participants.	The study protocol was registered retrospectively (ACTRN 12611000638932).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the institution of the authors, or conducted

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									without external funding.
Enakpene 2007	Randomization was by simple random selection. An independent statistician generated sets of four random letters, which were in boxes, and each box contained four separate random allocations which was equivalent to an opaque sealed envelope stratified in a block of four.	Used opaque sealed envelopes.	The study was "single-blinded". The identity of those blinded was not reported.	Assessor blinding was not reported.	Investigators appraised blood loss by a combination of careful collection in a receptacle after the delivery of the baby, by visual estimation of blood loss, and by extrapolation of blood loss using the weight difference of the total perineal pad used up to 24 hours postpartum.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of transfusion, chest pain and abdominal pain were omitted).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the National Postgraduate Medical College and Faculty of Obstetrics and Gynecology of the University College Hospital in Ibadan, Nigeria (the institution of the authors).
Ezeama 2014	Used computer-generated randomisation numbers.	A person uninvolved with the study prepared the study drugs. The labels on the ampoules (which were similar in size and colour) were	"A person uninvolved with the study prepared the study drugs: 1-mL ampoules containing either 10 IU of oxytocin (Labtocin; Laborate Pharmaceutical India, Panipat, India) or 0.5 mg of ergometrine	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by collection with "a fresh large perineal pad with plastic backing". They placed all the gauzes and perineal pads used to absorb the blood into a polythene bag, and subtracted the dry weight from the wet weight. Volume of blood loss was calculated on the basis that 1 g is equivalent to 1 mL.	Data were collected completely from all randomised study participants.	The study protocol was registered (PACTR 201105000292708).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the institution of the authors.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
		removed and the ampoules were placed in opaque sealed envelopes.	(Ergosav; Savorite Pharmaceuticals, Vadodara, India). The labels on the ampoules (which were similar in size and colour) were removed and the ampoules were placed in opaque sealed envelopes, such that only the computer generated randomization numbers on the envelopes were available to identify the study drug. Both drugs were purchased from a public pharmacy."						
Fahmy 2015	An online randomization program (http://ww.randomizer.org) was used to generate random list and to allocate patients into the four study groups.	Random allocation numbers were concealed in opaque closed envelops but there is no mention of the envelopes being sequentially numbered.	Blinding (of study participants and caregivers) was unclear as a placebo saline infusion is mentioned but no sufficient details of how blinding was achieved.	Assessor blinding was not reported.	The calculated estimated blood loss = Estimated blood volume X (preoperative PCV – postoperative PCV) / preoperative PCV. (Where estimated blood volume = Booking weight (kg) X 85ml)	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Fahmy 2016	Randomization was performed	Allocation concealment	Both drugs were prepared preoperatively and	Assessor blinding was not reported.	Methods of evaluating blood loss were not reported.	The study authors did not mention any	The protocol of the study was	The authors did not specify whether all those who were	Source(s) of funding for the

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	by using computer-generated program.	was not reported.	coded so that the working investigator and the obstetrician were blinded to the type of drug injected.			incomplete outcome data.	unavailable for verification.	enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	study were not reported.
Fakour 2013	Sequence generation was not reported.	Allocation concealment was not reported.	The study used double dummy.	The study used double dummy.	Methods of evaluating blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Fararjeh 2003	Used urn block randomisation.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised blood loss by collection with scale vessels, and by subtraction of the dry weight(s) of cloths and pads from the soaked weight(s) of these items.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Fawole 2011	Treatment was allocated in blocks of 6-8 women by the research nurse, who used a computer-generated randomisation sequence.	The trial drugs were concealed in sealed, sequentially numbered opaque envelopes.	Placebo was identical in shape, colour, size, and design.	Blinded.	Blood collection was initiated as soon as possible after administration of the trial medication. A low-profile plastic fracture bedpan was placed below the woman's perineum to collect all subsequent blood loss for a period of 1 hour. Blood collected in the bedpan and all blood soaked small gauze swabs were emptied into a plastic measuring jar and the volume was measured.	No losses stated by authors but 27 women randomised were not included in the analysis for the primary outcome.	No available protocol.	27 women randomised were not included in the analysis for the primary outcome.	
Fawzy 2012	Randomly allocated but no further	Allocation concealment was not reported.	No blinding.	Not blinded.	All patients were closely observed for time of placental delivery, amount of blood loss by haemoglobin and	The study authors did not mention any	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	details were reported.				haematocrit value pre and immediately post-delivery (within 1 h), {then calculation of estimated blood loss using the following equation EBL= (BV)X(HCTO-HCTf)/HCTave where: EBL = estimated blood loss, BV: blood volume= body weight X600 cc KG&HCTO = initial haematocrit HCTf = final haematocrit HCTave = (HCTO + HCTF)/2}	incomplete outcome data.		allocated to treatment were included in the analysis, in the groups to which they were randomised.	
Fazel 2013	Using a table of random numbers	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised intraoperative blood loss by collection with an isolated suction. The volume of blood collected in suction was combined with the volume of blood collected in gauzes and gowns: every small gauze soaked with blood was considered to contain 20 mL, and every large gauze soaked with blood 50 mL, and every g increase in the weight of a gown was considered as equivalent to 1 mL of blood.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the Kashan University of Medical Sciences (the institution of the authors).
Fekih 2009	The randomisation was computer-generated.	A slip of paper was placed inside an opaque, sealed envelope.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised perioperative blood loss as a combination of the volume of liquid in the suction collection jar, and the weight of swabs and pads.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Fenix 2012	Computer-generated code	Used sealed, consecutively-numbered envelopes	"The patient and the principal investigator attending the delivery were blinded to the type of medication	"The patient and the principal investigator attending the delivery were blinded	Investigators appraised blood loss by visual estimation, not including blood loss considered to result from repair of lacerations.	"9 women in the carbetocin group and 6 women in the oxytocin group failed to have a paired haemoglobin	The protocol of the study was unavailable for verification.	Not all study participants were included in the analysis.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
			administered" [additional information from the authors].	to the type of medication administered " [additional information from the authors].		test to measure the change in haemoglobin 24 hours after delivery because they refused further blood extraction. These 15 women were excluded".			
Fu 2003	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Investigators appraised blood loss in the 2 hours after delivery and after all amniotic fluids had been drained, by collection in a small tray and absorption into disposable, sterile, water-resistant gauze. The contents were weighed and volume was determined on the basis that 1.05 g is equivalent to 1 mL of blood. A measuring cup was used to estimate the blood in the tray; blood that soaked into the gauze was measured on the basis that material measuring 10 cm by 10 cm holds 10 mL of blood. These 3 measurements were combined to ascertain total blood loss.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Fuks 2014	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Methods of evaluating blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
Garg 2005	Randomised in 1:1 ratio by random number sequence.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Methods of evaluating blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Gavilanes 2015	Computer-generated randomisation.	Allocation concealment was not reported.	Study participants and caregivers were not blinded to treatment allocations.	Assessor blinding was not reported.	Investigators appraised postoperative blood loss by collection with "suction apparatus and sterile drapes before irrigation" and by weighing the blood collected in abdominal swabs and gauzes with a calibrated scale (Zhongshan Camry Electronic Co Ltd, model EK 4052-E, Guangdong, China). Investigators estimated the volume of blood loss "by subtraction of amniotic fluid at 30 cc per each centimetre reported by amniotic fluid index".	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Gerstenfeld 2001	The randomisation was carried out by an uninvolved party and was determined by a random number sequence.	The random number sequence was prepared by a third party and was concealed until the patient was enrolled. Packets were prepared in advance of	The random number sequence was "concealed until the patient was enrolled" and "packets were prepared in advance of randomisation".	Assessors were blinded to treatment allocations.	Investigators appraised blood loss (a) by collection with drapes placed under the mother. Each drape included a plastic pouch and measured volume in mL. Meanwhile the dry weights of delivery linen and sponges were subtracted from bloodied weights to determine the volume of blood collected with these materials, on the basis that 1 g is equivalent to 1 mL. The volumes of blood in drapes and linen were added together. Furthermore "if	"Of the 75 women who were excluded from analysis, 73 underwent caesarean deliveries, one woman was discharged to home before delivery, and one had an initial haemoglobin of 6.8 mg/dL".	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
		randomization.			amniotic fluid loss [after placement of the drape] was significant... the approximate percentage was recorded on the data sheet and blood loss was adjusted accordingly". Investigators appraised blood loss (b) by estimation of the delivery attendant(s). Investigators appraised blood loss (c) by measurement of haemoglobin and haematocrit values were obtained on admission and on postpartum day 1. The differences between these 2 values were recorded.				
Gore 2017	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	The evaluation of blood loss was assessed by placing cotton pads under the buttocks prior to the delivery of baby. After the delivery of the placenta the total pads and linen used were weighed in grams. The weight of 1gm of cotton pad or linen was equal to 1ml (Langford 2000). From this the known dry weight subtracted and the calculated volume added.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The authors report no funding sources.
Gulmezoglu 2001	The random allocation schedule was generated centrally at WHO, Geneva, Switzerland, by computer-generated	The treatment packs were sealed, numbered sequentially, and could only be taken from the dispenser	"The treatment packs and their contents were identical in shape, colour, weight, and feel."	Assessors were blinded to treatment allocations.	Investigators appraised blood loss from the time of delivery of the baby until the third stage of the labour was completed, when the mother was transferred to postnatal care (usually up to 1 hour postpartum). Immediately after the cord was clamped and cut, they passed a flat bedpan or an unsoiled receiver under the mother. The collected blood	Investigators excluded "37 and 34 women with emergency caesarean section, and 13 and 4 women lost to follow-up in misoprostol and oxytocin groups, respectively, for	The study report matches the study protocol that was published in advance.	Not all study participants were included in the analysis.	The study was supported by funding from the UNDP/UNFPA/ WHO/World Bank (public funding). Special Programme of Research, Development and Research Training in

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	random numbers and was stratified by country. Within the strata, women were individually randomised into one of two intervention groups with randomly varying block sizes of 4–6 women.	consecutively.			was poured into a standard measuring jar provided by WHO for volumetric measurement. "To simplify the procedure... small gauze swabs soaked with blood were put into the measuring jar and included in the measurement together with the blood and clots".	blood loss ≥ 1000 mL, and 2 and 4 women without information on the need for additional uterotonics".			Human Reproduction of WHO. Searle (Skokie, IL, USA) and Novartis (Basel, Switzerland) donated the active and placebo medications used in the trial.
Gupta 2006	Randomisation was achieved using computer-generated random tables.	A sealed envelope with a code number was opened when vaginal delivery was imminent. The code was not broken till the end of the study.	The study was "double-blind". "Each envelope contained either three tablets of 200 mcg misoprostol and an ampoule of normal saline or 3 identical looking placebo tablets and an ampoule of 10 IU oxytocin".	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by collection with a BRASS-V calibrated drape placed under the mother. Pre-weighed gauzes were used to clean any perineal tears or episiotomy. After 1 hour the dry weight of the sponges was subtracted from the soiled weight, and added to the volume of blood collected in the drape on the basis that 1 g is equivalent to 1 mL.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Hamm 2005	Sequence generation was not reported.	"The group assignments were available only to the pharmacy. The nurse selected an opaque vial	Study participants and caregivers were blinded to treatment allocations.	Assessors were blinded to treatment allocations.	Methods of appraising blood loss were not reported.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were unclear.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
		from the drug cabinet that contained either a 200-mg misoprostol tablet or placebo. The vial number (which had been assigned in the pharmacy) and patient identification were sent to the pharmacy."							
Harriott 2009	Computer-generated block randomisation was used to randomly assign participants.	Allocation concealment was not reported.	"Both the patient and the midwife conducting the delivery were aware of the drug administered" .	Assessors were not blinded to treatment allocations.	Investigators appraised blood loss by collection with a modified plastic drape placed under the mother from the commencement of the third stage of labour, until 1 hour after delivery. The collection drape measured 168 cm by 84 cm, and contained folded over side-wings (to act as a chute) and a 34-cm collection pouch made by folding the distal end of the drape. Standard sterile drapes were placed above the blood collection drape. Every effort was made to avoid soiling the sterile drapes before delivery of the baby, because they were not weighed. After delivery, overlying sterile drapes were	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the Mona Campus and Research Publication Committee of the University of the West Indies (the institution of the authors).

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					removed to facilitate the use of the collection drape.				
Hernandez-Castro 2016	Randomisation was based on a computer-generated sequence in blocks of six.	The drugs were kept in opaque containers, prepared by the hospital's pharmacy department, marked with the number assigned to the patient.	Patients, clinicians, investigators, and data analysts were masked to group assignment is stated but the placebo used was folic acid tablets which are different shape than misoprostol.	Patients, clinicians, investigators, and data analysts were masked to group assignment is stated but the placebo used was folic acid tablets which are different shape than misoprostol.	Visual estimation of blood loss was performed by the anaesthesiologist.	123 women were randomised in the study, but 3 were excluded because of inadequate drug administration (n=1), uterine artery injury (n=1) and incorrect fetal weight calculation (n=1) after randomisation.	The study report matches the study protocol that was registered prospectively (ClinicalTrials.gov:NCT01733329).	Those who were excluded from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.
Hofmeyr 1998	Computer-generated random sequence, in balanced blocks of eight.	The containers were ordered according to a computer generated random sequence, in balanced blocks of eight.	"The tablets were either misoprostol 2 x 200 mcg or two placebo tablets similar in size and colour but not shape. Efforts to obtain identical placebo tablets were unsuccessful. This method of blinding proved to be effective. In only one case did the attending midwife inadvertently catch sight of the tablets.	Blinded.	Within a minute of delivery, investigators removed any linen soiled with amniotic fluid, and placed a fresh, disposable absorbent linen-saver sheet with plastic backing, and a low wedge-shaped plastic "fracture" bedpan under the mother. "This was found to be a comfortable and efficient way of collecting the great majority of blood lost after delivery, and could be left in place without discomfort even during perineal suturing. When active bleeding had stopped, any blood clots were expressed from the uterus, the bedpan was removed and a sanitary towel was applied. The [volume of] blood in the bedpan was measured in a	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the South African Medical Research Council (public funding).

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					measuring jug. An hour after delivery, any bloodstained linen-savers and sanitary towels were placed in a plastic bag and weighed in g". After subtracting the known dry weights of these materials, the bloodstained weights were added to the volume of blood collected in the bedpan to ascertain the total blood loss in the first hour after delivery.				
Hofmeyr 2001	Random assignments generated by computer in blocks of 18.	Used sequentially-numbered, opaque test tubes.	Misoprostol and placebo were similar in size and colour but not shape. Efforts to obtain identical placebo tablets were unsuccessful. This method of blinding proved to be effective.	Blinded.	Within a minute of delivery, investigators removed any linen soiled with amniotic fluid, and placed a fresh, disposable absorbent linen-saver sheet with plastic backing, and a low wedge-shaped plastic "fracture" bedpan under the mother. "This was found to be a comfortable and efficient way of collecting the great majority of blood lost after delivery, and could be left in place without discomfort even during perineal suturing. When active bleeding had stopped, any blood clots were expressed from the uterus, the bedpan was removed and a sanitary towel was applied. The [volume of] blood in the bedpan was measured in a measuring jug. An hour after delivery, any bloodstained linen-savers and sanitary towels were placed in a plastic bag and weighed in g". After subtracting the known dry weights of these materials, the bloodstained weights were	"There were no withdrawals after randomisation and all outcomes were analysed in the allocated group". However the primary outcome data of 1 study participant in the placebo group were unavailable.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the South African Medical Research Council (public funding) and University of the Witwatersrand (the institution of the authors).

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
					added to the volume of blood collected in the bedpan to ascertain the total blood loss in the first hour after delivery.				
Hofmeyr 2011	Computer-generated random numbers and was stratified by country in blocks of 6–8.	"The trial medication was provided, and the study drug packswere prepared, by Gynuity Health Projects. When a participant enrolled, the researcher took the next study drug pack from the dispenser and immediately wrote the woman's name both on the pack and in the participant number list, which was kept separate from the case record forms. Enrolment took place when the	The study was "double-blind". "The packs were identical in shape, colour, weight, and feel, and contained either 2 tablets of 200 mcg of misoprostol (HRA Pharma, Paris, France) or 2 matching placebo tablets".	Assessors were blinded to treatment allocations.	Similarly to the study team of Gulmezoglu 2001, investigators appraised blood loss by collection with a fresh non-absorbent sheet and low plastic “fracture” bedpan placed under the mother from as soon as possible after delivery until 1 hour postpartum. Investigators considered that "longer-term blood loss measurement is more difficult to standardise". They transferred the blood collected in the sheet and the bedpan (together with any soaked small gauze swabs) to a measuring jar to ascertain the volume. Alternatively, they collected blood with a plastic sheet placed under the mother immediately after delivery. If bleeding continued beyond 1 hour, investigators restarted collection and measurement until bleeding subsided. Attempts were made to minimise any losses on the drapes and gowns of delivery attendants. In addition, "the placental interstices also contain maternal blood (about 9% of placental weight). Because overestimations (amniotic fluid) and underestimations (blood loss) were likely to be distributed equally between the 2 study	"Data for the primary outcome were not available for 4 of the 1103 women".	The prospectively registered protocol of the study (ClinicalTrials.gov NCT 00124540) lists some secondary outcomes different to those included the study report (≥ 1000 mL within the first hour only, transfusion, haemoglobin < 8 g/dL 24 hours after delivery).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from Gynuity Health Projects through a grant from the Bill and Melinda Gates Foundation (public funding).

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
		pack was removed from the pack dispenser. The pack could not be used for another woman or returned to the dispenser."			groups, and most would have occurred before the onset of measurement, the data were not corrected.				
Hoj 2005	Using a list of random numbers.	Used opaque envelopes that were consecutively-numbered and filled with the study drugs.	"Misoprostol and placebo tablets of identical form, size, colour, and packing were produced".	Assessors were blinded to treatment allocations.	After delivery of the baby and drainage of the amniotic fluid, investigators placed a clean plastic-lined absorbent drape under the mother. They changed the drape as many times as needed. The mother stayed on the drape or was asked to wear a pad over the next 60 minutes. All drapes and pads were weighed with an electronic scale and the known dry weights were subtracted in order to ascertain the volume of blood loss on the basis that 1 g is equivalent to 1 mL.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the Danish Society of Obstetrics and Gynaecology, the Illum Foundation, and the Danish International Development Agency (public funding).
Hong 2007	Sequence generation was not reported.	Allocation concealment was not reported.	placebo is mentioned but insufficient detail is reported to decide on blinding (of study participants and caregivers).	placebo is mentioned but insufficient detail is reported to decide on blinding of outcome assessors.	Methods of appraising blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
Humera 2016	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	After delivery of the baby amniotic fluid was allowed to drain away (if present) and amniotic fluid soaked bed linen covered with dry disposable linen saver, corrugated rubber sheet placed under buttocks, sterile kidney tray placed at the vulva was used to collect blood loss over next 1 hour. Collected blood was measured using a measuring jar, blood clots weighed separately (1gm=1ml). Blood soaked swabs were weighed, the known dry weight subtracted and the calculated volume added to that of the blood volume of measuring jar.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	No funding sought for this study.
Ibrahim 2017	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding was not reported	Blinding was not reported.	Blood loss was measured using an absorbent drape, and woman was asked to wear a pad 60 minutes after delivery. All drapes and pads were weighed on an electronic scale.	The study authors did not mention any incomplete outcome data.	Study reported the primary outcome as reported in the protocol as well as other others not specified in the protocol.	Intention to treat not specified but assumed	Study did not receive external funding, not further details given.
Ibrahim 2020	Computer generated random tables.	Allocation concealment was not reported.	Patients were blinded only - single blinded trial.	Study reports single-blinded trial, therefore outcome assessors not blinded.	Surgeons estimated blood loss visually, using number of swabs and amount of aspirated blood.	Data were collected completely from all randomised study participants.	Unable to access protocol. However study did not report the primary outcome of 'occurrence of major PPH defined as blood loss >1000ml within 24 hours of delivery'	Intention to treat not specified but assumed	Self-funded research

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Is 2012	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Methods of appraising blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Jago 2007	Computer-generated list of random numbers.	Used numbers that were labelled on envelopes.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Methods of appraising blood loss were not reported.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Jain 2019	Computer generated random tables.	Allocation concealment was not reported.	Blinding was not reported	Blinding was not reported.	Blood loss was measured using a drape with a collecting bag. Blood clots were weighed and blood soaked swabs were weighed.	Data were collected from most participants randomised. 1 participant in each arm was excluded post-randomisation for PPH >500ml.	No protocol available to compare reported outcomes to	Intention to treat not specified but assumed	Source(s) of funding for the study were not reported
Jangsten 2011	Computer-generated sequence.	Used sealed envelopes containing the randomisation group prepared in consecutive order and kept in another unit. At randomisation, midwives phoned the	"Because of the nature of the study, blinding was not possible for the midwives, but the parturients were not informed of which management was to be used for them".	Assessors were not blinded to treatment allocations.	Investigators appraised blood loss by removing pads soaked with amniotic fluid and placing a dry sanitary pad under the mother, immediately after the birth of the baby. They weighed all sanitary towels and pads before and after use. Blood loss was recorded (a) between the birth of the baby and the expulsion of the placenta, and (b) from expulsion of the placenta up to 2 hours postpartum.	171 randomised women were not included in the study analysis. Among those randomised to receive oxytocin, 4 withdrew consent, 75 had caesareans, and 14 were lost to follow up. In the control group, 2 withdrew consent, 56 had	The protocol of the study was unavailable for verification.	The authors excluded 131 randomised study participants from the analysis because they experienced caesarean deliveries.	The study was supported by funding from the Research and Development Board in Göteborg and Bohuslän, Baby Bag and the SU Foundation in Sweden (public funding).

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		staff at the other unit who opened the envelopes and disclosed the assigned intervention and trial number.				caesareans, and 20 were lost to follow up.			
Jans 2016	Randomisation was carried out by a lottery method "Randomization was achieved using two numbered and sealed opaque envelopes. Each envelope contained a sticker indicating one of the allotted treatments. When the midwife was confident that the birth would be completed in her care (defined for primigravid women	Allocation concealment was not reported but unlikely to have been implemented with a lottery method of randomisation.	Not blinded.	Not blinded.	Used digital scales, 10 disposable pre-weighed incontinence pads (a small impermeable multilayered sheet with high absorbency) and graduated measuring cups.	1704 women were randomised in the study, but 18 were excluded because of referral to hospital (n=16) and were lost to follow up or withdrew from the study (n=2) after randomisation.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The trial was funded by the Prevention Fund of the Netherlands.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	when a large part of the baby's head was presenting and for multiparous women at the beginning of the second stage of labour), the woman herself or someone else designated by her would choose one of the two envelopes."								
Jerbi 2007	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Methods of appraising blood loss were not reported.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were unclear.
Jirakul sawas 2000	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Methods of appraising blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Kabir 2015	Used a computer generated	Allocation concealment	Blinding (of study participants and	Assessor blinding was not reported.	Used pre-weighted standardized delivery mat (Quaiyum's mat) and pre-	110 women were randomised in	The protocol of the study was	Those who were excluded from the study after	Source(s) of funding for the

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	randomisation.	was not reported.	caregivers) was unclear.		weighted sanitary pads for blood collection after delivery to each of the pregnant woman to measure blood loss and measured the amount of blood loss in gram by digital postal scale.	the study, but 16 were excluded because of preeclampsia (n=5), eclampsia (n=5), placenta praevia (n=2), placental abruption (n=2) and multiple pregnancy (n=2) after randomisation.	unavailable for verification.	randomisation were not included in the analysis.	study were not reported.
Kang 2022	Computer generated coding system	Allocation concealment was not reported.	Blinding was not reported	Blinding was not reported.	Blood loss measured using absorption in the surgical drapes, gauzes and pads, and also the volume in the suction bottle.	Data were collected from most participants.	Protocol available but unable to view as not in English.	Intention to treat.	Study was supported by the Suzhou People's Well-Being Project in China and the Suzhou Introduction of Clinical Expert Team Project
Karkanis 2002	A statistician developed blocked randomisation tables for each centre.	Pharmacy assembled consecutively-numbered opaque, sealed packets that contained the group allocation.	Study participants and caregivers were not blinded to treatment allocations.	Assessors were not blinded to treatment allocations.	Methods of appraising blood loss were not reported.	"13 women randomised subsequently delivered by caesarean and were excluded from analysis. 2 women were lost to follow-up early in the trial when their packets were opened but the manoeuvre was not completed and no data were recorded".	The protocol of the study was unavailable for verification.	Not all study participants were included in the analysis.	The study was supported by funding from the physicians of Ontario, through the Physician Services Incorporated Foundation (public funding).

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Kerekes 1979	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised blood loss by collection in a container placed under the mother during the third stage of labour until 2 hours postpartum. The contents of the container were transferred to a measuring cylinder. However, blood loss data were not reported in a format that could be extracted for the purpose of this review.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Khan 1995	Number code by the hospital pharmacist who alone was aware of the content of the ampoules.	Participants were assigned an opaque sealed envelope. Each envelope carried the instruction to use a numbered vial of the study drug.	Study participants and caregivers were blinded to treatment allocations.	Assessors were blinded to treatment allocations.	Investigators appraised blood loss "in the standard way" by measurement of blood and clots in a graduated jug, and by weighing swabs and linen.	"12 patients had to be excluded from the trial (oxytocin 5; ergometrine plus oxytocin 7) after randomisation because they no longer fulfilled the inclusion criteria (2 who required caesarean section and 10 who were delivered by forceps or ventouse (oxytocin, 4; Ergometrine plus oxytocin 6).	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.
Khurshid 2010	Randomisation was done using random tables.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Blood loss was estimated by collecting blood and blood clots in the kidney tray and adding the difference in the weight of the drapes before use and after birth.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups	Source(s) of funding for the study were not reported.

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								to which they were randomised.	
Koen 2016	"Randomisation was carried out by a lottery method "Randomisation was by means of sealed not transparent envelopes. Each had a label inside with a letter A (oxytocin group) or B (oxytocin + ergometrine), which corresponded to a pair of prepacked colour-coded ampoules that were used for the two different groups."	"Randomisation was carried out by a lottery method "Randomisation was by means of sealed not transparent envelopes. Each had a label inside with a letter A (oxytocin group) or B (oxytocin + ergometrine), which corresponded to a pair of prepacked colour-coded ampoules that were used for the two different groups."	Double blinded.	Blinded.	Calculation of blood loss was done using calculated pregnancy preoperative blood volume (0.75 × [{height inches × 50} + {weight pounds × 25}) × percentage of blood volume lost ([pre-delivery haematocrits – post-delivery haematocrits]/pre-delivery haematocrits).	540 women were randomised in the study, but 124 were excluded because of giving birth vaginally (n=80), incomplete data or protocol violations (n=44) after randomisation.	The study report matches the study protocol that was registered prospectively (ClinicalTrials.gov NCT02046499).	Those who were excluded from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.
Kumar 2016	Sequence generation was not reported.	Used sequentially-numbered sealed envelopes.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Perineal drapes were replaced by calibrated Brasss V obstetric drape after the delivery of the baby. The average time taken for episiotomy suturing was around 10 min in both the groups and did not have any significant impact on the blood loss and duration of bleeding. Brasss V drape was removed	1 woman was excluded because of a fourth degree tear after randomisation.	The protocol of the study was unavailable for verification.	Those who were excluded from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.

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					10 min after the episiotomy suturing in all patients unless the patient continued to have significant PPH.				
Kumar 2021	Computer generated randomiser program.	Allocation concealment was not reported	Participants were blinded to the intervention received.	Investigators were blinded to the intervention received.	Blood loss measured objectively using a drape with a blood collection chamber. Blood soaked swabs were also weighed.	Data were collected completely from all randomised study participants.	No protocol available to compare reported outcomes to.	Intention to treat not specified but assumed.	Source(s) of funding for the study were not reported
Kumru 2005	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised intraoperative blood loss by weighing compresses and rolls before and after the birth of the baby, and calculating the difference between these measurements. Pre-weighted pads were distributed in advance to each mother, and collected at intervals of 3-6 hours hour intervals after the aspiration of amniotic fluid.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Kundo dyiwa 2001	Computer-generated using a random sequence.	The participant was asked to randomly pick a numbered sealed opaque envelope from the study cooler-box.	"Identical placebo tablets could not be obtained from the manufacturers. The tablets were similar in size and colour but not in shape. However, most reviewed trials on misoprostol had this similar problem although this method of blinding proved to be effective."	"The data sheet was completed by the midwife supervising the delivery and collected and checked by the research assistant".	After delivery, investigators appraised blood loss by removing linen soiled with amniotic fluid, and then placing a fresh disposable incontinence pad with a plastic backing under the mother. Blood expressed from the uterus was measured with a calibrated measuring jug. The volume of blood soiling linen savers and sanitary pads was determined as the difference between dry weights and soiled weights: these measurements were added to the volume recorded by the calibrated jug.	"Data for 1 woman were excluded because she delivered undiagnosed twins after randomisation".	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

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Kushtagi 2006	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Amount of blood loss was quantified by noting the increment in weight of standardised tampons which were placed high up in the vagina immediately after placental delivery.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Lam 2004	Allocated using a random number-generated table.	Allocation concealment was not reported.	Study participants and caregivers were not blinded to treatment allocations.	Assessor blinding was not reported.	Investigators appraised blood loss during the third stage by visual estimation, and by objective measurement on the basis of a method previously described by Newton et al. Whilst any blood clots were collected and measured with a jug, white linen was placed under the mother during delivery and subsequently processed for 15 minutes with sodium hydroxide solution in an automatic stomacher (laboratory blender), to achieve the formation of alkaline hematin. "The optical density at 550 nm of the alkaline hematin was measured by spectrophotometry and compared with that of a known volume of a sample of the patient's venous blood" to calculate the volume of blood loss.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	It was unclear from the study report whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Lamont 2001	Sequence generation was not reported.	Allocation concealment was not reported.	Not blinded.	The randomisation slips were contained in envelopes which were opened by a	Blood loss was measured as accurately as possible, taking into consideration the liquor amnii and soiling of the surgical drapes.	530 women were randomised in the study, but 1 was excluded because did not receive the	The protocol of the study was unavailable for verification.	Those who were excluded from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
				person not involved in the postpartum assessments who resealed the envelope and drew 1 ml of the appropriate medication into a syringe. The nature of the medication was not revealed and the resealed envelope was retained in the woman's notes. The medication was administered by a competent person other than the one who had opened the envelope and filled the syringe.		allocated agent (carboprost) after randomisation.			
Lapaire 2006	The hospital pharmacy performed the 1:1 computer-	Used identical study boxes from pharmacy.	The study was "double-blind": "the study drugs and placebos [were provided by	Assessors were blinded to treatment allocations.	When the membranes ruptured before delivery, investigators appraised intraoperative and postoperative blood loss by	"3 patients in the oxytocin group were excluded from statistical analysis	The study protocol that was registered retrospectively (ClinicalTrials.go	The authors excluded 3 study participants in the oxytocin group from the analysis because they incurred	The study was supported by funding from the Scientific Pool of Basel University

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	generated randomisation that assigned the participants to their group.		the pharmacy] in unidentifiable form".		determining the difference in weight of cloths and pads used to absorb blood during surgery and in the intermediate care unit. When membranes did not rupture preoperatively, investigators appraised blood loss by collection in suction bottles and subtracting estimated amniotic fluid volume. Investigators considered that 1 g is equivalent to 1 mL of blood or amniotic fluid.	because of errors in drug administration". Moreover calculated blood loss data were unavailable in 13 cases and for these women the primary outcome was estimated clinically."	v) lists PPH as the primary outcome of the study, but the study report lists the primary outcomes as intraoperative and postoperative blood loss and drug-related adverse effects (these items are listed only as secondary outcomes in the registration file). The study does not report the incidence of PPH ≥ 500 mL, nor PPH ≥ 1000 mL.	errors in drug administration.	Hospital (the institution of the authors).
Leung 2006	Computer-generated code before the recruitment.	This was performed by opening a sealed, consecutively-numbered, opaque envelope.	Study participants and caregivers were blinded to treatment allocations.	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by visual estimation.	"15 women in the carbetocin group and 14 women in the ergometrine plus oxytocin group failed to have a paired haemoglobin test to measure the change in haemoglobin 48 hours after delivery either because they had requested early home or refused further	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of fever were omitted).	Those who withdrew from the study after randomisation were not included in the analysis.	The study was supported by funding from Ferring Pharmaceuticals .

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						blood taking. These 29 women were excluded."			
Liu 2020	Computer generated randomisation sequence.	Randomisation results were kept in a closed study box.	Participants, midwives and obstetricians were blinded to the allocated intervention.	Healthcare professionals assumed outcome assessors, therefore blinded.	Blood loss collected into a plastic basin placed under mother's pelvis. Napkin for postpartum blood collection was used for blood collection up to 24 hours. Blood-soaked pads were weighed and calculated in ml.	Data were collected from most participants.	Study reported outcomes as reported in the protocol	Intention to treat not specified but assumed.	No source of funding
Lokugamage 2001	The randomisation was undertaken by means of computer-generated random numbers.	Used sealed opaque envelopes.	"The obstetrician, surgical assistant, scrub nurse and recovery midwife were blinded to the treatment. The anaesthetist and the anaesthetic assistant were not blinded as it was important for patient safety that a record was kept of all drugs administered."	Assessor blinding was not reported.	Investigators appraised intraoperative and postoperative (up to 1 hour) blood loss by visual estimation "in a standard manner (volume of blood in suction bottle plus soiling of swabs and bed sheets)".	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by "assistance" from the Department of Anaesthesia at University College London Hospitals NHS Trust (the institution of the authors).
Lumbiganon 1999	Random allocation sequence, generated centrally.	The treatment packs were consecutively-numbered and sealed.	"The packs were identical in shape, colour, weight and feel. Each woman received an injection and 3 tablets. Thus, the trial was double-blinded using double placebos".	Assessors were blinded to treatment allocations.	Investigators appraised blood loss from the delivery of the baby until the mother was transferred to postnatal care. The collected blood was poured into a standard measuring jar provided by WHO for the purpose of volumetric measurement. Linen was not weighed but clots and small gauze swabs soaked with blood were included in the measurement.	Exclusion after randomisation: 8 women in the oxytocin group did not comply with treatment (6 had an emergency caesarean section, 1 was HIV positive and mistakenly excluded, 1 whose ampoule	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the WHO (public funding). Active and placebo medications, syringes and swabs were donated by Searle, Novartis Pharma AG and Becton

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						was not located). 1 woman in the 600 mcg group was excluded.			Dickinson International.
Maged 2016	Participants were equally randomized using automated web-based randomisation system.	Only states that ensured allocation concealment with no further details.	Blinding (of study participants and caregivers) was not reported in sufficient detail even though the authors state it was double-blinded.	Assessor blinding was not reported.	Investigators appraised blood loss by weighing swabs and using pictorial charts.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Maged 2017	Randomised using automated web based randomisation system.	Allocation concealment was not reported in sufficient detail.	The authors state the study was double-blinded but blinding (of study participants and caregivers) was not described in sufficient detail.	Assessor blinding was not reported.	Calculated estimated blood loss.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Maged 2020	Automated web-based randomisation sequence.	Allocation was concealed with the web-based system.	Participants and personnel were not blinded	Investigators were not blinded	Blood loss was measured using a plastic sheet for collection and blood absorbed into drapes. Gauzes, tampons, and pads were used and collected and weighed.	Data were collected completely from all randomised study participants.	Unable to locate protocol.	Intention to treat not specified but assumed.	Source(s) of funding for the study were not reported
Malik 2018	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Amount of blood loss was calculated by weighing the gauzes/sponges before delivery followed by again weighing them after delivery.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Mannaerts 2018	Participants are randomly assigned	Allocation concealment	Medication was prepared by a midwife not treating the patient	Medication was prepared by a midwife	Methods of evaluating blood loss were not reported.	68 women were randomised in the study, but 10 were excluded	The study report matches the study protocol that was	The authors did not specify whether all those who were enrolled and randomly	Source(s) of funding for the

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	following simple randomisation procedure in 1 : 1 ratio to one of the two treatment groups. A computer-generated randomization list was generated using SPSS21.	was not reported.	to make sure that patient, gynaecologist, anaesthesiologist, and midwife clinically in charge of the patient are blinded for the medication.	not treating the patient to make sure that patient, gynaecologist, anaesthesiologist, and midwife clinically in charge of the patient are blinded for the medication.		because of incomplete data after randomisation.	registered prospectively (ISRCTN 95504420).	allocated to treatment were included in the analysis, in the groups to which they were randomised.	study were not reported.
Masse 2022	Computer generated randomisation sequence.	Allocation was concealed in opaque sealed envelopes	Participants, physicians and nursing staff were blinded. Anaesthetist who administered the intervention was unblinded. The delivering physician could be unblind to facilitate administration of appropriate additional uterotonic.	Nurse was responsible for measuring and documenting blood loss, therefore outcome assessment was blinded.	Blood loss was measured by quantifying blood suctioned off the surgical field, weighing surgical sponges, and blood collected on the underbody pad.	Data were collected completely from all randomised study participants.	Unable to locate protocol.	Intention to treat analysis	Study supported by the Department of Maternal Fetal Medicine Fellowship Fund
McDonagh 2022	Randomised by a research coordinator using by computer-generated block randomisation with a	'Group allocation and drug dilution instructions were provided in a sealed opaque envelope to an	The patient was blinded to the study drug and the infusion administered	The anaesthetist and obstetrician were blinded to the study drug and infusion administered '	Blood loss was calculated by the difference in haematocrit values measured before surgery and at 24 h after delivery according to the following formula: estimated blood loss (ml) = estimated blood volume (ml) x pre-operative haematocrit – postoperative haematocrit/pre-operative haematocrit, based	Data were collected completely from all randomised study participants.	The study report matches the study protocol that was registered (ClinicalTrials.gov NCT03168698)	Analysis was done per protocol	The study was supported by Merit Award from the University of Toronto.

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	block size of 8.	anaesthetist or research assistant who was not involved in the care of the patient.'			on women's' estimated weight of 85 kg				
McDonald 1993	The ampoules were numbered by Sandoz by using simple randomisation. There was no blocking or prognostic stratification.	The ampoules were numbered by third party (Sandoz).	Delivery attendants were blinded to treatment allocations.	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by the estimation of attending obstetricians and midwives.	"All women allocated to receive a drug were included in that group, excluding only the 14 women for whom drug allocation was not recorded".	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from Sandoz.
Mitchell 1993	Unclear sequence: described as without any blocking or stratification.	Used identical study boxes prepared by third party (Sandoz).	Study participants and caregivers were blinded to treatment allocations.	Assessors were blinded to treatment allocations.	Investigators appraised blood loss "in the standard way by graduated jug measurement plus an allowance for spillage".	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the Perinatal Trials Service (public funding), for the Department of Health for England and Wales, and for Birthright (the charitable arm of the RCOG). Coded medication ampoules were provided by Sandoz.
Mobeen 2011	A computer-generated random	Study medication was packed	"Both women and TBAs were blinded	Assessors were blinded	To appraise postpartum blood loss, blood was collected with a perineal sheet and bedpan	"Invalid blood loss measures, which mainly	The study report matches the study protocol	All those who were enrolled and randomly allocated to treatment	The study was supported by funding from the

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	code in blocks of six was maintained by Gynuity Health Projects in New York and not revealed until data collection and cleaning were completed.	in numbered colour-coded boxes by Gynuity Health Projects in New York.	to study assignment".	to treatment allocations.	placed under the mother for a minimum of 1 hour or until active bleeding stopped (whichever occurred last). "Blood collected in the bedpan was transferred to a measuring jar, which was then closed, and the perineal sheet and cotton roll were placed in a sealed plastic bag. The closed measuring jar and sealed plastic bag were then placed inside a plastic cooler which was tightly closed and stored in a secure place in the woman's home until the local health visitor or community health nurse arrived for weighing, 1–2 days after delivery".	occurred when monitoring visits were not possible because of poor weather conditions, were excluded from our analysis".	that was registered (ClinicalTrials.gov NCT00120237).	were included in the analysis, in the groups to which they were randomised.	Bill and Melinda Gates Foundation (public funding).
Modi 2014	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Used BRASS-V drapes to measure the blood loss.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	No funding sought for this study.
Moertl 2011	Randomisation was performed by a computer-generated randomisation sequence 1:1 ratio—blocks of ten without stratification.	Allocation concealment was not reported.	"Study medication was double-blinded to the clinical staff (obstetricians as well as anaesthesiologists) and the technicians performing the measurements".	Assessors were blinded to treatment allocations.	Investigators did not appraise blood loss.	After randomisation, investigators excluded 28 women from analysis for technical problems (n = 15), change to general anaesthesia (n = 9), recording artefacts (n = 3)	The study report matches the study protocol that was registered (EudraCT 2007-005498-78).	Not all study participants were included in the analysis.	CNSystems Medizintechnik AG in Graz, Austria provided the Task Force® Monitor 3040i system used to measure haemodynamic parameters. No other external funding was

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						and patient withdrawal (n = 1).			required for the study.
Mohamed 2015	Randomization was performed by computer generated randomization system.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	After delivery of the placenta, the volume of blood loss was assessed by weight or saturation assessment techniques by subtracting the dry weight of absorbing materials (pads, sponges, etc) from the weight of blood-containing materials and using the conversion 1gm weight = 1ml to quantify the blood volume contained in the materials.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Moir 1979	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Investigators appraised blood loss by "the haemoglobin extraction-dilution technique, which is acceptably accurate (Roe, Gardiner and Dudley, 1962; Thornton et al, 1963) and particularly suited to obstetric use (Moir and Wallace, 1967; Wallace, 1967). The perdometer apparatus was used and all blood and blood-stained linen were collected".	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Moodie 1976	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised blood loss by collection with the placenta bowl and soiled linen and swabs. "The principles of the haemoglobin extraction-dilution technique employed have been discussed by Roe, Gardiner and Dudley (1962) and Thornton and colleagues (1963).	There were 148 study participants but blood loss data were available in only 80 cases.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
Mukta 2013	Randomly divided into two equal groups.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised blood loss in mL, by collection with a calibrated plastic drape, after the drainage of amniotic fluid and delivery of the baby until the third stage of labour was completed.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Musa 2015	Allocation was done by blocked (restrictive), using computer-generated random numbers prepared by an independent statistician.	Used opaque envelopes but no other details provided.	"Participants, caregivers, and outcome assessors (researchers or research assistants) were masked to group allocation. Investigators were not masked for data analysis".	"Participants, caregivers, and outcome assessors (researchers or research assistants) were masked to group allocation. Investigators were not masked for data analysis".	Investigators appraised blood loss by "the gravimetric method" (Ambardekar 2009) until 1 hour after delivery.	235 study participants were randomised but only 200 were analysed due to protocol deviations and missing data.	The study protocol was registered retrospectively (PACTR 201407000825227).	Not all study participants were included in the analysis.	The study was supported by funding from the University of Ilorin Teaching Hospital (the institution of the authors).
Nahaer 2020	Randomised by a computer generated randomisation sequence	Allocation concealment was not reported	Blinding (of study participants and caregivers) was not reported	Assessor blinding was not reported	Visual estimation by the surgeon, number of used sanitary pad and amount of aspirated blood	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	Analysis is assumed to be intention to treat	Source(s) of funding for the study were not reported.
Nankaly 2016	Sequence generation was not reported in "The randomization was done via block randomization and in the	Allocation concealment was not reported.	Not blinded.	Not blinded.	Lost blood volume gained from calculating the total collected blood in suction container and counting the number of blood gases.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	form of four blocks".								
Nasr 2009	Allocated by a computer-generated random allocation system created at the Statistics Unit of Assiut University Hospital.	Allocation codes were placed in sealed, opaque, consecutively-numbered envelopes.	The study was "double-blind": active treatments and placebo treatments were "identical-looking".	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by the estimation of attending physicians.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were unclear.
Nayak 2017	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	The quantity of blood (mL) = (weight of (used material + unused material) after surgery-weight of all materials prior to surgery)/1.05 plus the volume included in the suction container after placental delivery. In addition, pads used after completion of caesarean section to 2 hours postpartum weighed.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Nellore 2006	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Methods of evaluating blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Ng 2001	Randomisation based on a table of computer-generated blocks of	Consecutively-numbered opaque sealed envelopes.	"This was not a double-blinded study".	Assessors were not blinded to treatment allocations.	Investigators appraised blood loss by the estimation of attending physicians.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	random numbers.								
Ng 2004	Sequence generation was not reported.	Allocation concealment was not reported.	Double - Blinding of personnel and participants (placebo use) but insufficient details from abstract only.	Assessor blinding was not reported.	Methods of evaluating blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Ng 2007	The randomisation was based on a table of computer-generated random numbers.	Used consecutively-numbered and sealed opaque packages.	"The placebo was identical in size and colour but had a different shape to the misoprostol tablet. All women were asked to swallow the tablets directly from the opaque cup without looking at them. The identity of the active medication and placebo were concealed from the caregivers and the parturient."	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by the estimation of attending physicians.	"5 women were excluded from the analysis because of missing post-delivery haemoglobin level".	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of tachycardia and dizziness were omitted).	Those who withdrew from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.
Nihar 2022	Sequence generation not reported	Allocation concealment was not reported	Blinding (of study participants and caregivers) was not reported	Assessor blinding was not reported	Blood loss in ml was measured through separate suctioning	The study authors did not mention any incomplete outcome data	The protocol of the study was unavailable for verification.	Analysis is assumed to be intention to treat	Source(s) of funding for the study were not reported.
Nirmala 2009	Computer-generated randomisation.	Used sealed, sequentially-numbered envelopes.	"The preparation and administration of the medication was carried out by midwives who were not involved in the	Assessor blinding was not reported.	Investigators appraised blood loss by "the gravimetric method" from immediately after drug administration. They used a digital scale (Soehnle, Venezia) for weight measurement. In order to	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
			management of the patient except for the drug administration".		minimise confounding by fluid absorbed into drapes, they collected blood with a new plastic sheet placed under the mother after delivery of the baby. They also weighed any gauzes, tampons and pads used in the first hour after delivery of the placenta, and subtracted the dry weights of these materials to calculate blood loss on the basis that 1 g is equivalent to 1 mL.				
Nordstrom 1997	Computer-generated randomisation.	Ampoules were prepared at the hospital pharmacy and consecutively-numbered.	"The content of the ampoules was unknown to mothers, midwives and doctors until the study was completed".	Assessors were blinded to treatment allocations.	"Investigators appraised blood loss "by measuring collected blood and adding what was estimated to have been absorbed by surgical cloths and tissues".	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the County Council and County Health Authority Research and Development Foundation in the County of Jämtland, Sweden (public funding).
Nuamsiri 2016	Random allocation scheme using a computer-generated list of numbers.	Used sealed and consecutively numbered opaque envelopes were prepared by a research assistant not involved in the study. The women were randomly allocated to	The study drug and placebo were prepared by the research assistant not involved in the study. The obstetrician and nursing staff were all blinded to the type of injectable substance.	The study drug and placebo were prepared by the research assistant not involved in the study. The obstetrician and nursing staff were all blinded to the type of	Used the blood collection drape, which was placed under the buttocks after placental delivery. Blood-soaked swabs were weighed in grams, and the known dry weight of the swabs was subtracted, this volume was added to the measured blood volume from the drape (assuming an equivalence of 1 g to 1 ml).	Data were collected completely from all randomised study participants.	The study report matches the study protocol that was registered retrospectively (TCTR20150820001).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
		one of the two study groups by opening the next available envelope just before delivery.		injectable substance.					
Oboro 2003	Generated by using random tables.	Pharmacy prepared opaque sealed sequentially-numbered packets.	"The identity of the active medication and placebo were concealed from the caregivers and parturients".	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by the estimation of attending obstetricians.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Ogunbode 1979	Restricted random allocation.	Used sealed sequentially-numbered envelopes.	"The identity of the various drugs was not known to the investigators until after completion of the trial".	Assessor blinding was not reported.	Investigators appraised blood loss by collection in a dish pressed against the vulva for 3 minutes: the contents were carefully measured.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from Sandoz.
Orji 2008	Sequence generation was not reported.	Allocation was done by sealed sequentially-numbered envelopes.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised blood loss by "using a pre-weighed gauze that was weighed again after delivery".	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of transfusion and PPH ≥ 1000 mL were omitted).	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
Ortiz-Gomez 2013	Computer-generated sequence.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Investigators appraised blood loss by the estimation of delivery attendants, but blood loss data were not reported in a format that could be extracted for the purpose of this review.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Othman 2016	Randomization was done using a computer-generated random table.	"Allocation concealment was done using serially numbered closed opaque envelopes. Each envelope was labelled with a serial number and had a card noting the intervention type inside. Allocation was never changed after opening the envelopes."	Not blinded.	Assessor blinding was not reported.	"The volume of blood loss during caesarean delivery and 2 hours postoperatively was assessed. Total blood loss during caesarean delivery was measured by adding the volume of the suction bottle with the blood soaked sponges (know dry weight). Blood loss 2 hours after caesarean delivery was measured by using blood collection drape. The whole blood loss was estimated by adding the blood in the suction bottle, blood soaked sponges and blood collection drape."	120 women were randomised in the study, but 10 were excluded from the analysis from the oxytocin group after randomisation.	The study report matches the study protocol that was registered prospectively (NCT02562300).	Those who were excluded from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.
Otoide 2020	Randomised via computer generated random numbers. Eligible women were requested to randomly	The identity of the packs was revealed only on completion of the project.	The patient was blinded as the treatment packs both contained four powdered tablets and a syringe and needle containing 2 ml of sterile	The outcome assessor was blinded as the treatment packs both contained four	Blood was collected in a bedpan at delivery and continued for at least 2 hours after delivery in the labour ward. The estimated blood loss was the sum of the measured blood loss and	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	Intention to treat analysis	The study did not receive any funding

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	select from a pool of random numbers. Each number was matched with similarly numbered sealed treatment packs containing pre-packaged mixtures.		solution and were identical in shape, colour, and weight.	powdered tablets and a syringe and needle containing 2 ml of sterile solution and were identical in shape, colour, and weight.	visual estimation of the soaked pads and beddings				
Ottun 2021	Sequence generation unclear - randomly assigned (1:1)	The identical misoprostol and matched Vitamin C tablets were packaged by a designated hospital pharmacist who had no role in the study. A list of the numbers on the packs with their medications was kept by the pharmacist and was not made available until the	The patient was blinded as the misoprostol and matched Vitamin C tablets were identical and packaged by a designated hospital pharmacist who had no role in the study.	The outcome assessor was blinded as the misoprostol and matched Vitamin C tablets were identical and packaged by a designated hospital pharmacist who had no role in the study.	Blood loss was measured from the time of delivery of the baby until 1h after completion of the third stage of labour. A modified non-absorbent blood collection drape was placed under the patient's buttocks with a lower pouch serving as receptacle for blood. All pads were supplied by the researcher and were weighed.	14 women were not included in the analysis as they did not receive the intervention	The study report matches the study protocol that was registered ClinicalTrials.gov (NCT02424201)	Intention to treat analysis	The study did not receive any funding

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
		conclusion of the study.							
Owoni koko 2011	Allocation sequence was developed by a statistician who was not otherwise involved with the study using computer-generated table of random numbers and varied permutated blocks.	Used sealed, opaque envelopes.	"The anaesthetist was blind to the allocation until he opened each participant's envelope at surgery. The obstetricians were unaware of what oxytocic was given as the faces of the patients were screened off during the surgery".	"The obstetricians were unaware of what oxytocic was given as the faces of the patients were screened off during the surgery".	Investigators appraised blood loss by collection in a suction bottle, and by weighing delivery drapes and gauzes on the basis that 1 g is equivalent to 1 mL of blood. "Both the surgeon and anaesthetist estimated blood loss independently. The scrub nurse weighed the drapes and gauze before and after the operation, noted the amount of blood in the suction bottle, and recorded these. The postoperative care nurse also recorded the blood loss during the first 4 hours after surgery". Finally a research assistant (not part of the medical team) calculated the mean estimated blood loss from all these values.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Paknia t 2015	Sequence generation was not reported.	Allocation concealment was not reported.	The study is stated to be double-blinded but blinding (of study participants and caregivers) was unclear. The study used dummy infusion and tablets but there was no mention of a dummy for the intravenous bolus that one of the groups received. There is insufficient detail reported to decide	Assessor blinding was not reported.	The volume of blood in the suction bottle and blood-soaked sponges was measured.	Data were collected completely from all randomised study participants.	The study report matches the study protocol that was registered prospectively (NCT01571323).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
			on the adequacy of the blinding.						
Parsons 2006	Computer-generated allocation.	Used sequentially-numbered, opaque, sealed envelopes.	"We acknowledge that unblinding for some participants was possible because the envelopes for women who were initially randomised but who subsequently underwent caesarean section were returned and used for the next women enrolled".	Assessor blinding was not reported.	Investigators appraised blood loss by the estimation of attending physicians and midwives.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from Matercare International and the Society of Obstetricians and Gynaecologists of Canada (public funding).
Parsons 2007	Sequence generation was not reported.	Used sequentially-numbered, opaque, sealed envelopes.	"Unblinding for some participants was possible because the envelopes for women who were initially randomised but who subsequently underwent caesarean section were returned and used for the next women enrolled".	Assessor blinding was not reported.	Investigators appraised blood loss by the estimation of attending physicians and midwives.	Estimated blood loss data were unavailable in 9 cases (misoprostol 7; oxytocin 2) and haemoglobin measurements (misoprostol 4; oxytocin 6) were unavailable in 10 cases.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from Matercare International and the Society of Obstetricians and Gynaecologists of Canada (public funding).
Patil 2013	Using a computer generated randomization table, randomization of the study subjects was done.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Once the active bleeding stopped, collected blood was weighed. Swabs and pads used during 3rd stage were not counted for blood loss, but were kept to minimum of <3.	200 women were randomised in the study, but 2 were excluded because of third degree perineal tear (n=1) and adherent placenta (n=1)	The protocol of the study was unavailable for verification.	Those who were excluded from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
						after randomisation.			
Patil 2016	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	The blood loss during third stage of labour and the immediate postpartum period (1 hour after delivery) was estimated quantitatively using Brasss V Drape.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Penaranda 2002	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised blood loss from cord clamping until 1 hour after delivery.	3 women were excluded from the analysis after entering the study because of liquor contamination during blood collection.	The protocol of the study was unavailable for verification.	Not all study participants were included in the analysis.	Source(s) of funding for the study were not reported.
Perez-Rumbos 2017	The numbers for the assignment to each treatment group were generated with a table of random numbers.	A sealed system was used that contained the location of each patient to the treatment groups. The envelopes were opened at the beginning of each treatment.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	The blood lost was collected in a calibrated and all the gauzes used were weighed.	500 women were randomised in the study, but 108 were excluded because of missing data after randomisation.	The protocol of the study was unavailable for verification.	Those who were excluded from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.
Poeschmann 1991	Randomisation was within blocks	Allocated identical numbered	A nurse not involved with the delivery room	Blinded.	Blood loss was calculated by measuring the amount of blood and clots collected in the	77 women were randomised in the study, but 3	The protocol of the study was	Those who were excluded from the study after	Sulprostone was supplied by Schering without

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	of 10 but the sequence generation method was not reported.	boxes containing trial medications.	prepared the injections.		bedpan and by weighing the bloodstained swabs and linen obtained for 1hr postpartum.	were excluded because of induction of labour (n=2) and instrumental delivery (n=1) after randomisation.	unavailable for verification.	randomisation were not included in the analysis.	charge but no other funding sources are reported.
Prendiville 1988	Sequence generation was not reported.	Used sequentially-numbered, opaque, sealed envelopes.	Study participants and caregivers were not blinded to treatment allocations.	Assessor blinding was not reported.	Investigators appraised blood loss by the estimation of attending physicians.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the South Western Regional Health Authority of the United Kingdom (public funding).
Quibel 2016	An independent, centralized, computer-generated randomisation sequence (Clean-Web; Télémedecine Technologies, Boulogne, France) was used for this allocation based on a randomisation list established by an independent statistician according to a permuted block method	To conceal allocation, treatment boxes were sealed and numbered sequentially according to the randomisation sequence and were stored in the predelivery unit of each maternity ward.	"The placebo tablets were provided by the pharmacy of the Assistance Publique-Hôpitaux de Paris. They were identical to misoprostol tablets in colour but their shape was slightly different. Therefore, the treatment was administered by a research midwife who did not otherwise participate in this trial, to maintain the treatment blind of patients and staff, before or after randomisation."	"The placebo tablets were provided by the pharmacy of the Assistance Publique-Hôpitaux de Paris. They were identical to misoprostol tablets in colour but their shape was slightly different. Therefore, the treatment was administered by a research	"Blood loss was collected into a calibrated plastic bag placed under the mother's pelvis. The transparent, graduated bag allowed continuous monitoring of blood loss and was maintained in place for at least 2 hours after the neonate's delivery. It did not require sterilization and could be used in a dorsal, lateral, or lithotomy position. Blood from blood-soaked gauze swabs was also transferred into the plastic bag."	1721 women were randomised in the study, but 118 were excluded because of caesarean during labour (n=113) and withdrawals from the study (n=5) after randomisation.	The study report matches the study protocol that was registered prospectively (NCT01113229).	Those who were excluded from the study after randomisation were not included in the analysis.	Supported by a grant from Programme Hospitalier de Recherche Clinique Clinique—PHRC 2009 (Ministère de la Santé N° AOR 09010).

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	balanced and stratified by center.			midwife who did not otherwise participate in this trial, to maintain the treatment blind of patients and staff, before or after randomisation."					
Rajaei 2014	Allocation using simple randomisation with computer-generated numbers in 1:1 ratio.	Allocation concealment was not reported.	The study was "double-blind": "for blinding the study, identical-appearing solutions and tablets corresponding to the two pharmacological groups were prepared by the pharmacy and kept in the fridge until required".	Assessors were blinded to treatment allocations.	Investigators appraised blood loss during the first hour after delivery, by collection with pads weighed before and after absorbance of blood.	The study authors did not mention any incomplete outcome data.	The study protocol was registered (ClinicalTrials.gov NCT01863706) but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of diarrhoea, nausea and vomiting were not completely reported). Moreover, the study publication reports outcomes (hypotension, nausea, transfusion) not listed in the	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the Hormozgan University of Medical Sciences (the institution of the authors).

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
							registered protocol.		
Ramirez 2001	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Methods of evaluating blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Rashid 2009	Computer-generated random sequence of numbers.	Used sequentially-numbered, sealed envelopes.	Study participants and caregivers were not blinded to treatment allocations.	Assessors were not blinded to treatment allocations.	Investigators appraised blood loss "clinically in a standard way" by collection with a plastic sheet that was subsequently drained (with clots) into a graduated measuring jug, and by weighing swabs and towels. "Any delayed haemorrhage within 24 hours after delivery was calculated".	Outcome data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of requirement for additional syntometrine [ergometrine plus oxytocin] were omitted).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Ray 2001	Sequence generation was not reported.	Allocation concealment was not reported.	Study participants and caregivers were blinded to treatment allocations.	Assessor blinding was not reported.	Investigators appraised blood loss in the first 2 hours after delivery of the placenta, by "clinical estimation". However, blood loss data were not reported in a format that could be extracted for the purpose of this review.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
							results in the study report.		
Reddy 2001	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Methods of evaluating blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Reyes 2011	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Methods of appraising blood loss were not reported.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of PPH were omitted).	Not all study participants were included in the analysis.	Ferring Pharmaceuticals donated carbetocin. No other external funding was required for the study.
Reyes, Gonzalez 2011	Computer-generated code.	Used opaque, sealed envelopes.	The study was "double-blind": "because the two drugs are administered differently, a double dummy system for administration was used".	Assessors were blinded to treatment allocations.	Methods of appraising blood loss were not reported.	2 women were excluded from the study analysis after randomisation ("1 given drug before expulsion of placenta; 1 ampoule of the drug broken before use").	The protocol of the study was unavailable for verification.	Those who withdrew from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.
Rogers 1998	The randomisation schedule used variably	Used sequentially-numbered, opaque,	Study participants and caregivers were not blinded to treatment allocations.	Assessors were not blinded to treatment allocations.	Investigators appraised blood loss by the estimation of attending midwives.	Blood loss data were collected completely from all randomised	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups	The study was supported by funding from the Public Health and Operational

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	sized balanced blocks, and the randomisation envelopes were prepared in advance in the National Perinatal Epidemiology Unit (NEPU).	sealed envelopes.				study participants.		to which they were randomised.	Research Committee of the Anglia and Oxford Regional Health Authority, United Kingdom (public funding).
Rossel and 2013	A computer-generated list of random numbers was used. The block size varied between six and nine. Stratified randomization with two strata, body mass index less than 30 and body mass index of 30 or more.	Used sequentially-numbered, opaque, sealed envelopes.	The study was "double-blinded": "to maintain blinding of the participants and investigators, the test medicine was delivered to the Department of Anaesthesiology in 10 mL syringes containing 5 mL of solution marked only with trial identification and randomisation numbers. The 10-ml syringes with the test medicines were prepared by a staff anaesthesiologist, who was otherwise uninvolved in the study.	Assessors were blinded to treatment allocations.	Investigators appraised blood loss with the following formula: (0.75 x height in inches x 50) + (weight in pounds x 50) x ((predelivery haematocrit measurement - postdelivery haematocrit measurement) / predelivery haematocrit measurement).	Data were collected completely from all randomised study participants.	The study report matches the study protocol that was registered (ClinicalTrials.gov NCT00977769).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from Ferring Pharmaceuticals.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
Sadiq 2011	Random assignments generated by dice-box.	Allocation concealment was not reported.	Study participants and caregivers were not blinded to treatment allocations.	Assessor blinding was not reported.	Investigators appraised blood loss at delivery by collection with pre-calibrated kidney dishes.	"46 of the administered questionnaires were invalidated leaving a total of 1819 valid questionnaires (912 for oxytocin and 907 for misoprostol). The data were further reduced through a process of computer randomisation so as to have equal study populations."	The protocol of the study was unavailable for verification.	Not all study participants were included in the analysis.	The study was supported by funding from the University of Maiduguri Teaching Hospital. Study medications were donated by Emzor Pharmaceutical Industries.
Samimi 2013	Randomisation was performed using a random number table.	Allocation concealment was not reported.	"Patients and medical personnel were blinded to the type of drug".	Assessors were blinded to treatment allocations.	Methods of appraising blood loss were not reported.	At 24 hours postpartum, blood samples could not be collected from 16 women (9 in the carbetocin group and 7 in the ergometrine plus oxytocin group).	The study report matches the study protocol that was registered (Iranian registry of clinical trials number 138810212854N2).	The authors excluded 16 study participants from the analysis because postpartum haemoglobin measurements were not available.	The study was supported by funding from the Kashan University of Medical Sciences (the institution of the authors).
Shady 2017	A statistician prepared computer-generated randomization tables.	Investigators placed the allocation data in serially numbered closed opaque envelopes. Each envelope had a card	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Immediately after delivery of the baby, and after liquor drainage, the patient was placed over a blood drape of known weight and a graduated container was placed under the delivery bed to collect blood. The amount of blood collected in the blood drape was measured. Then the patient was given pre-weighed	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
		noting the intervention type inside. The envelopes were opened only by the principal investigator administering the study medications according to the order of attendance of women.			pads, which were weighed 4 hours post-partum.				
Shady 2019	A statistician prepared computer-generated randomisation tables and placed the allocation data in serially numbered closed opaque envelopes.	The envelopes were opened only by the principal investigator administering the study medications according to the order of attendance of women	Blinding was not possible as the routes of administration were different	Assessor blinding was not reported	The blood loss was measured by measuring the blood collected in the drape and by weighing the pads before and after delivery.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	Analysis is assumed to be intention to treat	Source(s) of funding for the study were not reported.
Shaheen 2019	two drug randomisation table form randomisation.com	drugs were placed in numbered envelopes according to the generated table	Blinding (of study participants and caregivers) was not reported	Assessor blinding was not reported	Methods of evaluating blood loss were not reported.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	Analysis is assumed to be intention to treat. 12 women were excluded due to incomplete responses. Don't appear to have taken part	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
Shrestha 2011	Randomly allocated as per the lottery technique.	Allocation concealment was not reported.	Study participants and caregivers were not blinded to treatment allocations.	Assessor blinding was not reported.	Investigators appraised blood loss in the 48 hours postpartum, by collection with pre-weighed sterile pads and a calibrated bucket. All the soaked drapes and pads were weighed and the dry weights of these materials were subtracted to calculate blood loss on the basis that 1 g is equivalent to 1 mL.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Singh 2009	The drug packets were sealed and coded using a computer-generated random number chart by the same individual.	Used sealed drug packets.	The study was "double-blind": active treatments and placebo treatments were "identical" and investigators were "thus blinded".	Assessors were blinded to treatment allocations.	Investigators removed any linen soiled with amniotic fluid, and placed a disposable and absorbent pre-weighed linen saver sheet with a pre-weighed polythene bag under the mother to collect blood from the uterine cavity. Any blood clots were expressed from the vagina into the polythene bag, which was then removed and weighed. A fresh pre-weighed sanitary napkin was applied. Separate swabs were not included in the final calculation (addition of the various gravimetric measurements), that was performed 1 hour after delivery. "The specific gravity of blood being 1.08, the amount of blood lost in mL was equal to the weight in grams".	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (changes in haemoglobin measurements were unspecified beyond textual summary that "all groups showed a slight decrease in mean haemoglobin concentration 24 hours postpartum [maximum decrease of 0.6 g/dL]; however, the difference was not	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
							significant [ANOVA, P > 0.05]").		
Sitaula 2017	Computer generated random table.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Methods of evaluating blood loss were objective involved weighing the swabs but also visual estimation "fist full of clot was 500 ml" .	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Soltan 2007	Randomisation was computer-generated.	Used opaque, closed envelopes.	Study participants and caregivers were not blinded to treatment allocations.	Assessor blinding was not reported.	Investigators appraised blood loss by collection with a graduated plastic bag, and by weighing towels, linen and gauzes.	"144 women were excluded from analysis because they were exposed to trauma to the perineum, vagina or cervix during labour and had traumatic excessive bleeding".	The protocol of the study was unavailable for verification.	Not all study participants were included in the analysis.	Source(s) of funding for the study were not reported.
Sood 2012	Randomisation was by computer-generated random numbers.	Used sequentially-numbered, opaque, sealed envelopes made at pharmacy.	Study participants and caregivers were blinded to treatment allocations.	Assessors were blinded to treatment allocations.	Investigators appraised intraoperative blood loss by collection with suction apparatus and sterile drapes before irrigation, and by evaluating the blood in abdominal swabs and gauzes.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Stanton 2013	The 52 CHOs were randomly allocated equally to either the intervention or the	Allocation concealment was not reported but less of an issue in cluster	"The random allocation was not masked".	Assessors were not blinded to treatment allocations.	Investigators appraised postpartum blood loss by collection with a BRASS-V calibrated plastic drape placed under the mother, who was asked to remain recumbent for 1 hour following delivery of the baby, or for 2 hours if active	"7 and 9 enrolled women in the oxytocin and control arms, respectively, lacked a blood-loss measure".	The study report matches the study protocol that was registered (ClinicalTrials.gov NCT01108289).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the Bill and Melinda Gates Foundation (public funding).

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	control group; this allocation was stratified by both district and distance (#10 km or .10 km) to emergency obstetric care. The randomisation sequence was determined using Stata (version 12)	randomised trials.			bleeding persisted. "Fluids, urine, and faeces were excluded from the blood loss measure by sweeping them to the side and into a receptacle".				
Su 2009	Randomisation was blocked and stratified by parity. The randomisation list with the allocation of the mode of intervention was forwarded from the Biostatistics Unit to the Department of Pharmacy at National University Hospital, where the purchased	Used opaque packages made at pharmacy.	"The identities of the medications were not known to the midwives, obstetricians and the participants. The medication codes were only broken following completion of the trial".	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by the visual estimation of attending obstetricians and midwives.	Data were collected completely from all randomised study participants.	The study protocol was registered 2 years after beginning recruitment (ClinicalTrial.gov NCT00499005).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the National Healthcare Group of Singapore (public funding).

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	medications were kept.								
Sultana 2007	Sequence generation was not reported.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Investigators appraised blood loss by the estimation of attending physicians after collection in a plastic bowl.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Supe 2016	Randomisation was carried out by using a randomization table.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	The blood and blood clots in the kidney tray were weighed. A plastic pouch was placed under the buttocks prior to the delivery. The blood lost was collected in this pouch. After the delivery of the placenta, the content of the pouch was transferred to a graduated jar.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Funding was not required.
Surbeck 1999	Generated by random tables.	Randomisation performed by pharmacy.	The study was "double-masked": "for proper masking, the study drugs were prepared by the hospital pharmacy as three identical gelatine capsules".	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by the estimation of attending physicians.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Sweed 2018	The recruited women were randomised using computer generated list in a 1:1:1 ratio using	636 sealed envelopes were prepared according to the computer generated list and the	Investigators, care providers, and outcome assessors were masked	Investigators, care providers, and outcome assessors were masked - codes were	The surgical towels were weighed (g) with its wrapping before and after the operation using a highly accurate digital balance and the difference in weight between dry and soaked linen towels was calculated. Blood loss was estimated accordingly: volume	Data were collected completely from all randomised study participants.	The study report matches the study protocol that was registered ClinicalTrials.gov (NCT02083107).	Analysis is assumed to be intention to treat	The study did not receive any funding

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	random block size of four, into three groups	codes were not broken until the end of the study and after the data were tabulated and analysed		not broken until the end of the study and after the data were tabulated and analysed	of the contents of the suction bottle (ml) (A), weight difference of linen towels (g) (B) [weight of soaked linen towels (g) − weight of dry linen towels (g)], AFV (ml) (C). Therefore, blood loss during operation (ml)=(A +B) − C				
Taheripanah 2017	Described as block randomisation.	Selection and randomisation of the patients were performed by a coordinating nurse, using a series of sequentially numbered sealed envelopes; therefore, the sequence of allocation was hidden.	The authors state "The women and practitioners were not aware of the type of intervention" but blinding (of study participants and caregivers) was unclear as it is not described in sufficient detail.	Assessor blinding was not reported.	Methods of evaluating blood loss were not reported.	Data were collected completely from all randomised study participants.	The protocol of the study was registered retrospectively (NCT02079558).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Tewatia 2014	Computer-generated random number sequence.	Used sequentially-numbered, opaque envelopes.	"Due to [the] nature of administration of the drugs, [the] patient or clinical care team could not be blinded. However, [the] statistician was unaware of the group allocation".	Assessor blinding was not reported.	Investigators removed any linen soiled with amniotic fluid, and placed a calibrated plastic bag under the mother to collect blood from the uterine cavity. After delivery of the placenta, a pre-weighed pad was placed high up in vagina until 1 hour afterwards. In cases of episiotomy, a separate pad was applied to the episiotomy site, and the	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
					fluid collected by this pad was not included in blood loss measurements.				
Thilaganathan 1993	Randomly allocated using standard randomisation tables.	Allocation concealment was not reported.	Study participants and caregivers were not blinded to treatment allocations.	Assessor blinding was not reported.	Investigators appraised blood loss by the estimation of attending physicians.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was conducted without external funding.
Ugwu 2014	Generated by random tables	Used sequentially-numbered, opaque envelopes	"There were no look-alike placebo tablets for women who had oxytocin alone but the fact that no member of the obstetric team had knowledge of which agent the patient received, is expected to ensure allocation concealment. In addition, there was incomplete blinding of the anaesthetist, although this was not likely to affect the study outcome, since the anaesthetist ' sestimated blood loss was not used."	"There were no look-alike placebo tablets for women who had oxytocin alone but the fact that no member of the obstetric team had knowledge of which agent the patient received, is expected to ensure allocation concealment . In addition, there was incomplete blinding of the anaesthetist, although this was not likely to affect the study	Investigators appraised intraoperative and postoperative blood loss by collection in a suction bottle. Furthermore, soiled drapes, abdominal packs and pieces of gauze were weighed and the known dry weights subtracted. Finally, vulva pads applied during the 4 hours post-operation, were also weighed and the known dry weights subtracted. Measurements obtained by these 3 methods were added together. Weight measurements were performed with a weighing scale made in China, of total weighing capacity of 5 kg and graduations of 0.25 g. Investigators considered that 1 g is equivalent to 1 mL of blood.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification, but not all of the outcomes projected by methodological descriptions were reported as results in the study report (cases of nausea, vomiting, diarrhoea, headaches, fatigue, dizziness, chills, flatulence and abdominal pain were omitted).	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
				outcome, since the anaesthetist ' sestimated blood loss was not used."					
Tripti 2006	Randomisation was done using random number tables.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	Blood loss was estimated by blood and blood clots collected in the kidney tray and adding the difference in the weight of the drapes before use and after delivery.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Un Nisa 2012	Study participants (patients) were divided by lottery system in the two groups, each group comprising of 50 patients.	Allocation concealment was not reported.	Study participants and caregivers were not blinded to treatment allocations.	Assessor blinding was not reported.	Investigators appraised blood loss after the delivery of baby "by squeezing the soaked pads and quantifying the amount of blood clots in a kidney tray of standard size to be equal to 500 mL".	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Uncu 2015	Generated by random tables.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	Methods of appraising blood loss were not reported.	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Vagge 2014	Used simple random sampling.	Allocation concealment was not reported.	Study participants and caregivers were not blinded to treatment allocations.	Assessor blinding was not reported.	Methods of appraising blood loss were not reported.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
								analysis, in the groups to which they were randomised.	
Vaid 2009	Allocation by a computer-generated random number.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was unclear.	Assessor blinding was not reported.	After the drainage of amniotic fluid, investigators appraised blood loss by collection with a sterile calibrated BRASS-V drape placed under the mother. The drape remained in placed for 1 hour. Furthermore, "blood loss in gauze pieces was calculated by subtracting the weight of dry gauze from the weight of blood-soaked gauze pieces".	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Van Der Nelson 2021	A computer-generated drug allocation sequence was created by an independent statistician, with an assignment ratio of 1:1:1 and block size of nine, stratified by site	Allocation concealment was not reported	all uterotonics were in identical ampoules and blinded by snapper tops and opaque labels with boxes labelled according to allocation sequence	All clinical staff (outcome assessors), researchers and participants remained blinded until data lock after study closure.	Methods of evaluating blood loss were not reported	Data were collected from nearly all randomised study participants.	The protocol of the study was unavailable for verification.	modified intention to treat and per protocol	Source(s) of funding for the study were not reported.
van Selm 1995	Sequence generation was not reported.	Assignment to pharmacy coded boxes occurred, after informed consent, in first stage labour.	Double - Blinding of personnel and participants (placebo use).	Double - Blinding of personnel and participants (placebo use).	Measured the blood and clots by collecting and weighing the blood stained linen and pads.	81 women were randomised in the study, but 12 were excluded because of exclusion criteria all in the ergometrine plus oxytocin group	The protocol of the study was unavailable for verification.	Those who were excluded from the study after randomisation were not included in the analysis.	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
						after randomisation.			
Verma 2006	Sequence generation was not reported.	Allocation concealment was not reported.	The study was "double-blind": active treatments and placebo treatments were "identical-looking".	Assessors were blinded to treatment allocations.	Investigators appraised blood loss "accurately with a specially designed calibrated blood collection drape (BRASS-V drape)".	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	It was unclear from the study report whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were unclear.
Vimala 2004	Generated by random tables.	Used sequentially-numbered, opaque, sealed envelopes.	Treatments were administered via different routes and the authors did not report any double dummy.	Assessor blinding was not reported.	Investigators appraised blood loss by the estimation of attending nurses and obstetricians. After delivery of the baby, amniotic fluid was allowed to drain away, and amniotic fluid-soaked bed linens were covered with dry disposable 'linen-savers'. A wedge-shaped plastic bedpan was placed under the mother for 1 hour. Blood and clots from the bedpan were decanted into a measuring cylinder and measured. Blood-soaked swabs and linen-savers were weighed; the known dry weights were subtracted, for the weight of blood contained within them to be added to the value indicated by the measuring cylinder.	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	Source(s) of funding for the study were not reported.
Vimala 2006	Computer-generated random number.	Used opaque, sealed envelopes.	Study participants and caregivers were not blinded to treatment allocations.	Assessor blinding was not reported.	Investigators appraised blood loss intraoperatively and in the first hour postoperatively "in a standard manner". They measured the volume of blood in the suction bottle, and weighed blood-soaked	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from the Division of Reproductive Health and Nutrition, Indian

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
					sponges and linen savers. Then they added the difference between dry and blood-soaked weights of sponges and linen savers, to the volume measured in the suction bottle.				Council of Medical Research (public funding).
Walley 2000	Computer-generated random numbers.	Used sequentially-numbered, opaque packets made by administrative staff.	"The identity of the placebo and active medications were concealed from caregivers and participants".	Assessors were blinded to treatment allocations.	Investigators appraised blood loss by the estimation of attending physicians.	Of those women randomised, blood loss measurements were unavailable in 3 cases, and postpartum haemoglobin samples were unavailable in 9 cases.	The protocol of the study was unavailable for verification.	All those who were enrolled and randomly allocated to treatment were included in the analysis, in the groups to which they were randomised.	The study was supported by funding from MaterCare International and the Canadian International Development Agency (public funding).
Whigham 2016	Computer-generated randomisation at pharmacy level and none of the operating or anaesthetic doctors will have access to this.	Randomisation performed by pharmacy.	Pharmacy used a study label, which included study title, number and expiry date to cover the trade label. Patients, anaesthetists and operating obstetricians were blinded to the intervention drug. These ampoules were stocked in the emergency theatre fridge in boxes labelled only with the matching study label.	Assessors were blinded to treatment allocations.	Investigators appraised intra-operative blood loss by the estimation of attending physicians. Excess blood was collected in measuring container by suction, and weighed together with any swabs soaked in blood.	114 women were randomised in the study, but 10 were excluded because they had a general anaesthetic (n=2) or ampoules discarded (n=8) after randomisation.	The study report matches the study protocol that was registered prospectively (ACTRN 12612000466842).	Those who were excluded from the study after randomisation were not included in the analysis.	This project was awarded the Peninsula Health Grant for Health Research.
Widmer 2018	The random allocation sequence	Both HS carbetocin and oxytocin	The ampoules, trial packs and dispensers were	Blinded.	Once the cord was clamped and cut, a blood collection plastic drape (BRASSS-V™)	Data were collected completely from	The study report matches the study protocol	All those who were enrolled and randomly allocated to treatment	The research in this publication was supported

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
	was generated at WHO using computer-generated random numbers. Randomization was stratified by country using permuted blocks of size ten, with an allocation ratio 1:1.	were in 1 ml ampoules in consecutively numbered treatment packs arranged in dispensers. Allocation was by opening the consecutively numbered treatment pack in the dispenser.	identical in shape, size and weight ensuring that investigators were blinded to individual treatment allocation. Although carbetocin was heat stable and did not require cold storage we kept the dispensers in cold storage (2-8ºC) to give oxytocin maximum efficacy and maintain double-blinding.		was placed under the woman's buttocks. The blood was collected for one hour, or two hours if the bleeding continued beyond one hour. The drape with the blood was then weighed by a digital scale, the weight recorded in grams and then converted to volume (ml) at the analysis stage.	all randomised study participants.	that was registered prospectively (Trial registration: HRP Trial A65870; UTN U1111-1162-8519; ACTRN12614000870651; CTRI/2016/05/006969, EUDRACT 2014-004445-26).	were included in the analysis, in the groups to which they were randomised.	by funding from MSD, through its MSD for Mothers Program. MSD for Mothers is an initiative of Merck & Co., Inc., Kenilworth, N.J., U.S.A. . The funder had no commercial interest in the investigational drug, no influence on the protocol, the statistical analysis plan and the final manuscript; the funder could provide comments, but there was no obligation on the trial team to accept any. The HS carbetocin was provided by Ferring International Center S.A. (Saint Prex, Switzerland) and oxytocin by Novartis (Basel, Switzerland) free of charge. Neither company had any influence on any of the trial

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
									documents or processes.
Yesmin 2022	randomised by lottery method using different coloured cards in sealed envelopes.	Allocation concealment was not reported	Blinding (of study participants and caregivers) was not reported	Assessor blinding was not reported	Blood loss were estimated by visual estimation, measuring collected fluid/blood in suction container before and after delivery of the placenta and weight of all blood soaked materials and clots. Calculated by(wet item in gram wt-dry item in gram wt=blood loss in gram wt.1gram wt=1ml blood loss)6	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	Analysis is assumed to be intention to treat	Source(s) of funding for the study were not reported.
Yuen 1995	Used computer-generated random numbers.	Used sequentially-numbered, opaque envelopes.	"When a patient entered the study, a nursing officer who was not involved in the management of the patient drew up the indicated medication and handed this to the patient's attendants". Study participants and caregivers were thus blinded to treatment allocations until the codes were revealed after all data were collected in the study.	Assessors were blinded to treatment allocations.	Investigators appraised blood loss during delivery "by measuring the amount of blood clots and weighing the towels used".	"9 [randomised participants] were excluded: 3 had a twin pregnancy, 1 had blood transfusion during labour, and the other 5 had unavailable records".	The protocol of the study was unavailable for verification.	Not all study participants were included in the analysis.	Source(s) of funding for the study were not reported.
Zachariah 2006	Used computer-generated random numbers.	Allocation concealment was not reported.	Blinding (of study participants and caregivers) was not reported.	Assessor blinding was not reported.	After the drainage of amniotic fluid, investigators appraised blood loss by collection with a large sterile plastic bag placed under the mother until she was transferred to the postnatal	The study authors did not mention any incomplete outcome data.	The protocol of the study was unavailable for verification.	The authors did not specify whether all those who were enrolled and randomly allocated to treatment were included in the	Source(s) of funding for the study were not reported.

Study	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of participants and personnel (performance bias)	Blinding of outcome assessment (detection bias)	Objective assessment of blood loss	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)	Intention to treat analysis	Funding Source
					department. The blood collected in the plastic bag was then transferred to a measuring jar. Mops were not used in the labour room, and gauze pieces were counted.			analysis, in the groups to which they were randomised.	
Zgaya 2020	randomization was done by computer and the result is marked on a card kept by a third person.	Allocation concealment was not reported	Blinding (of study participants and caregivers) was not reported	Assessor blinding was not reported	Methods of evaluating blood loss were not reported	Data were collected completely from all randomised study participants.	The protocol of the study was unavailable for verification.	Analysis is assumed to be intention to treat	Source(s) of funding for the study were not reported.
Al Zubaidi 2022	Sequence generation was not reported.	Allocation concealment was not reported.	Operating obstetricians, care givers, and investigators were blinded. Ampules, trial packs and dispensers were identical in shape and size and weight.	Outcome assessors were blinded.	Blood was collected using suction and weighed. Blood soak drapes and swabs were also collected and weighed.	The study authors did not mention any incomplete outcome data	Study reported outcomes as reported in the protocol.		Source(s) of funding for the study were not reported

D3 – Postpartum haemorrhage ≥1000mL

Table 3: Evidence table for postpartum haemorrhage ≥1000mL

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Abdel-Aleem 2010	both high and low risk; vaginal delivery	Oxytocin ; 10 IU; Intramuscularly	4	1291	Placebo or control; ; (Control)	4	659	NA	NA	NA	NA	NA	NA
Acharya 2001	high risk; elective caesarean section	Oxytocin ; 10 IU; by an intravenous bolus	1	30	Misoprostol; 400 mcg; orally	1	30	NA	NA	NA	NA	NA	NA
Adanikin 2012	high risk; elective caesarean section	Oxytocin ; 25 IU; by an intravenous bolus + infusion	0	109	Misoprostol plus Oxytocin ; 600 mcg plus 5 IU; rectally plus by an intravenous bolus	0	109	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Afolabi 2010	low risk; vaginal delivery	Oxytocin ; 10 IU; Intramuscularly	0	100	Misoprostol; 400 mcg; orally	0	100	NA	NA	NA	NA	NA	NA
Al-Sawaf 2013	both high and low risk; vaginal delivery	Placebo or control; ; (Control)	6	39	Misoprostol; 200 mcg; sublingually	2	28	Oxytocin ; 5 IU; Intramuscularly	1	37	NA	NA	NA
Al Zubaidi 2021	high risk; emergency caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	13	100	Oxytocin ; 10 IU; by an intravenous bolus	21	200	NA	NA	NA	NA	NA	NA
Amant 1999	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	1	96	Ergometrine; 200 mcg; by an intravenous bolus	0	93	NA	NA	NA	NA	NA	NA
Amornpetchakul 2018	high risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	0	176	Oxytocin ; 5 IU ; by an intravenous bolus	0	174	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Askar 2011	low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	0	120	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	1	120	NA	NA	NA	NA	NA	NA
Attilakos 2010	high risk; both elective or emergency caesarean	Carbetocin; 100 mcg; by an intravenous bolus	9	188	Oxytocin; 5 IU; by an intravenous bolus	9	189	NA	NA	NA	NA	NA	NA
Atukunda 2014	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	14	570	Misoprostol; 600 mcg; sublingually	18	570	NA	NA	NA	NA	NA	NA
Badejoko 2012	high risk; vaginal delivery	Oxytocin; 30 IU; by an intravenous bolus + infusion	5	129	Misoprostol plus Oxytocin; 600 mcg plus 20 IU; rectally plus by an intraven	3	126	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
					ous infusion								
Bamigboye, Hofmeyr 1998	low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	13	270	Placebo or control; ; (Placebo)	19	272	NA	NA	NA	NA	NA	NA
Balki 2021	high risk; caesarean section	Ergometrine plus Oxytocin ; 0.25 mg plus 5 IU; by an intravenous bolus	18	33	Oxytocin ; 5 IU; by an intravenous bolus	23	35	NA	NA	NA	NA	NA	NA
Baskett 2007	both high and low risk; vaginal delivery	Oxytocin ; 5 IU; by an intravenous bolus	7	311	Misoprostol; 400 mcg; orally	14	311	NA	NA	NA	NA	NA	NA
Begley 1990	low risk; vaginal delivery	Ergometrine; 500 mcg; Intravenous bolus	1	705	Placebo or control; ; (Control)	11	724	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Bellad 2012	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	0	321	Oxytocin; 10 IU; Intramuscularly	0	331	NA	NA	NA	NA	NA	NA
Benchimol 2001	both high and low risk; vaginal delivery	Placebo or control; ; (Control)	13	220	Oxytocin; 2.5 IU; by an intravenous bolus	12	196	Misoprostol; 600 mcg; orally	16	186	NA	NA	NA
Bhatti 2014	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	0	60	Oxytocin; 10 IU; Intramuscularly	0	60	NA	NA	NA	NA	NA	NA
Boucher 1998	high risk; elective caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	0	29	Oxytocin; 32.5 IU; by an intravenous bolus + infusion	0	28	NA	NA	NA	NA	NA	NA
Bugalho 2001	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	0	323	Oxytocin; 10 IU; Intramuscularly	1	339	NA	NA	NA	NA	NA	NA
Caliskan 2002	both high and low risk;	Misoprostol plus Oxytocin	11	401	Misoprostol; 400	17	396	Oxytocin; 10 IU; by an	14	407	Ergometrine plus Oxytocin	7	402

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	vaginal delivery	; 400 mcg plus 10 IU; rectally plus by an intravenous infusion			mcg; rectally			intravenous infusion			; 200 mcg plus 10 IU; Intramuscularly plus by an intravenous infusion		
Caliskan 2003	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; orally plus by an intravenous infusion	6	404	Misoprostol; 400 mcg; orally	14	388	Oxytocin; 10 IU; by an intravenous infusion	15	384	Ergometrine plus Oxytocin; 200 mcg plus 10 IU; Intramuscularly plus by an intravenous infusion	5	398
Carbonell i Esteve 2009	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg and 200 mcg plus 10 IU; sublingu	13	702	Oxytocin; 10 IU; Intramuscularly	11	698	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
		ally and rectally plus intramuscularly											
Chandiok 2006	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	1	600	Ergometrine; 200 mcg; Intramuscularly	0	600	NA	NA	NA	NA	NA	NA
Chaudhuri 2010	high risk; both elective or emergency caesarean	Misoprostol; 800 mcg; rectally	1	96	Oxytocin; 40 IU; by an intravenous infusion	6	94	NA	NA	NA	NA	NA	NA
Chaudhuri 2012	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	1	265	Oxytocin; 10 IU; Intramuscularly	2	265	NA	NA	NA	NA	NA	NA
Chaudhuri 2015	high risk; emergency caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an	5	198	Oxytocin; 20 IU; Intramuscular bolus plus an intravenous infusion	3	198	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
		intramuscular bolus and intravenous infusion											
Chaudhuri 2016	high risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; sublingually plus intramuscularly	2	144	Oxytocin; 10 IU; Intramuscularly	4	144	NA	NA	NA	NA	NA	NA
Chhabra 2008	low risk; vaginal delivery	Misoprostol; ≤600 mcg; sublingually	0	200	Ergometrine; 200 mcg; by an intravenous bolus	0	100	NA	NA	NA	NA	NA	NA
Choy 2002	low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU;	3	500	Oxytocin; 10 IU; by an intravenous bolus	6	491	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
		Intramuscularly											
Cook 1999	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; orally	13	424	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	7	310	Oxytocin; 10 IU; Intramuscularly	0	129	NA	NA	NA
de Groot 1996	low risk; vaginal delivery	Placebo or control; ; (Placebo)	16	143	Oxytocin; 5 IU; Intramuscularly	7	78	NA	NA	NA	NA	NA	NA
Derman 2006	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	2	812	Placebo or control; ; (Placebo)	10	808	NA	NA	NA	NA	NA	NA
Diallo 2017	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; orally	2	154	Oxytocin; 5 IU; by an intravenous bolus	4	150	NA	NA	NA	NA	NA	NA
El Behery 2015	high risk; emergency caesare	Carbetocin; 100 mcg; by an intraven	2	90	Oxytocin; 20 IU; by an intraven	12	90	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	an section	ous bolus			ous infusion								
Elbohoty 2016	high risk; elective caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	3	88	Misoprostol; 400 mcg; sublingually	7	89	Oxytocin; 30 IU; by an intravenous bolus + infusion	5	86	NA	NA	NA
El-Refaey 2000	both high and low risk; vaginal delivery	Misoprostol; 500 mcg; orally	9	501	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	10	499	NA	NA	NA	NA	NA	NA
Elsedeek 2012	high risk; elective caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; rectally plus by an intravenous infusion	0	200	Oxytocin; 10 IU; by an intravenous infusion	0	200	NA	NA	NA	NA	NA	NA
Enakpene 2007	Low risk; vaginal delivery	Misoprostol; 400	3	432	Ergometrine; 500 mcg;	1	432	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
		mcg; orally			Intramuscularly								
Fararjeh 2003	low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	5	49	Ergometrine plus Oxytocin; 200 mcg plus 10 IU; Intramuscularly	3	48	NA	NA	NA	NA	NA	NA
Fekih 2009	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 200 mcg plus 20 IU; sublingually plus by an intravenous bolus and infusion	19	125	Oxytocin; 20 IU; by an intravenous bolus + infusion	24	125	NA	NA	NA	NA	NA	NA
Fenix 2012	high risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	0	30	Oxytocin; 10 IU; by an intravenous infusion	0	30	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Gavilanes 2015	high risk; elective caesarean section	Misoprostol; 400 mcg; sublingually	12	50	Oxytocin; 10 IU; by an intravenous infusion	13	50	NA	NA	NA	NA	NA	NA
Gerstenfeld 2001	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	15	154	Oxytocin; 20 IU; by an intravenous infusion	14	161	NA	NA	NA	NA	NA	NA
Gulmezoglu 2001	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	366	9214	Oxytocin; 10 IU; Intramuscularly or by an intravenous bolus	263	9228	NA	NA	NA	NA	NA	NA
Gupta 2006	Both high and low risk; vaginal delivery	Misoprostol; 600 mcg; rectally	0	100	Oxytocin; 10 IU; Intramuscularly	0	100	NA	NA	NA	NA	NA	NA
Hamm 2005	high risk; both elective or emergency	Misoprostol plus Oxytocin; 200 mcg plus 20 IU; sublingu	24	173	Oxytocin; 20 IU; by an intravenous infusion	22	179	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	caesarean	ally plus by an intravenous infusion											
Harriott 2009	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	1	70	Misoprostol; 400 mcg; rectally	0	70	NA	NA	NA	NA	NA	NA
Hernandez-Castro 2016	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intravenous infusion	3	60	Oxytocin; 20 IU; by an intravenous infusion	7	60	NA	NA	NA	NA	NA	NA
Hofmeyr 1998	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	15	250	Placebo or control; ; (Placebo)	23	250	NA	NA	NA	NA	NA	NA
Hofmeyr 2001	unspecified;	Misoprostol; 600	27	300	Placebo or	29	299	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	vaginal delivery	mcg; orally			control; ; (Placebo)								
Hofmeyr 2011	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; sublingually plus intramuscularly	5	546	Oxytocin; 10 IU; Intramuscularly	1	553	NA	NA	NA	NA	NA	NA
Hoj 2005	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; sublingually	37	330	Placebo or control; ; (Placebo)	56	331	NA	NA	NA	NA	NA	NA
Humera 2016	high risk; vaginal delivery	Misoprostol; 600 mcg; orally	0	50	Ergometrine; 200 mcg; by an intravenous bolus	0	50	NA	NA	NA	NA	NA	NA
Jago 2007	both high and low risk; vaginal delivery	Ergometrine; 500 mcg; Intramuscularly	0	254	Oxytocin; 10 IU; by an intravenous bolus	0	256	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Jangsten 2011	low risk; vaginal delivery	Oxytocin ; 10 IU; by an intravenous bolus	82	810	Placebo or control; ; (Control)	138	821	NA	NA	NA	NA	NA	NA
Jans 2016	low risk; vaginal delivery	Oxytocin ; 5 IU; Intramuscularly	54	851	Placebo or control; ; (Control)	99	835	NA	NA	NA	NA	NA	NA
Jerbi 2007	low risk; vaginal delivery	Oxytocin ; 5 IU; by an intravenous bolus	0	65	Placebo or control; ; (Control)	0	65	NA	NA	NA	NA	NA	NA
Kabir 2015	both high and low risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	0	47	Oxytocin ; 10 IU; Intramuscularly	4	47	NA	NA	NA	NA	NA	NA
Kang 2022	high risk; caesarean section	Carbetocin; 100 mcg ; by intravenous bolus	14	440	Oxytocin ; 30 IU; uterine injection plus intravenous infusion	21	401	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Khan 1995	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	11	1012	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	9	1016	NA	NA	NA	NA	NA	NA
Kundodyiwa 2001	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	9	243	Oxytocin; 10 IU; Intramuscularly	5	256	NA	NA	NA	NA	NA	NA
Lam 2004	low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; by an intravenous bolus	0	30	Misoprostol; 600 mcg; sublingually	1	30	NA	NA	NA	NA	NA	NA
Lamont 2001	both high and low risk; both caesarean and vaginal delivery	Carboprost; 250 mcg; Intramuscularly	7	263	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	4	266	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Lapaire 2006	high risk; elective caesarean section	Oxytocin; 25 IU; by an intravenous bolus + infusion	11	19	Misoprostol plus Oxytocin; 800 mcg plus 5 IU; orally plus by an intravenous bolus	13	24	NA	NA	NA	NA	NA	NA
Leung 2006	low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	0	150	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	1	150	NA	NA	NA	NA	NA	NA
Lui 2020	high risk; vaginal delivery	Carbetocin; 100 mcg; Intravenous infusion	10	314	Oxytocin; 10 IU; intravenous infusion	11	310	NA	NA	NA	NA	NA	NA
Lokugamage 2001	high risk; both elective or emergency	Oxytocin; 10 IU; by an intravenous bolus	3	20	Misoprostol; 500 mcg; orally	3	20	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	caesarean												
Lumbiganon 1999	both high and low risk; vaginal delivery	Misoprostol; ≤ 600 mcg; orally	22	397	Oxytocin; 10 IU; Intramuscularly	13	200	NA	NA	NA	NA	NA	NA
Maged 2016	high risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	0	100	Oxytocin; 5 IU; Intramuscularly	1	100	NA	NA	NA	NA	NA	NA
Maged 2017	high risk; both elective or emergency caesarean	Carbetocin; 100 mcg; by an intravenous bolus	4	150	Ergometrine plus Oxytocin; 200 mcg plus 5 IU; by an intravenous bolus	15	150	NA	NA	NA	NA	NA	NA
Masse 2022	high risk; caesarean section	Ergometrine plus Oxytocin; 0.2 mg plus 30 IU; intramuscularly plus intraven	28	80	Oxytocin; 30 IU; intravenous infusion	47	80	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
		ous infusion											
McDonagh 2022	high risk; caesarean section	Carbetocin; 20 mcg and 100 mcg; intravenous bolus	47	139	Oxytocin; 5.5 IU; intravenous infusion	49	135	NA	NA	NA	NA	NA	NA
McDonald 1993	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	68	1730	Oxytocin; 10 IU; Intramuscularly	83	1753	NA	NA	NA	NA	NA	NA
Mitchell 1993	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	0	228	Oxytocin; 5 IU; Intramuscularly	1	230	NA	NA	NA	NA	NA	NA
Mobeen 2011	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	10	514	Placebo or control; ; (Placebo)	19	558	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Modi 2014	low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	0	25	Ergometrine; 200 mcg; by an intravenous bolus	0	25	Carboprost; 125 mcg; Intramuscularly	2	25	Misoprostol; 600 mcg; rectally	0	25
Moir 1979	low risk; vaginal delivery	Ergometrine; 500 mcg; by an intravenous bolus	1	44	Oxytocin; 10 IU; by an intravenous bolus	0	44	NA	NA	NA	NA	NA	NA
Nahaer 2018	high risk; caesarean section	Carbetocin; 100 mcg; Intravenous bolus	0	50	Oxytocin; 10 IU; NR	4	50	NA	NA	NA	NA	NA	NA
Nasr 2009	low risk; vaginal delivery	Misoprostol; 800 mcg; rectally	0	257	Oxytocin; 5 IU; by an intravenous infusion	0	257	NA	NA	NA	NA	NA	NA
Nellore 2006	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	0	60	Carboprost; 125 mcg; Intramuscularly	0	60	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Ng 2001	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	5	1026	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	4	1032	NA	NA	NA	NA	NA	NA
Ng 2007	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	2	178	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	1	177	NA	NA	NA	NA	NA	NA
Nordstrom 1997	both high and low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	32	513	Placebo or control; ; (Placebo)	43	487	NA	NA	NA	NA	NA	NA
Nuamsiri 2016	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 200 mcg plus 20 IU; by an intravenous	0	162	Oxytocin; 20 IU; by an intravenous infusion	0	161	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
		bolus + infusion											
Oboro 2003	low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	0	249	Misoprostol; 600 mcg; orally	0	247	NA	NA	NA	NA	NA	NA
Orji 2008	both high and low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	0	297	Ergometrine; 250 mcg; by an intravenous bolus	0	303	NA	NA	NA	NA	NA	NA
Otoide 2020	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	2	150	Ergometrine; 0.5 mg; intravenous	1	150	NA	NA	NA	NA	NA	NA
Owonikoko 2011	high risk; both elective or emergency caesarean	Oxytocin; 20 IU; by an intravenous infusion	5	50	Misoprostol; 400 mcg; sublingually	4	50	NA	NA	NA	NA	NA	NA
Parsons 2006	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	0	225	Misoprostol; 800 mcg; orally	0	225	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Parsons 2007	both high and low risk; vaginal delivery	Oxytocin ; 10 IU; Intramuscularly	1	224	Misoprostol; 800 mcg; rectally	0	217	NA	NA	NA	NA	NA	NA
Patil 2013	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	1	100	Ergometrine; 200 mcg; by an intravenous bolus	0	99	NA	NA	NA	NA	NA	NA
Penaranda 2002	both high and low risk; vaginal delivery	Misoprostol; 50 mcg; sublingually	1	25	Oxytocin ; 16mIU/min; by an intravenous infusion	3	25	Ergometrine; 200 mcg; Intramuscularly	3	25	NA	NA	NA
Perez-Rumbos 2017	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; rectally	0	195	Oxytocin ; 20 IU; Intramuscularly	3	197	NA	NA	NA	NA	NA	NA
Poeschmann 1991	low risk; vaginal delivery	Oxytocin ; 5 IU; Intramuscularly	2	28	Carboprost; 500 mcg; Intramuscularly	1	22	Placebo or control; ; (Placebo)	3	24	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Prendiville 1988	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin ; 500 mcg plus 5 IU; Intramuscularly	7	846	Placebo or control; ; (Control)	26	849	NA	NA	NA	NA	NA	NA
Quibel 2016	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin ; 400 mcg plus 10 IU; orally plus by an intravenous bolus	13	806	Oxytocin ; 10 IU; by an intravenous bolus	17	797	NA	NA	NA	NA	NA	NA
Rashid 2009	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin ; 500 mcg plus 5 IU; Intramuscularly	6	340	Oxytocin ; 10 IU; by an intravenous infusion	8	346	NA	NA	NA	NA	NA	NA
Rogers 1998	low risk; vaginal delivery	Ergometrine plus Oxytocin ;	13	748	Placebo or control; ; (Control)	20	764	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
		unspecified; Intramuscularly											
Rossel and 2013	high risk; elective caesarean section	Oxytocin; 5 IU; Intravenous bolus	0	26	Carbetocin; 100 mcg; Intravenous bolus	0	25	Placebo or control; ; (Placebo)	0	25	NA	NA	NA
Sadiq 2011	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	0	900	Misoprostol; 600 mcg; orally	0	900	NA	NA	NA	NA	NA	NA
Shaheen 2019	low risk; vaginal delivery	Oxytocin; 10 IU; intramuscularly	18	106	Misoprostol; 600 mcg; sublingually	2	106	NA	NA	NA	NA	NA	NA
Sitaula 2017	high risk; elective caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; rectally plus by an intraven	0	100	Oxytocin; 20 IU; by an intravenous infusion	1	100	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
		ous infusion											
Soltan 2007	both high and low risk; vaginal delivery	Ergometrine; 200 mcg; Intramuscularly	1	266	Misoprostol; ≤600 mcg; sublingually	0	271	Misoprostol; >600 mcg to ≤800 mcg; sublingually	1	269	Misoprostol; >800 mcg to ≤1000 mcg; sublingually	0	278
Sood 2012	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intravenous infusion	6	90	Oxytocin; 20 IU; by an intravenous infusion	4	84	NA	NA	NA	NA	NA	NA
Stanton 2013	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	1	682	Placebo or control; ; (Control)	8	887	NA	NA	NA	NA	NA	NA
Su 2009	low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	1	185	Ergometrine plus Oxytocin; 500 mcg plus	0	185	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
					5 IU; Intramuscularly								
Sultana 2007	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	5	210	Oxytocin; 10 IU; Intramuscularly	3	190	NA	NA	NA	NA	NA	NA
Tewatia 2014	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous infusion	0	50	Misoprostol; 600 mcg; sublingually	0	50	NA	NA	NA	NA	NA	NA
Ugwu 2014	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intravenous infusion	1	60	Oxytocin; 20 IU; by an intravenous infusion	2	60	NA	NA	NA	NA	NA	NA
Vagge 2014	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous infusion	2	100	Misoprostol; 800 mcg; rectally	1	100	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Van Der Nelson 2021	low risk; vaginal delivery	carbetocin; 100 mcg; intramuscularly	386	1909	Ergometrine plus oxytocin; 500 mcg plus 5 IU; intramuscularly	411	1914	Oxytocin; 10 IU; Intramuscularly	429	1894	NA	NA	NA
van Selm 1995	high risk; vaginal delivery	Ergometrine plus Oxytocin; 200 mcg plus 5 IU; Intramuscularly	9	36	Carboprost; 500 mcg; Intramuscularly	3	33	NA	NA	NA	NA	NA	NA
Vimala 2004	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	0	60	Ergometrine; 200 mcg; by an intravenous bolus	0	60	NA	NA	NA	NA	NA	NA
Vimala 2006	high risk; both elective or emergency caesarean	Misoprostol; 400 mcg; sublingually	6	50	Oxytocin; 20 IU; by an intravenous infusion	10	50	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Walley 2000	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	0	202	Oxytocin; 10 IU; Intramuscularly	0	196	NA	NA	NA	NA	NA	NA
Whigham 2016	high risk; emergency caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	7	59	Oxytocin; 5 IU; by an intravenous bolus	8	53	NA	NA	NA	NA	NA	NA
Widmer 2018	both high and low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	222	14651	Oxytocin; 10 IU; Intramuscularly	212	14677	NA	NA	NA	NA	NA	NA
Yesmin 2022	high risk; caesarean section	Carbetocin; 100 mcg; intravenous bolus	0	32	Oxytocin; 10 IU; intravenous bolus	3	32	NA	NA	NA	NA	NA	NA
Yuen 1995	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	6	496	Oxytocin; 10 IU; Intramuscularly	10	495	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Zacharia h 2006	both high and low risk; vaginal delivery	Misopro stol; 400 mcg; orally	1	730	Oxytocin ; 10 IU; Intramus cularly	4	617	Ergomet rine; 200 mcg; by an intraven ous bolus	6	676	NA	NA	NA

D4 – Severe maternal morbidity – intensive care admission

Table 4: Evidence table for severe maternal morbidity - intensive care admission

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total
Abdel-Aleem 2010	both high and low risk ; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	0	1291	Placebo or control; ; (Control)	0	659
Afolabi 2010	low risk ; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	0	100	Misoprostol; 400 mcg; orally	0	100
Amin 2014	both high and low risk ; vaginal delivery	Oxytocin; 5 IU; by an intravenous bolus	0	100	Misoprostol; 800 mcg; rectally	0	100
Attilakos 2010	high risk ; both elective or emergency caesarean	Carbetocin; 100 mcg; by an intravenous bolus	1	188	Oxytocin; 5 IU; by an intravenous bolus	0	189
Atukunda 2014	both high and low risk ; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	8	570	Misoprostol; 600 mcg; sublingually	11	570
Carbonell i Esteve 2009	both high and low risk ; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg and 200 mcg plus 10 IU; sublingually and rectally plus intramuscularly	1	702	Oxytocin; 10 IU; Intramuscularly	2	698

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total
Chaudhuri 2010	high risk ; both elective or emergency caesarean	Misoprostol; 800 mcg; rectally	0	96	Oxytocin; 40 IU; by an intravenous infusion	0	94
Derman 2006	low risk ; vaginal delivery	Misoprostol; 600 mcg; orally	2	812	Placebo or control; ; (Placebo)	2	808
El Tahan 2012	high risk ; elective caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; sublingually plus by an intravenous bolus	0	179	Oxytocin; 10 IU; by an intravenous infusion	0	187
Enakpene 2007	Low risk ; vaginal delivery	Misoprostol; 400 mcg; orally	1	432	Ergometrine; 500 mcg; Intramuscularly	0	432
Gulmezoglu 2001	both high and low risk ; vaginal delivery	Misoprostol; 600 mcg; orally	4	9224	Oxytocin; 10 IU; Intramuscularly or by an intravenous bolus	5	9231
Ibrahim 2017	high risk; vaginal birth	Carbetocin; 100 mcg; intravenous infusion	0	30	Misoprostol; 600 mcg; sublingually	2	30
Kundodyiwa 2001	low risk ; vaginal delivery	Misoprostol; 400 mcg; orally	0	243	Oxytocin; 10 IU; Intramuscularly	0	256
Musa 2015	low risk ; vaginal delivery	Misoprostol; 600 mcg; orally	0	100	Oxytocin; 10 IU; Intramuscularly	0	100
Nasr 2009	low risk ; vaginal delivery	Misoprostol; 800 mcg; rectally	0	257	Oxytocin; 5 IU; by an intravenous infusion	0	257
Nirmala 2009	high risk ; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	0	60	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	0	60
Samimi 2013	low risk ; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	0	100	Ergometrine plus Oxytocin; 200 mcg plus 5 IU; Intramuscularly	0	100
Shrestha 2011	low risk ; vaginal delivery	Misoprostol; 1000 mcg; rectally	0	100	Oxytocin; 10 IU; Intramuscularly	0	100
Tewatia 2014	low risk ; vaginal delivery	Oxytocin; 10 IU; by an intravenous infusion	0	50	Misoprostol; 600 mcg; sublingually	0	50
Ugwu 2014	high risk ; both elective or emergency caesarean	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intravenous infusion	0	60	Oxytocin; 20 IU; by an intravenous infusion	0	60

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total
Widmer 2018	both high and low risk ; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	26	14737	Oxytocin; 10 IU; Intramuscularly	23	14733
Yuen 1995	both high and low risk ; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	1	496	Oxytocin; 10 IU; Intramuscularly	0	495

D5 – Need for additional uterotonics

Table 5: Evidence table for need for additional uterotonics

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Abdel-Aleem 2010	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	41	1260	Placebo or control; ; (Control)	55	641	NA	NA	NA	NA	NA	NA
Acharya 2001	high risk; elective caesarean section	Oxytocin; 10 IU; by an intravenous bolus	3	30	Misoprostol; 400 mcg; orally	2	30	NA	NA	NA	NA	NA	NA
Afolabi 2010	low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	4	100	Misoprostol; 400 mcg; orally	3	100	NA	NA	NA	NA	NA	NA
Al-Sawaf 2013	both high and low risk; vaginal delivery	Placebo or control; ; (Control)	8	39	Misoprostol; 200 mcg; sublingually	3	28	Oxytocin; 5 IU; Intramuscularly	2	37	NA	NA	NA
Alwani 2014	high risk; both elective or emergency caesarean	Misoprostol; 600 mcg; rectally	4	100	Oxytocin; 10 IU; Intramuscularly	9	100	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Al Zubaidi 2021	high risk; emergency caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	7	100	Oxytocin; 10 IU; by an intravenous bolus	39	200	NA	NA	NA	NA	NA	NA
Amant 1999	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	12	94	Ergometrine; 200 mcg; by an intravenous bolus	4	91	NA	NA	NA	NA	NA	NA
Amornpetchakul 2018	high risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	16	176	Oxytocin; 5 IU; by an intravenous bolus	48	174	NA	NA	NA	NA	NA	NA
Anupama 2021	high risk; elective caesarean section	Misoprostol; 400 mcg; sublingually	12	45	placebo or control; N/A; sublingually	26	45	NA	NA	NA	NA	NA	NA
Askar 2011	low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	18	120	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	21	120	NA	NA	NA	NA	NA	NA
Attilakos 2010	high risk; both elective or emergency caesarean	Carbetocin; 100 mcg; by an intravenous bolus	63	188	Oxytocin; 5 IU; by an intravenous bolus	86	189	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Atukunda 2014	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	31	570	Misoprostol; 600 mcg; sublingually	47	570	NA	NA	NA	NA	NA	NA
Badejoko 2012	high risk; vaginal delivery	Oxytocin; 30 IU; by an intravenous bolus + infusion	5	129	Misoprostol plus Oxytocin; 600 mcg plus 20 IU; rectally plus by an intravenous infusion	6	126	NA	NA	NA	NA	NA	NA
Balki 2008	high risk; emergency caesarean section	Ergometrine plus Oxytocin; 250 mcg plus 20 IU; by an intravenous bolus	5	24	Oxytocin; 20 IU; by an intravenous bolus + infusion	13	24	NA	NA	NA	NA	NA	NA
Balki 2021	high risk; caesarean section	Ergometrine plus Oxytocin; 0.25 mg plus 5 IU; by an intravenous bolus	11	33	Oxytocin; 5 IU; by an intravenous bolus	13	35	NA	NA	NA	NA	NA	NA
Bamigboye, Hofmeyr 1998	low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	9	271	Placebo or control; ; (Placebo)	13	275	NA	NA	NA	NA	NA	NA
Bamigboye,	low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	4	231	Ergometrine plus Oxytocin; 500	1	233	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Merrell 1998					mcg and 5 IU; Intramuscularly								
Barton 1996	high risk; elective caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	8	62	Placebo or control; ; (Placebo)	41	57	NA	NA	NA	NA	NA	NA
Baskett 2007	both high and low risk; vaginal delivery	Oxytocin; 5 IU; by an intravenous bolus	126	311	Misoprostol; 400 mcg; orally	159	311	NA	NA	NA	NA	NA	NA
Begley 1990	low risk; vaginal delivery	Ergometrine; 500 mcg; Intravenous bolus	14	705	Placebo or control; ; (Control)	93	724	NA	NA	NA	NA	NA	NA
Bellad 2012	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	1	321	Oxytocin; 10 IU; Intramuscularly	8	331	NA	NA	NA	NA	NA	NA
Bhatti 2014	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	1	60	Oxytocin; 10 IU; Intramuscularly	3	60	NA	NA	NA	NA	NA	NA
Bhullar 2004	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 200 mcg plus 20 IU; sublingually plus by an	10	377	Oxytocin; 20 IU; by an intravenous infusion	13	379	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
		intravenous infusion											
Borruto 2009	high risk; both elective or emergency caesarean	Carbetocin; 100 mcg; by an intravenous bolus	2	52	Oxytocin; 10 IU; by an intravenous infusion	5	52	NA	NA	NA	NA	NA	NA
Boucher 1998	high risk; elective caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	0	29	Oxytocin; 32.5 IU; by an intravenous bolus + infusion	3	28	NA	NA	NA	NA	NA	NA
Boucher 2004	high risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	12	83	Oxytocin; 10 IU; Intravenous infusion	12	77	NA	NA	NA	NA	NA	NA
Bugalho 2001	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	7	323	Oxytocin; 10 IU; Intramuscularly	7	339	NA	NA	NA	NA	NA	NA
Butwick 2010	high risk; elective caesarean section	Placebo or control; ; (Placebo)	7	15	Oxytocin; ≤ 1 IU; by an intravenous bolus	6	29	Oxytocin; > 1 IU to ≤ 5 IU; by an intravenous bolus	2	30	NA	NA	NA
Caliskan 2002	both high and low risk;	Misoprostol plus Oxytocin; 400 mcg plus	17	401	Misoprostol; 400 mcg; rectally	33	396	Oxytocin; 10 IU; by an	26	407	Ergometrine plus Oxytocin;	9	402

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	vaginal delivery	10 IU; rectally plus by an intravenous infusion						intravenous infusion			200 mcg plus 10 IU; Intramuscularly plus by an intravenous infusion		
Caliskan 2003	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; orally plus by an intravenous infusion	10	404	Misoprostol; 400 mcg; orally	23	388	Oxytocin; 10 IU; by an intravenous infusion	26	384	Ergometrine plus Oxytocin; 200 mcg plus 10 IU; Intramuscularly plus by an intravenous infusion	9	398
Carbonell i Esteve 2009	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg and 200 mcg plus 10 IU; sublingually and rectally plus intramuscularly	33	702	Oxytocin; 10 IU; Intramuscularly	54	698	NA	NA	NA	NA	NA	NA
Carillo-Gaucin 2016	high risk; emergency caesarean section	Carbetocin; unspecified dose; by an unspecified route	1	60	Oxytocin; unspecified dose; by an unspecified route	9	57	NA	NA	NA	NA	NA	NA
Chandiok 2006	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	4	600	Ergometrine; 200 mcg;	3	600	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
					Intramuscularly								
Chaudhuri 2010	high risk; both elective or emergency caesarean	Misoprostol; 800 mcg; rectally	11	96	Oxytocin; 40 IU; by an intravenous infusion	14	94	NA	NA	NA	NA	NA	NA
Chaudhuri 2012	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	20	265	Oxytocin; 10 IU; Intramuscularly	23	265	NA	NA	NA	NA	NA	NA
Chaudhuri 2015	high risk; emergency caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intramuscular bolus and intravenous infusion	18	198	Oxytocin; 20 IU; Intramuscular bolus plus an intravenous infusion	45	198	NA	NA	NA	NA	NA	NA
Chaudhuri 2016	high risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; sublingually plus intramuscularly	12	144	Oxytocin; 10 IU; Intramuscularly	22	144	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Chhabra 2008	low risk; vaginal delivery	Misoprostol; ≤600 mcg; sublingually	9	200	Ergometrine; 200 mcg; by an intravenous bolus	3	100	NA	NA	NA	NA	NA	NA
Choy 2002	low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	52	500	Oxytocin; 10 IU; by an intravenous bolus	36	491	NA	NA	NA	NA	NA	NA
Chua 1995	unspecified; vaginal delivery	Carboprost; 125 mcg; Intramuscularly	2	54	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	2	58	NA	NA	NA	NA	NA	NA
Cook 1999	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; orally	95	424	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	28	310	Oxytocin; 10 IU; Intramuscularly	6	129	NA	NA	NA
Danserau 1999	high risk; elective caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	15	317	Oxytocin; 25 IU; by an intravenous bolus + infusion	32	318	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
de Groot 1996	low risk; vaginal delivery	Placebo or control; ; (Placebo)	26	143	Oxytocin; 5 IU; Intramuscularly	14	78	NA	NA	NA	NA	NA	NA
Derman 2006	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	3	812	Placebo or control; ; (Placebo)	6	808	NA	NA	NA	NA	NA	NA
Dhananjaya 2014	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	0	50	Ergometrine; 200 mcg; Intramuscularly	9	50	NA	NA	NA	NA	NA	NA
Diallo 2017	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; orally	7	154	Oxytocin; 5 IU; by an intravenous bolus	6	150	NA	NA	NA	NA	NA	NA
Eftekhari 2009	high risk; elective caesarean section	Misoprostol; 400 mcg; sublingually	7	50	Oxytocin; 20 IU; by an intravenous infusion	16	50	NA	NA	NA	NA	NA	NA
El Behery 2015	high risk; emergency caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	2	90	Oxytocin; 20 IU; by an intravenous infusion	64	90	NA	NA	NA	NA	NA	NA
El Tahan 2012	high risk; elective caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; sublingually plus by an	12	179	Oxytocin; 10 IU; by an intravenous infusion	52	187	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
		intravenous bolus											
Elbohoty 2016	high risk; elective caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	5	88	Misoprostol; 400 mcg; sublingually	20	89	Oxytocin; 30 IU; by an intravenous bolus + infusion	11	86	NA	NA	NA
Elgafor el Sharkwy 2013	high risk; elective caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intravenous infusion	31	190	Carbetocin; 100 mcg; by an intravenous bolus	26	190	NA	NA	NA	NA	NA	NA
El-Refaey 2000	both high and low risk; vaginal delivery	Misoprostol; 500 mcg; orally	68	501	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	50	499	NA	NA	NA	NA	NA	NA
Elsedeek 2012	high risk; elective caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; rectally plus by an intravenous infusion	14	200	Oxytocin; 10 IU; by an intravenous infusion	36	200	NA	NA	NA	NA	NA	NA
Enakpene 2007	Low risk; vaginal delivery	Misoprostol; 400 mcg; orally	33	432	Ergometrine; 500 mcg;	80	432	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
					Intramuscularly								
Ezeama 2014	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	35	151	Ergometrine; 500 mcg; Intramuscularly	11	149	NA	NA	NA	NA	NA	NA
Fahmy 2015	high risk; elective caesarean section	Oxytocin; 10 IU; by an intravenous bolus	10	50	Carbetocin; 100 mcg; by an intravenous bolus	6	50	NA	NA	NA	NA	NA	NA
Fahmy 2016	high risk; elective caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	4	30	Oxytocin; 20 IU; by an intravenous bolus	15	30	NA	NA	NA	NA	NA	NA
Fenix 2012	high risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	3	30	Oxytocin; 10 IU; by an intravenous infusion	27	30	NA	NA	NA	NA	NA	NA
Garg 2005	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	10	100	Ergometrine; 200 mcg; by an intravenous bolus	7	100	NA	NA	NA	NA	NA	NA
Gavilanes 2015	high risk; elective caesarean section	Misoprostol; 400 mcg; sublingually	10	50	Oxytocin; 10 IU; by an intravenous infusion	12	50	NA	NA	NA	NA	NA	NA
Gerstenfeld 2001	both high and low risk;	Misoprostol; 400 mcg; rectally	36	159	Oxytocin; 20 IU; by an	18	166	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	vaginal delivery				intravenous infusion								
Gulmezoglu 2001	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	1398	9225	Oxytocin; 10 IU; Intramuscularly or by an intravenous bolus	1002	9228	NA	NA	NA	NA	NA	NA
Gupta 2006	Both high and low risk; vaginal delivery	Misoprostol; 600 mcg; rectally	5	100	Oxytocin; 10 IU; Intramuscularly	1	100	NA	NA	NA	NA	NA	NA
Hamm 2005	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 200 mcg plus 20 IU; sublingually plus by an intravenous infusion	45	173	Oxytocin; 20 IU; by an intravenous infusion	76	179	NA	NA	NA	NA	NA	NA
Harriott 2009	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	6	70	Misoprostol; 400 mcg; rectally	6	70	NA	NA	NA	NA	NA	NA
Hernandez-Castro 2016	high risk; both elective or emergency	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually	6	60	Oxytocin; 20 IU; by an intravenous infusion	24	60	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	caesarean	plus by an intravenous infusion											
Hofmeyr 1998	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	21	250	Placebo or control; ; (Placebo)	33	250	NA	NA	NA	NA	NA	NA
Hofmeyr 2001	unspecified; vaginal delivery	Misoprostol; 600 mcg; orally	42	300	Placebo or control; ; (Placebo)	54	300	NA	NA	NA	NA	NA	NA
Hong 2007	high risk; caesarean (unspecified whether elective or emergency)	Oxytocin; 20 IU; by an intravenous infusion	31	118	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; rectally plus by an intravenous infusion	28	96	NA	NA	NA	NA	NA	NA
Humera 2016	high risk; vaginal delivery	Misoprostol; 600 mcg; orally	2	50	Ergometrine; 200 mcg; by an intravenous bolus	1	50	NA	NA	NA	NA	NA	NA
Ibrahim 2017	high risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	5	30	Misoprostol; 600 mcg; sublingually	8	30	NA	NA	NA	NA	NA	NA
Ibrahim 2020	high risk; caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	0	80	Oxytocin; 10 IU; intravenous infusion	68	80	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Jans 2016	low risk; vaginal delivery	Oxytocin; 5 IU; Intramuscularly	79	842	Placebo or control; ; (Control)	195	830	NA	NA	NA	NA	NA	NA
Kabir 2015	both high and low risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	0	47	Oxytocin; 10 IU; Intramuscularly	5	47	NA	NA	NA	NA	NA	NA
Kang 2022	high risk; caesarean section	Carbetocin; 100 mcg; by intravenous bolus	81	440	Oxytocin; 30 IU; uterine injection plus intravenous infusion	98	401	NA	NA	NA	NA	NA	NA
Karkanis 2002	low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	28	110	Oxytocin; 5 IU; by an intravenous bolus or intramuscularly	20	113	NA	NA	NA	NA	NA	NA
Khurshid 2010	both high and low risk; vaginal delivery	Carboprost; 125 mcg; Intramuscularly	0	100	Ergometrine; 200 mcg; by an intravenous bolus	1	100	NA	NA	NA	NA	NA	NA
Koen 2016	high risk; both elective or emergency caesarean	Oxytocin; 12.5 IU; by an intravenous bolus + infusion	16	214	Ergometrine plus Oxytocin; 500 mcg plus 15 IU; intramuscularly plus by an	20	202	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
					intravenous infusion								
Kumar 2016	both high and low risk; vaginal delivery	Carboprost; 125 mcg; Intramuscularly	4	100	Oxytocin; 10 IU; Intramuscularly	21	100	NA	NA	NA	NA	NA	NA
Kundo dyiwa 2001	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	13	243	Oxytocin; 10 IU; Intramuscularly	7	256	NA	NA	NA	NA	NA	NA
Lam 2004	low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; by an intravenous bolus	0	30	Misoprostol; 600 mcg; sublingually	3	30	NA	NA	NA	NA	NA	NA
Lapaire 2006	high risk; elective caesarean section	Oxytocin; 25 IU; by an intravenous bolus + infusion	0	25	Misoprostol plus Oxytocin; 800 mcg plus 5 IU; orally plus by an intravenous bolus	0	28	NA	NA	NA	NA	NA	NA
Leung 2006	low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	13	150	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	10	150	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Lui 2020	high risk; vaginal delivery	Carbetocin; 100 mcg; Intravenous infusion	75	314	Oxytocin; 10 IU; intravenous infusion	73	310	NA	NA	NA	NA	NA	NA
Lokugamage 2001	high risk; both elective or emergency caesarean	Oxytocin; 10 IU; by an intravenous bolus	1	20	Misoprostol; 500 mcg; orally	6	20	NA	NA	NA	NA	NA	NA
Lumbiganon 1999	both high and low risk; vaginal delivery	Misoprostol; ≤ 600 mcg; orally	41	397	Oxytocin; 10 IU; Intramuscularly	28	200	NA	NA	NA	NA	NA	NA
Maged 2016	high risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	23	100	Oxytocin; 5 IU; Intramuscularly	37	100	NA	NA	NA	NA	NA	NA
Maged 2017	high risk; both elective or emergency caesarean	Carbetocin; 100 mcg; by an intravenous bolus	5	150	Ergometrine plus Oxytocin; 200 mcg plus 5 IU; by an intravenous bolus	26	150	NA	NA	NA	NA	NA	NA
Maged 2020	low risk; vaginal delivery	Carbetocin; 100 mcg; intravenous	0	75	misoprostol; 800 mcg; rectal	7	75	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Mannaerts 2018	high risk; elective caesarean section	Oxytocin; 15 IU; by an intravenous bolus + infusion	2	26	Carbetocin; 100 mcg; by an intravenous bolus	0	32	NA	NA	NA	NA	NA	NA
Masse 2022	high risk; caesarean section	Ergometrine plus Oxytocin; 0.2 mg plus 30 IU; intramuscularly plus intravenous infusion	16	80	Oxytocin; 30 IU; intravenous infusion	44	80	NA	NA	NA	NA	NA	NA
McDonagh 2022	high risk; caesarean section	Carbetocin; 20 mcg and 100 mcg ; Intravenous bolus	23	139	Oxytocin; 5.5 IU; intravenous infusion	28	138	NA	NA	NA	NA	NA	NA
McDonald 1993	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	301	1730	Oxytocin; 10 IU; Intramuscularly	360	1753	NA	NA	NA	NA	NA	NA
Modi 2014	low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	0	25	Ergometrine; 200 mcg; by an intravenous bolus	0	25	Carboprost; 125 mcg; Intramuscularly	2	25	Misoprostol; 600 mcg; rectally	0	25
Moertl 2011	high risk; elective	Carbetocin; 100 mcg; by	0	28	Oxytocin; 5 IU; by an	0	28	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	caesarean section	an intravenous bolus			intravenous bolus								
Mukta 2013	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	22	100	Oxytocin; 10 IU; Intramuscularly	16	100	NA	NA	NA	NA	NA	NA
Musa 2015	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	20	100	Oxytocin; 10 IU; Intramuscularly	19	100	NA	NA	NA	NA	NA	NA
Nahaer 2018	high risk; caesarean section	Carbetocin; 100 mcg; Intravenous bolus	2	50	Oxytocin; 10 IU; NR	18	50	NA	NA	NA	NA	NA	NA
Nagaria 2006	both high and low risk; vaginal delivery	Carboprost; 125 mcg; Intramuscularly	0	100	Ergometrine; 200 mcg; by an intravenous bolus	2	100	NA	NA	NA	NA	NA	NA
Nankaly 2016	high risk; both elective or emergency caesarean	Oxytocin; 20 IU; by an intravenous infusion	9	63	Misoprostol; 400 mcg or 200 mcg; sublingually	15	122	NA	NA	NA	NA	NA	NA
Nasr 2009	low risk; vaginal delivery	Misoprostol; 800 mcg; rectally	6	257	Oxytocin; 5 IU; by an intravenous infusion	4	257	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Nayak 2017	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; sublingually plus by an intravenous bolus	4	100	Oxytocin; 10 IU; by an intravenous infusion	7	100	NA	NA	NA	NA	NA	NA
Nellore 2006	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	10	60	Carboprost; 125 mcg; Intramuscularly	2	60	NA	NA	NA	NA	NA	NA
Ng 2001	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	232	1026	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	144	1032	NA	NA	NA	NA	NA	NA
Ng 2007	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	41	178	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	24	177	NA	NA	NA	NA	NA	NA
Nihar 2022	high risk; both elective or emergency	Oxytocin; 10 IU; intravenous	4	50	ergometrine; 0.2 mg; intramuscularly	0	50	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	caesarean												
Nirmala 2009	high risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	3	60	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	9	60	NA	NA	NA	NA	NA	NA
Nordstrom 1997	both high and low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	40	513	Placebo or control; ; (Placebo)	67	487	NA	NA	NA	NA	NA	NA
Nuamsiri 2016	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 200 mcg plus 20 IU; by an intravenous bolus + infusion	0	162	Oxytocin; 20 IU; by an intravenous infusion	2	161	NA	NA	NA	NA	NA	NA
Oboro 2003	low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	27	249	Misoprostol; 600 mcg; orally	31	247	NA	NA	NA	NA	NA	NA
Orji 2008	both high and low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	18	297	Ergometrine; 250 mcg; by an intravenous bolus	30	303	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Ortiz-Gomez 2013	high risk; elective caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	0	52	Oxytocin; >1 IU to ≤ 5 IU; by an intravenous bolus + infusion	5	52	Oxytocin; >10 IU; by an intravenous bolus + infusion	4	52	NA	NA	NA
Othman 2016	high risk; elective caesarean section	Misoprostol; 400 mcg; sublingually	10	60	Oxytocin; 20 IU; by an intravenous infusion	14	50	NA	NA	NA	NA	NA	NA
Otoide 2020	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	26	150	Ergometrine; 0.5 mg; intravenous	21	150	NA	NA	NA	NA	NA	NA
Ottun 2022	low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	107	517	Misoprostol plus Oxytocin; 200 mcg plus 10 IU; sublingually and intramuscular	55	519	NA	NA	NA	NA	NA	NA
Owonikoko 2011	high risk; both elective or emergency caesarean	Oxytocin; 20 IU; by an intravenous infusion	21	50	Misoprostol; 400 mcg; sublingually	24	50	NA	NA	NA	NA	NA	NA
Pakniat 2015	high risk; both elective or emergenc	Misoprostol; 400 mcg; sublingually	8	50	Misoprostol plus Oxytocin; 200 mcg plus 5	7	50	Oxytocin; 20 IU; by an intravenous infusion	7	50	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	y caesarean				IU; sublingually plus by an intravenous bolus								
Parsons 2006	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	21	225	Misoprostol; 800 mcg; orally	16	225	NA	NA	NA	NA	NA	NA
Parsons 2007	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	19	224	Misoprostol; 800 mcg; rectally	9	223	NA	NA	NA	NA	NA	NA
Patil 2013	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	6	99	Ergometrine; 200 mcg; by an intravenous bolus	2	99	NA	NA	NA	NA	NA	NA
Patil 2016	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	21	100	Carboprost; 125 mcg; Intramuscularly	4	100	NA	NA	NA	NA	NA	NA
Perez-Rumbos 2017	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; rectally	7	195	Oxytocin; 20 IU; Intramuscularly	22	197	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Poeschmann 1991	low risk; vaginal delivery	Oxytocin; 5 IU; Intramuscularly	0	28	Carboprost; 500 mcg; Intramuscularly	0	22	Placebo or control; ; (Placebo)	2	24	NA	NA	NA
Prendiville 1988	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	54	846	Placebo or control; ; (Control)	252	849	NA	NA	NA	NA	NA	NA
Quibel 2016	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; orally plus by an intravenous bolus	19	806	Oxytocin; 10 IU; by an intravenous bolus	25	797	NA	NA	NA	NA	NA	NA
Rajaei 2014	both high and low risk; vaginal delivery	Oxytocin; 20 IU; by an intravenous infusion	21	200	Misoprostol; 400 mcg; orally	9	200	NA	NA	NA	NA	NA	NA
Rashid 2009	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	35	340	Oxytocin; 10 IU; by an intravenous infusion	34	346	NA	NA	NA	NA	NA	NA
Ray 2001	both high and low risk;	Misoprostol; 400 mcg; orally	2	100	Ergometrine; unspecified dose; by an	5	100	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	vaginal delivery				unspecified route								
Reyes 2011	high risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	0	45	Oxytocin; 20 IU; by an intravenous infusion	3	90	NA	NA	NA	NA	NA	NA
Reyes, Gonzalez 2011	high risk; both caesarean and vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	0	26	Oxytocin; 10 IU; by an intravenous infusion	1	29	NA	NA	NA	NA	NA	NA
Rogers 1998	low risk; vaginal delivery	Ergometrine plus Oxytocin; unspecified; Intramuscularly	24	748	Placebo or control; ; (Control)	161	764	NA	NA	NA	NA	NA	NA
Rossel and 2013	high risk; elective caesarean section	Oxytocin; 5 IU; Intravenous bolus	5	26	Carbetocin; 100 mcg; Intravenous bolus	5	25	Placebo or control; ; (Placebo)	23	25	NA	NA	NA
Sadiq 2011	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	148	900	Misoprostol; 600 mcg; orally	32	900	NA	NA	NA	NA	NA	NA
Samimi 2013	low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	1	100	Ergometrine plus Oxytocin; 200 mcg plus 5 IU; Intramuscularly	11	100	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Shady 2017	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	2	120	Misoprostol; 600 mcg; sublingually	20	120	NA	NA	NA	NA	NA	NA
Shady 2019	low risk; vaginal delivery	Oxytocin; 10 IU; intravenous	2	120	misoprostol; 600 mcg; buccal	20	120	NA	NA	NA	NA	NA	NA
Shaheen 2019	low risk; vaginal delivery	Oxytocin; 10 IU; intramuscular	15	106	Misoprostol; 600 mcg; sublingually	10	106	NA	NA	NA	NA	NA	NA
Singh 2009	low risk; vaginal delivery	Misoprostol; ≤600 mcg; sublingually	2	150	Oxytocin; 5 IU; by an intravenous bolus	2	75	Ergometrine; 200 mcg; by an intravenous bolus	11	75	NA	NA	NA
Soltan 2007	both high and low risk; vaginal delivery	Ergometrine; 200 mcg; Intramuscularly	7	266	Misoprostol; ≤600 mcg; sublingually	7	271	Misoprostol; >600 mcg to ≤800 mcg; sublingually	9	269	Misoprostol; >800 mcg to ≤1000 mcg; sublingually	6	278
Sood 2012	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intravenous infusion	20	90	Oxytocin; 20 IU; by an intravenous infusion	36	84	NA	NA	NA	NA	NA	NA
Su 2009	low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	25	185	Ergometrine plus Oxytocin; 500 mcg plus 5	31	185	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
					IU; Intramuscularly								
Sultana 2007	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	5	210	Oxytocin; 10 IU; Intramuscularly	6	190	NA	NA	NA	NA	NA	NA
Supe 2016	both high and low risk; vaginal delivery	Misoprostol; 800 mcg; rectally	1	50	Ergometrine; 200 mcg; Intramuscularly	2	50	Carboprost; 125 mcg; Intramuscularly	4	50	Placebo or control; ; (Control)	5	50
Surbeck 1999	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	5	31	Placebo or control; ; (Placebo)	13	34	NA	NA	NA	NA	NA	NA
Sweed 2018	high risk; caesarean section	oxytocin; 5 IU; intravenous	33	212	Misoprostol plus Oxytocin; 400 mcg plus 5IU; rectal or sublingual plus intravenous	52	424	NA	NA	NA	NA	NA	NA
Taheripanah 2017	high risk; emergency caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	11	110	Oxytocin; 30 IU; by an intravenous infusion	40	110	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Tewatia 2014	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous infusion	3	50	Misoprostol; 600 mcg; sublingually	7	50	NA	NA	NA	NA	NA	NA
Thilaganathan 1993	low risk; vaginal delivery	Placebo or control; ; (Control)	7	90	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	1	103	NA	NA	NA	NA	NA	NA
Ugwu 2014	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intravenous infusion	16	58	Oxytocin; 20 IU; by an intravenous infusion	40	60	NA	NA	NA	NA	NA	NA
Uncu 2015	both high and low risk; vaginal delivery	Placebo or control; ; (Control)	0	49	Misoprostol; ≤600 mcg; orally, vaginally or rectally	4	151	Misoprostol; >600 mcg to ≤800 mcg; oral, vaginally	1	48	NA	NA	NA
Vagge 2014	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous infusion	3	100	Misoprostol; 800 mcg; rectally	4	100	NA	NA	NA	NA	NA	NA
Vaid 2009	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	9	66	Ergometrine; 200 mcg; Intramuscularly	14	67	Carboprost; 125 mcg; Intramuscularly	9	67	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Van Der Nelson 2021	low risk; vaginal delivery	carbetocin; 100 mcg; intramuscularly	364	1909	Ergometrine plus oxytocin; 500 mcg plus 5 IU; intramuscularly	298	1914	Oxytocin; 10 IU; Intramuscularly	368	1894	NA	NA	NA
Verma 2006	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	4	100	Ergometrine; 200 mcg; Intramuscularly	2	100	NA	NA	NA	NA	NA	NA
Vimala 2004	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	5	60	Ergometrine; 200 mcg; by an intravenous bolus	3	60	NA	NA	NA	NA	NA	NA
Vimala 2006	high risk; both elective or emergency caesarean	Misoprostol; 400 mcg; sublingually	16	50	Oxytocin; 20 IU; by an intravenous infusion	18	50	NA	NA	NA	NA	NA	NA
Walley 2000	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	6	168	Oxytocin; 10 IU; Intramuscularly	8	172	NA	NA	NA	NA	NA	NA
Whigham 2016	high risk; emergency caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	13	59	Oxytocin; 5 IU; by an intravenous bolus	7	53	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Widmer 2018	both high and low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	1533	14770	Oxytocin; 10 IU; Intramuscularly	1528	14768	NA	NA	NA	NA	NA	NA
Yesmin 2022	high risk; caesarean section	Carbetocin; 100 mcg; intravenous bolus	0	32	Oxytocin; 10 IU; intravenous bolus	5	32	NA	NA	NA	NA	NA	NA
Yuen 1995	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	44	496	Oxytocin; 10 IU; Intramuscularly	70	495	NA	NA	NA	NA	NA	NA
Zachariah 2006	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; orally	63	730	Oxytocin; 10 IU; Intramuscularly	38	617	Ergometrine; 200 mcg; by an intravenous bolus	51	676	NA	NA	NA
Zgaya 2020	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	5	111	Placebo or control; N/A; NR	13	100	NA	NA	NA	NA	NA	NA

D6 – Need for blood transfusion

Table 6: Evidence table for need for blood transfusion

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Abdel-Aleem 2010	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	8	1257	Placebo or control; ; (Control)	7	642	NA	NA	NA	NA	NA	NA
Acharya 2001	high risk; elective caesarean section	Oxytocin; 10 IU; by an intravenous bolus	1	30	Misoprostol; 400 mcg; orally	1	30	NA	NA	NA	NA	NA	NA
Afolabi 2010	low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	0	100	Misoprostol; 400 mcg; orally	0	100	NA	NA	NA	NA	NA	NA
Al-Sawaf 2013	both high and low risk; vaginal delivery	Placebo or control; ; (Control)	1	39	Misoprostol; 200 mcg; sublingually	0	28	Oxytocin; 5 IU; Intramuscularly	0	37	NA	NA	NA
Alwani 2014	high risk; both elective or emergency caesarean	Misoprostol; 600 mcg; rectally	2	100	Oxytocin; 10 IU; Intramuscularly	5	100	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Al Zubaidi 2021	high risk; emergency caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	7	100	Oxytocin; 10 IU; by an intravenous bolus	21	200	NA	NA	NA	NA	NA	NA
Amant 1999	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	1	100	Ergometrine; 200 mcg; by an intravenous bolus	1	100	NA	NA	NA	NA	NA	NA
Amornpetchakul 2018	high risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	0	176	Oxytocin; 5 IU; by an intravenous bolus	0	174	NA	NA	NA	NA	NA	NA
Askar 2011	low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	0	120	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	1	120	NA	NA	NA	NA	NA	NA
Attilakos 2010	high risk; both elective or emergency caesarean	Carbetocin; 100 mcg; by an intravenous bolus	4	188	Oxytocin; 5 IU; by an intravenous bolus	5	189	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Atukunda 2014	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	16	570	Misoprostol; 600 mcg; sublingually	7	570	NA	NA	NA	NA	NA	NA
Badejoko 2012	high risk; vaginal delivery	Oxytocin; 30 IU; by an intravenous bolus + infusion	6	129	Misoprostol plus Oxytocin; 600 mcg plus 20 IU; rectally plus by an intravenous infusion	1	126	NA	NA	NA	NA	NA	NA
Balki 2008	high risk; emergency caesarean section	Ergometrine plus Oxytocin; 250 mcg plus 20 IU; by an intravenous bolus	0	24	Oxytocin; 20 IU; by an intravenous bolus + infusion	0	24	NA	NA	NA	NA	NA	NA
Bamigboye, Merrell 1998	low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	0	231	Ergometrine plus Oxytocin; 500 mcg and 5 IU; Intramuscularly	0	233	NA	NA	NA	NA	NA	NA
Baskett 2007	both high and low risk;	Oxytocin; 5 IU; by an	0	311	Misoprostol; 400 mcg; orally	0	311	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	vaginal delivery	intravenous bolus											
Begley 1990	low risk; vaginal delivery	Ergometrine; 500 mcg; Intravenous bolus	1	705	Placebo or control; ; (Control)	3	724	NA	NA	NA	NA	NA	NA
Bellad 2012	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	1	321	Oxytocin; 10 IU; Intramuscularly	1	331	NA	NA	NA	NA	NA	NA
Bhatti 2014	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	1	60	Oxytocin; 10 IU; Intramuscularly	1	60	NA	NA	NA	NA	NA	NA
Bhullar 2004	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 200 mcg plus 20 IU; sublingually plus by an intravenous infusion	3	377	Oxytocin; 20 IU; by an intravenous infusion	6	379	NA	NA	NA	NA	NA	NA
Biswas 2007	both high and low risk; vaginal delivery	Carboprost; 125 mcg; Intramuscularly	0	50	Ergometrine; 200 mcg; Intramuscularly	2	50	NA	NA	NA	NA	NA	NA
Boucher 1998	high risk; elective	Carbetocin; 100 mcg; by an	0	29	Oxytocin; 32.5 IU; by an	0	28	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	caesarean section	intravenous bolus			intravenous bolus + infusion								
Bugalho 2001	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	2	323	Oxytocin; 10 IU; Intramuscularly	1	339	NA	NA	NA	NA	NA	NA
Butwick 2010	high risk; elective caesarean section	Placebo or control; ; (Placebo)	0	15	Oxytocin; ≤ 1 IU; by an intravenous bolus	0	29	Oxytocin; > 1 IU to ≤ 5 IU; by an intravenous bolus	0	30	NA	NA	NA
Caliskan 2002	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; rectally plus by an intravenous infusion	4	401	Misoprostol; 400 mcg; rectally	12	396	Oxytocin; 10 IU; by an intravenous infusion	13	407	Ergometrine plus Oxytocin; 200 mcg plus 10 IU; Intramuscularly plus by an intravenous infusion	4	402
Caliskan 2003	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; orally plus by an intravenous infusion	5	404	Misoprostol; 400 mcg; orally	14	388	Oxytocin; 10 IU; by an intravenous infusion	13	384	Ergometrine plus Oxytocin; 200 mcg plus 10 IU; Intramuscularly plus by an intravenous infusion	6	398
Carbonell i	both high and low	Misoprostol plus	5	702	Oxytocin; 10 IU;	13	698	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Esteve 2009	risk; vaginal delivery	Oxytocin; 400 mcg and 200 mcg plus 10 IU; sublingually and rectally plus intramuscularly			Intramuscularly								
Carillo-Gaucin 2016	high risk; emergency caesarean section	Carbetocin; unspecified dose; by an unspecified route	1	60	Oxytocin; unspecified dose; by an unspecified route	2	57	NA	NA	NA	NA	NA	NA
Chandiok 2006	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	1	600	Ergometrine; 200 mcg; Intramuscularly	0	600	NA	NA	NA	NA	NA	NA
Chaudhuri 2010	high risk; both elective or emergency caesarean	Misoprostol; 800 mcg; rectally	0	96	Oxytocin; 40 IU; by an intravenous infusion	3	94	NA	NA	NA	NA	NA	NA
Chaudhuri 2012	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	5	265	Oxytocin; 10 IU; Intramuscularly	3	265	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Chaudhuri 2015	high risk; emergency caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intramuscular bolus and intravenous infusion	10	198	Oxytocin; 20 IU; Intramuscular bolus plus an intravenous infusion	15	198	NA	NA	NA	NA	NA	NA
Chaudhuri 2016	high risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; sublingually plus intramuscularly	5	144	Oxytocin; 10 IU; Intramuscularly	12	144	NA	NA	NA	NA	NA	NA
Chhabra 2008	low risk; vaginal delivery	Misoprostol; ≤600 mcg; sublingually	0	200	Ergometrine; 200 mcg; by an intravenous bolus	0	100	NA	NA	NA	NA	NA	NA
Choy 2002	low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	13	493	Oxytocin; 10 IU; by an intravenous bolus	7	487	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Cook 1999	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; orally	5	424	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	3	310	Oxytocin; 10 IU; Intramuscularly	2	129	NA	NA	NA
Danserau 1999	high risk; elective caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	2	317	Oxytocin; 25 IU; by an intravenous bolus + infusion	2	318	NA	NA	NA	NA	NA	NA
de Groot 1996	low risk; vaginal delivery	Placebo or control; ; (Placebo)	3	143	Oxytocin; 5 IU; Intramuscularly	2	78	NA	NA	NA	NA	NA	NA
Derman 2006	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	1	812	Placebo or control; ; (Placebo)	7	808	NA	NA	NA	NA	NA	NA
Dhananjaya 2014	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	0	50	Ergometrine ; 200 mcg; Intramuscularly	4	50	NA	NA	NA	NA	NA	NA
Diallo 2017	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; orally	5	154	Oxytocin; 5 IU; by an intravenous bolus	7	150	NA	NA	NA	NA	NA	NA
Dutta 2016	low risk; vaginal delivery	Misoprostol; 600 mcg; rectally	5	200	Oxytocin; 10 IU;	4	200	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
					Intramuscularly								
El Behery 2015	high risk; emergency caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	0	90	Oxytocin; 20 IU; by an intravenous infusion	14	90	NA	NA	NA	NA	NA	NA
El Tahan 2012	high risk; elective caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; sublingually plus by an intravenous bolus	0	179	Oxytocin; 10 IU; by an intravenous infusion	11	187	NA	NA	NA	NA	NA	NA
Elbohoty 2016	high risk; elective caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	0	88	Misoprostol; 400 mcg; sublingually	1	89	Oxytocin; 30 IU; by an intravenous bolus + infusion	1	86	NA	NA	NA
Elgafor el Sharkwy 2013	high risk; elective caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intravenous infusion	4	190	Carbetocin; 100 mcg; by an intravenous bolus	1	190	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
El-Refaey 2000	both high and low risk; vaginal delivery	Misoprostol; 500 mcg; orally	9	501	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	11	499	NA	NA	NA	NA	NA	NA
Elsedeek 2012	high risk; elective caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; rectally plus by an intravenous infusion	0	200	Oxytocin; 10 IU; by an intravenous infusion	0	200	NA	NA	NA	NA	NA	NA
Ezeama 2014	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	9	151	Ergometrine; 500 mcg; Intramuscularly	1	149	NA	NA	NA	NA	NA	NA
Fahmy 2015	high risk; elective caesarean section	Oxytocin; > 5 to ≤ 10 IU; by an intravenous bolus	0	50	Carbetocin; 100 mcg; by an intravenous bolus	0	50	Oxytocin; > 10 IU; by intravenous bolus plus intravenous infusion	0	50	NA	NA	NA
Fahmy 2016	high risk; elective caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	1	30	Oxytocin; 20 IU; by an intravenous bolus	4	30	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Fazel 2013	high risk; elective caesarean section	Misoprostol; 400 mcg; rectally	0	50	Oxytocin; 10 IU; by an intravenous infusion	0	50	NA	NA	NA	NA	NA	NA
Fekih 2009	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 200 mcg plus 20 IU; sublingually plus by an intravenous bolus and infusion	0	125	Oxytocin; 20 IU; by an intravenous bolus + infusion	4	125	NA	NA	NA	NA	NA	NA
Fenix 2012	high risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	0	30	Oxytocin; 10 IU; by an intravenous infusion	0	30	NA	NA	NA	NA	NA	NA
Gerstenfeld 2001	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	2	159	Oxytocin; 20 IU; by an intravenous infusion	0	166	NA	NA	NA	NA	NA	NA
Gulmezoglu 2001	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	72	9221	Oxytocin; 10 IU; Intramuscularly or by an intravenous bolus	97	9226	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Gupta 2006	Both high and low risk; vaginal delivery	Misoprostol; 600 mcg; rectally	0	100	Oxytocin; 10 IU; Intramuscularly	0	100	NA	NA	NA	NA	NA	NA
Hamm 2005	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 200 mcg plus 20 IU; sublingually plus by an intravenous infusion	3	173	Oxytocin; 20 IU; by an intravenous infusion	3	179	NA	NA	NA	NA	NA	NA
Harriott 2009	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	0	70	Misoprostol; 400 mcg; rectally	0	70	NA	NA	NA	NA	NA	NA
Hernandez-Castro 2016	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intravenous infusion	0	60	Oxytocin; 20 IU; by an intravenous infusion	5	60	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Hofmeyr 1998	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	1	250	Placebo or control; ; (Placebo)	1	250	NA	NA	NA	NA	NA	NA
Hofmeyr 2001	unspecified; vaginal delivery	Misoprostol; 600 mcg; orally	1	299	Placebo or control; ; (Placebo)	2	300	NA	NA	NA	NA	NA	NA
Hong 2007	high risk; caesarean (unspecified whether elective or emergency)	Oxytocin; 20 IU; by an intravenous infusion	13	118	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; rectally plus by an intravenous infusion	11	96	NA	NA	NA	NA	NA	NA
Humera 2016	high risk; vaginal delivery	Misoprostol; 600 mcg; orally	0	50	Ergometrine; 200 mcg; by an intravenous bolus	0	50	NA	NA	NA	NA	NA	NA
Ibrahim 2017	high risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	3	30	Misoprostol; 600 mcg; sublingually	4	30	NA	NA	NA	NA	NA	NA
Ibrahim 2020	high risk; caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	0	80	Oxytocin; 10 IU; intravenous infusion	8	80	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Jangsten 2011	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	18	810	Placebo or control; ; (Control)	23	821	NA	NA	NA	NA	NA	NA
Jans 2016	low risk; vaginal delivery	Oxytocin; 5 IU; Intramuscularly	10	851	Placebo or control; ; (Control)	12	835	NA	NA	NA	NA	NA	NA
Jerbi 2007	low risk; vaginal delivery	Oxytocin; 5 IU; by an intravenous bolus	0	65	Placebo or control; ; (Control)	0	65	NA	NA	NA	NA	NA	NA
Kabir 2015	both high and low risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	0	47	Oxytocin; 10 IU; Intramuscularly	3	47	NA	NA	NA	NA	NA	NA
Kang 2022	high risk; caesarean section	Carbetocin; 100 mcg; by intravenous bolus	1	440	Oxytocin; 30 IU; uterine injection plus intravenous infusion	6	401	NA	NA	NA	NA	NA	NA
Karkanis 2002	low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	0	110	Oxytocin; 5 IU; by an intravenous bolus or intramuscularly	0	113	NA	NA	NA	NA	NA	NA
Khan 1995	both high and low	Oxytocin; 10 IU;	1	1012	Ergometrine plus	2	1016	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	risk; vaginal delivery	Intramuscularly			Oxytocin; 500 mcg plus 5 IU; Intramuscularly								
Koen 2016	high risk; both elective or emergency caesarean	Oxytocin; 12.5 IU; by an intravenous bolus + infusion	19	214	Ergometrine plus Oxytocin; 500 mcg plus 15 IU; intramuscularly plus by an intravenous infusion	7	202	NA	NA	NA	NA	NA	NA
Kumar 2016	both high and low risk; vaginal delivery	Carboprost; 125 mcg; Intramuscularly	0	100	Oxytocin; 10 IU; Intramuscularly	2	100	NA	NA	NA	NA	NA	NA
Kundodyiwa 2001	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	2	243	Oxytocin; 10 IU; Intramuscularly	1	256	NA	NA	NA	NA	NA	NA
Lapaire 2006	high risk; elective caesarean section	Oxytocin; 25 IU; by an intravenous bolus + infusion	0	25	Misoprostol plus Oxytocin; 800 mcg plus 5 IU; orally plus by an intravenous bolus	0	28	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Leung 2006	low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	5	150	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	2	150	NA	NA	NA	NA	NA	NA
Lokugamage 2001	high risk; both elective or emergency caesarean	Oxytocin; 10 IU; by an intravenous bolus	0	20	Misoprostol; 500 mcg; orally	1	20	NA	NA	NA	NA	NA	NA
Lui 2020	high risk; vaginal delivery	Carbetocin; 100 mcg; Intravenous infusion	1	314	Oxytocin; 10 IU; intravenous infusion	2	310	NA	NA	NA	NA	NA	NA
Lumbiganon 1999	both high and low risk; vaginal delivery	Misoprostol; ≤ 600 mcg; orally	0	397	Oxytocin; 10 IU; Intramuscularly	0	200	NA	NA	NA	NA	NA	NA
Maged 2016	high risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	1	100	Oxytocin; 5 IU; Intramuscularly	2	100	NA	NA	NA	NA	NA	NA
Masse 2022	high risk; caesarean section	Ergometrine plus Oxytocin; 0.2 mg plus	4	80	Oxytocin; 30 IU; intravenous infusion	18	80	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
		30 IU; intramuscularly plus intravenous infusion											
McDonald 1993	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	24	1730	Oxytocin; 10 IU; Intramuscularly	16	1753	NA	NA	NA	NA	NA	NA
Modi 2014	low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	0	25	Ergometrine; 200 mcg; by an intravenous bolus	0	25	Carboprost; 125 mcg; Intramuscularly	2	25	Misoprostol; 600 mcg; rectally	0	25
Nahaer 2018	high risk; caesarean section	Carbetocin; 100 mcg; Intravenous bolus	1	50	Oxytocin; 10 IU; NR	10	50	NA	NA	NA	NA	NA	NA
Nankaly 2016	high risk; both elective or emergency caesarean	Oxytocin; 20 IU; by an intravenous infusion	5	63	Misoprostol; 400 mcg or 200 mcg; sublingually	1	122	NA	NA	NA	NA	NA	NA
Nasr 2009	low risk; vaginal delivery	Misoprostol; 800 mcg; rectally	8	257	Oxytocin; 5 IU; by an	4	257	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
					intravenous infusion								
Nayak 2017	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; sublingually plus by an intravenous bolus	9	100	Oxytocin; 10 IU; by an intravenous bolus	23	100	NA	NA	NA	NA	NA	NA
Nellore 2006	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	1	60	Carboprost; 125 mcg; Intramuscularly	0	60	NA	NA	NA	NA	NA	NA
Ng 2001	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	15	1026	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	16	1032	NA	NA	NA	NA	NA	NA
Ng 2007	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	8	178	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	4	177	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Nirmala 2009	high risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	0	60	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	1	60	NA	NA	NA	NA	NA	NA
Nordstrom 1997	both high and low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	5	513	Placebo or control; ; (Placebo)	7	487	NA	NA	NA	NA	NA	NA
Nuamsiri 2016	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 200 mcg plus 20 IU; by an intravenous bolus + infusion	2	162	Oxytocin; 20 IU; by an intravenous infusion	1	161	NA	NA	NA	NA	NA	NA
Oboro 2003	low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	0	249	Misoprostol; 600 mcg; orally	0	247	NA	NA	NA	NA	NA	NA
Otoide 2020	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	0	150	Ergometrine; 0.5 mg; intravenous	0	150	NA	NA	NA	NA	NA	NA
Ottun 2022	low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	2	517	Misoprostol plus Oxytocin; 200 mcg	1	519	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
					plus 10 IU; sublingually and intramuscular								
Owonikoko 2011	high risk; both elective or emergency caesarean	Oxytocin; 20 IU; by an intravenous infusion	0	50	Misoprostol; 400 mcg; sublingually	1	50	NA	NA	NA	NA	NA	NA
Parsons 2006	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	2	221	Misoprostol; 800 mcg; orally	1	222	NA	NA	NA	NA	NA	NA
Parsons 2007	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	5	221	Misoprostol; 800 mcg; rectally	1	217	NA	NA	NA	NA	NA	NA
Patil 2013	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	1	100	Ergometrine; 200 mcg; by an intravenous bolus	0	99	NA	NA	NA	NA	NA	NA
Perez-Rumbos 2017	both high and low risk;	Misoprostol; 600 mcg; rectally	2	195	Oxytocin; 20 IU; Intramuscularly	3	197	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	vaginal delivery												
Prendiville 1988	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	18	846	Placebo or control; ; (Control)	48	849	NA	NA	NA	NA	NA	NA
Quibel 2016	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; orally plus by an intravenous bolus	5	806	Oxytocin; 10 IU; by an intravenous bolus	9	797	NA	NA	NA	NA	NA	NA
Rajaei 2014	both high and low risk; vaginal delivery	Oxytocin; 20 IU; by an intravenous infusion	4	200	Misoprostol; 400 mcg; orally	1	200	NA	NA	NA	NA	NA	NA
Rashid 2009	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	6	340	Oxytocin; 10 IU; by an intravenous infusion	2	346	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Ray 2001	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; orally	1	100	Ergometrine; unspecified dose; by an unspecified route	3	100	NA	NA	NA	NA	NA	NA
Reyes 2011	high risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	1	45	Oxytocin; 20 IU; by an intravenous infusion	0	90	NA	NA	NA	NA	NA	NA
Reyes, Gonzalez 2011	high risk; both caesarean and vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	0	26	Oxytocin; 10 IU; by an intravenous infusion	3	29	NA	NA	NA	NA	NA	NA
Rogers 1998	low risk; vaginal delivery	Ergometrine plus Oxytocin; unspecified; Intramuscularly	4	748	Placebo or control; ; (Control)	20	764	NA	NA	NA	NA	NA	NA
Rozenberg 2015	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; orally plus by an intravenous bolus	6	806	Oxytocin; 10 IU; by an intravenous bolus	11	796	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
Sadiq 2011	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	0	884	Misoprostol; 600 mcg; orally	0	900	NA	NA	NA	NA	NA	NA
Shady 2017	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	0	120	Misoprostol; 600 mcg; sublingually	13	120	NA	NA	NA	NA	NA	NA
Shady 2019	low risk; vaginal delivery	Oxytocin; 10 IU; intravenous	0	120	misoprostol; 600 mcg; buccal	13	120	NA	NA	NA	NA	NA	NA
Shaheen 2019	low risk; vaginal delivery	Oxytocin; 10 IU; intramuscular	1	106	Misoprostol; 600 mcg; sublingually	2	106	NA	NA	NA	NA	NA	NA
Singh 2009	low risk; vaginal delivery	Misoprostol; 400 or 600 mcg; sublingually	0	150	Oxytocin; 5 IU; by an intravenous bolus	0	75	Ergometrine; 200 mcg; by an intravenous bolus	3	75	NA	NA	NA
Sitaula 2017	high risk; elective caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; rectally plus by an intravenous infusion	0	100	Oxytocin; 20 IU; by an intravenous infusion	1	100	NA	NA	NA	NA	NA	NA
Soltan 2007	both high and low risk;	Ergometrine; 200 mcg; Intramuscularly	1	266	Misoprostol; ≤600 mcg; sublingually	0	271	Misoprostol; >600 mcg to ≤800 mcg; sublingually	1	269	Misoprostol; >800 mcg to ≤1000 mcg; sublingually	0	278

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	vaginal delivery												
Sood 2012	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intravenous infusion	3	90	Oxytocin; 20 IU; by an intravenous infusion	2	84	NA	NA	NA	NA	NA	NA
Su 2009	low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	1	185	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	0	185	NA	NA	NA	NA	NA	NA
Sultana 2007	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	4	210	Oxytocin; 10 IU; Intramuscularly	3	190	NA	NA	NA	NA	NA	NA
Supe 2016	both high and low risk; vaginal delivery	Misoprostol; 800 mcg; rectally	0	50	Ergometrine; 200 mcg; Intramuscularly	0	50	Carboprost; 125 mcg; Intramuscularly	0	50	Placebo or control; ; (Control)	0	50
Sweed 2018	high risk; caesarean section	oxytocin; 5 IU; intravenous	10	212	Misoprostol plus Oxytocin; 400 mcg plus 5IU;	9	424	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
					rectal or sublingual plus intravenous								
Taheripanah 2017	high risk; emergency caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	0	110	Oxytocin; 30 IU; by an intravenous infusion	0	110	NA	NA	NA	NA	NA	NA
Tewatia 2014	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous infusion	0	50	Misoprostol; 600 mcg; sublingually	0	50	NA	NA	NA	NA	NA	NA
Thilaganathan 1993	low risk; vaginal delivery	Placebo or control; ; (Control)	0	90	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	1	103	NA	NA	NA	NA	NA	NA
Ugwu 2014	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intravenous infusion	1	60	Oxytocin; 20 IU; by an intravenous infusion	1	59	NA	NA	NA	NA	NA	NA
Uncu 2015	both high and low risk;	Placebo or control; ; (Control)	0	49	Misoprostol; ≤600 mcg; orally,	2	151	Misoprostol; >600 mcg to	1	48	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
	vaginal delivery				vaginally or rectally			≤800 mcg; oral, vaginally					
Vagge 2014	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous infusion	1	100	Misoprostol; 800 mcg; rectally	1	100	NA	NA	NA	NA	NA	NA
Vaid 2009	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	1	66	Ergometrine; 200 mcg; Intramuscularly	0	67	Carboprost; 125 mcg; Intramuscularly	0	67	NA	NA	NA
Van Der Nelson 2021	low risk; vaginal delivery	carbetocin; 100 mcg; intramuscularly	54	1909	Ergometrine plus oxytocin; 500 mcg plus 5 IU; intramuscularly	51	1914	Oxytocin; 10 IU; Intramuscularly	58	1894	NA	NA	NA
van Selm 1995	high risk; vaginal delivery	Ergometrine plus Oxytocin; 200 mcg plus 5 IU; Intramuscularly	5	36	Carboprost; 500 mcg; Intramuscularly	3	33	NA	NA	NA	NA	NA	NA
Vimala 2004	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	0	60	Ergometrine; 200 mcg; by an intravenous bolus	0	60	NA	NA	NA	NA	NA	NA
Walley 2000	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	0	136	Oxytocin; 10 IU;	1	138	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 events	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 events	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 events	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 events	Arm 4 total
					Intramuscularly								
Whigham 2016	high risk; emergency caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	1	59	Oxytocin; 5 IU; by an intravenous bolus	1	53	NA	NA	NA	NA	NA	NA
Widmer 2018	both high and low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	229	14771	Oxytocin; 10 IU; Intramuscularly	198	14768	NA	NA	NA	NA	NA	NA
Yesmin 2022	high risk; caesarean section	Carbetocin; 100 mcg; intravenous bolus	0	32	Oxytocin; 10 IU; intravenous bolus	3	32	NA	NA	NA	NA	NA	NA
Yuen 1995	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	10	496	Oxytocin; 10 IU; Intramuscularly	12	495	NA	NA	NA	NA	NA	NA
Zachariah 2006	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; orally	1	730	Oxytocin; 10 IU; Intramuscularly	2	617	Ergometrine; 200 mcg; by an intravenous bolus	3	676	NA	NA	NA
Zgaya 2020	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	0	111	Placebo or control; N/A; NR	0	100	NA	NA	NA	NA	NA	NA

D7 – Blood loss volume (mL)

Table 7: Evidence table for blood loss volume (mL)

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Abdel-Aleem 1993	low risk; vaginal delivery	Ergometrine; 200 mcg; by an intravenous bolus	319	52.3	77	Carboprost; 250 mcg; Intramuscularly	179	59	73	NA	NA	NA	NA	NA	NA	NA	NA
Acharya 2001	high risk; elective caesarean section	Oxytocin; 10 IU; by an intravenous bolus	533	296.21	30	Misoprostol; 400 mcg; orally	545	192.82	30	NA	NA	NA	NA	NA	NA	NA	NA
Afolabi 2010	low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	155.6	57.96	100	Misoprostol; 400 mcg; orally	153.2	57.96	100	NA	NA	NA	NA	NA	NA	NA	NA
Ahmed 2014	high risk; both elective or emergency caesarean	Carbetocin; 100 mcg; by an intravenous bolus	323	542.17	40	Oxytocin; 10 IU; by an intravenous bolus	673	542.17	40	NA	NA	NA	NA	NA	NA	NA	NA
Al-Sawaf 2013	both high and low risk; vaginal delivery	Placebo or control; ; (Control)	438.6	130.2	39	Misoprostol; 200 mcg; sublingually	348	112	28	Oxytocin; 5 IU; Intramuscularly	314.7	94.6	37	NA	NA	NA	NA
Amin 2014	both high and low	Oxytocin; 5 IU; by an	250	262.77	100	Misoprostol; 800	300	262.77	100	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
	risk; vaginal delivery	intravenous bolus				mcg; rectally											
Anupama 2021	high risk; elective caesarean section	Misoprostol; 400 mcg; sublingually	370.8	5.47	45	placebo or control; N/A; sublingually	622.8	14.19	45	NA	NA	NA	NA	NA	NA	NA	NA
Askar 2011	low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	224.6	110.6	120	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	306.1	95.65	120	NA	NA	NA	NA	NA	NA	NA	NA
Asmat 2017	both high and low risk; vaginal delivery	Misoprostol; 800 mcg; rectally	322	199.86	839	Oxytocin; 10 IU; Intramuscularly	337	211.44	839	NA	NA	NA	NA	NA	NA	NA	NA
Attilakos 2010	high risk; both elective or emergency caesarean	Carbetocin; 100 mcg; by an intravenous bolus	500	222.39	188	Oxytocin; 5 IU; by an intravenous bolus	500	148.26	189	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Atukunda 2014	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	304.2	190.8	570	Misoprostol; 600 mcg; sublingually	341.5	206.2	570	NA	NA	NA	NA	NA	NA	NA	NA
Badejoko 2012	high risk; vaginal delivery	Oxytocin; 30 IU; by an intravenous bolus + infusion	386.73	298.51	129	Misoprostol plus Oxytocin; 600 mcg plus 20 IU; rectally plus by an intravenous infusion	387.28	203.09	126	NA	NA	NA	NA	NA	NA	NA	NA
Bagheri 2022	high risk; elective caesarean section	Oxytocin; 20 IU; Intravenous infusion	137.9	33.8	60	Misoprostol; 200 mcg; sublingually plus rectally	172.15	4.22	120	NA	NA	NA	NA	NA	NA	NA	NA
Balki 2008	high risk; emergency caesarean section	Ergometrine plus Oxytocin; 250 mcg plus 20 IU; by an intravenous bolus	1218	716	24	Oxytocin; 20 IU; by an intravenous bolus + infusion	1299	774	24	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Balki 2021	high risk; caesarean section	Ergometrine plus Oxytocin; 0.25 mg plus 5 IU; by an intravenous bolus	1145	103.75	33	Oxytocin; 5 IU; by an intravenous bolus	1180	85.19	35	NA	NA	NA	NA	NA	NA	NA	NA
Bamigboye, Merrell 1998	low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	187	92	231	Ergometrine plus Oxytocin; 500 mcg and 5 IU; Intramuscularly	183	68	233	NA	NA	NA	NA	NA	NA	NA	NA
Begley 1990	low risk; vaginal delivery	Ergometrine; 500 mcg; Intravenous bolus	148.9	127.1	705	Placebo or control; ; (Control)	234.8	223.9	724	NA	NA	NA	NA	NA	NA	NA	NA
Bellad 2012	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	192	123.98	321	Oxytocin; 10 IU; Intramuscularly	366	135.9	331	NA	NA	NA	NA	NA	NA	NA	NA
Benchimol 2001	both high and low risk; vaginal delivery	Placebo or control; ; (Control)	382	269.5	220	Oxytocin; 2.5 IU; by an intraven	278	253.96	196	Misoprostol; 600 mcg; orally	374	238.39	186	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
						ous bolus											
Bhatti 2014	both high and low risk; vaginal delivery	Misoprostol ; 400 mcg; sublingually	200	125	60	Oxytocin; 10 IU; Intramuscularly	360	136	60	NA	NA	NA	NA	NA	NA	NA	NA
Bhullar 2004	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 200 mcg plus 20 IU; sublingually plus by an intravenous infusion	322	114	377	Oxytocin; 20 IU; by an intravenous infusion	329	123	379	NA	NA	NA	NA	NA	NA	NA	NA
Borruto 2009	high risk; both elective or emergency caesarean	Carbetocin; 100 mcg; by an intravenous bolus	370.1	226	52	Oxytocin; 10 IU; by an intravenous infusion	400.5	226	52	NA	NA	NA	NA	NA	NA	NA	NA
Boucher 1998	high risk; elective caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	159	92	29	Oxytocin; 32.5 IU; by an intravenous bolus + infusion	188	115	28	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Boucher 2004	high risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	413.3	197.5	64	Oxytocin; 10 IU; Intravenous infusion	410.4	194.1	67	NA	NA	NA	NA	NA	NA	NA	NA
Bugalho 2001	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	155	122	323	Oxytocin; 10 IU; Intramuscularly	157.3	138.7	339	NA	NA	NA	NA	NA	NA	NA	NA
Butwick 2010	high risk; elective caesarean section	Placebo or control; ; (Placebo)	800	66.1	15	Oxytocin; ≤ 1 IU; by an intravenous bolus	801.24	38.04	29	Oxytocin; > 1 IU to ≤ 5 IU; by an intravenous bolus	702	21.64	30	NA	NA	NA	NA
Caliskan 2003	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; orally plus by an intravenous infusion	280	182	404	Misoprostol; 400 mcg; orally	328	152	388	Oxytocin; 10 IU; by an intravenous infusion	312	176	384	Ergometrine plus Oxytocin; 200 mcg plus 10 IU; Intramuscularly plus by an intravenous infusion	296	168	398

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Carbonell i Esteve 2009	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg and 200 mcg plus 10 IU; sublingually and rectally plus intramuscularly	243.63	181.22	702	Oxytocin; 10 IU; Intramuscularly	240.93	145.83	698	NA	NA	NA	NA	NA	NA	NA	NA
Carillo-Gaucin 2016	high risk; emergency caesarean section	Carbetocin; unspecified dose; by an unspecified route	482.5	126.5	60	Oxytocin; unspecified dose; by an unspecified route	464.04	180.72	57	NA	NA	NA	NA	NA	NA	NA	NA
Chandiok 2006	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	139.7	100.4	600	Ergometrine; 200 mcg; Intramuscularly	211	83.4	600	NA	NA	NA	NA	NA	NA	NA	NA
Chaudhuri 2010	high risk; both elective or emergenc	Misoprostol; 800 mcg; rectally	502.79	178.35	96	Oxytocin; 40 IU; by an intraven	592.41	225.35	94	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
	y caesarean					ous infusion											
Chaudhuri 2012	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	153.2	143.51	265	Oxytocin; 10 IU; Intramuscularly	146.9	158.52	265	NA	NA	NA	NA	NA	NA	NA	NA
Chaudhuri 2015	high risk; emergency caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intramuscular bolus and intravenous infusion	505.4	215.5	198	Oxytocin; 20 IU; Intramuscular bolus plus an intravenous infusion	587.3	201.5	198	NA	NA	NA	NA	NA	NA	NA	NA
Chaudhuri 2016	high risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; sublingually plus intramuscularly	225.8	156.7	144	Oxytocin; 10 IU; Intramuscularly	302.4	230.3	144	NA	NA	NA	NA	NA	NA	NA	NA
Chhabra 2008	low risk; vaginal delivery	Misoprostol; ≤600 mcg; sublingually	150	3.54	200	Ergometrine; 200 mcg; by an	150	5.2	100	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
						intravenous bolus											
Choy 2002	low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	200	111.19	500	Oxytocin; 10 IU; by an intravenous bolus	200	111.19	491	NA	NA	NA	NA	NA	NA	NA	NA
Cook 1999	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; orally	279	300.63	424	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	255.14	338.75	310	Oxytocin; 10 IU; Intramuscularly	98	71.55	129	NA	NA	NA	NA
Dasuki 2002	unspecified; vaginal delivery	Misoprostol; 600 mcg; orally	238.73	94.54	98	Oxytocin; 10 IU; Intramuscularly	225.87	94.54	98	NA	NA	NA	NA	NA	NA	NA	NA
de Groot 1996	low risk; vaginal delivery	Placebo or control; ; (Placebo)	520	419	143	Oxytocin; 5 IU; Intramuscularly	499	454	78	NA	NA	NA	NA	NA	NA	NA	NA
Derman 2006	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	214.3	144.6	811	Placebo or control; ;	262.3	203.2	808	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
						(Placebo)											
Dhananjaya 2014	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	219	86.3	50	Ergometrine; 200 mcg; Intramuscularly	345	109.53	50	NA	NA	NA	NA	NA	NA	NA	NA
Diallo 2017	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; orally	196.5	210	154	Oxytocin; 5 IU; by an intravenous bolus	208.4	324	150	NA	NA	NA	NA	NA	NA	NA	NA
Docherty 1981	unspecified; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	383	160.64	25	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	278	160.64	25	NA	NA	NA	NA	NA	NA	NA	NA
Dutta 2016	low risk; vaginal delivery	Misoprostol; 600 mcg; rectally	185.67	84.42	200	Oxytocin; 10 IU; Intramuscularly	168.47	68.38	200	NA	NA	NA	NA	NA	NA	NA	NA
Eftekhari 2009	high risk; elective caesarean section	Misoprostol; 400 mcg; sublingually	608.78	18.01	50	Oxytocin; 20 IU; by an intraven	673.86	27.03	50	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
						ous infusion											
El Behery 2015	high risk; emergency caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	689	580	90	Oxytocin; 20 IU; by an intravenous infusion	1027	659	90	NA	NA	NA	NA	NA	NA	NA	NA
El Tahan 2012	high risk; elective caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; sublingually plus by an intravenous bolus	324	97.44	179	Oxytocin; 10 IU; by an intravenous infusion	894	160.91	187	NA	NA	NA	NA	NA	NA	NA	NA
El-Refaey 2000	both high and low risk; vaginal delivery	Misoprostol; 500 mcg; orally	256	137.03	501	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	251	136.76	499	NA	NA	NA	NA	NA	NA	NA	NA
Elsedeek 2012	high risk; elective caesarean section	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; rectally plus	429	234	200	Oxytocin; 10 IU; by an intravenous infusion	620	375	200	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
		by an intravenous infusion															
Enakpene 2007	Low risk; vaginal delivery	Misoprostol; 400 mcg; orally	191.6	134.5	432	Ergometrine; 500 mcg; Intramuscularly	246	175.5	432	NA	NA	NA	NA	NA	NA	NA	NA
Ezeama 2014	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	301.8	109.2	151	Ergometrine; 500 mcg; Intramuscularly	287.1	84.4	149	NA	NA	NA	NA	NA	NA	NA	NA
Fahmy 2015	high risk; elective caesarean section	Oxytocin; > 5 to ≤ 10 IU; by an intravenous bolus	449	9.75	50	Carbetocin; 100 mcg; by an intravenous bolus	398.7	8.54	50	Oxytocin; > 10 IU; by intravenous bolus plus intravenous infusion	467.8	9.6	50	NA	NA	NA	NA
Fahmy 2016	high risk; elective caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	437	45	30	Oxytocin; 20 IU; by an intravenous bolus	721	50	30	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Fararjeh 2003	low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	587.95	359.99	49	Ergometrine plus Oxytocin; 200 mcg plus 10 IU; Intramuscularly	387.08	273.38	48	NA	NA	NA	NA	NA	NA	NA	NA
Fawzy 2012	low risk; vaginal delivery	Ergometrine; 500 mcg; by an intravenous bolus	275.76	165.5	100	Misoprostol; 200 mcg; sublingually or rectally	233.54	132.93	200	NA	NA	NA	NA	NA	NA	NA	NA
Fazel 2013	high risk; elective caesarean section	Misoprostol; 400 mcg; rectally	578	185	50	Oxytocin; 10 IU; by an intravenous infusion	620	213	50	NA	NA	NA	NA	NA	NA	NA	NA
Fekih 2009	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 200 mcg plus 20 IU; sublingually plus by an intravenous bolus and infusion	669.68	333.01	125	Oxytocin; 20 IU; by an intravenous bolus + infusion	852.52	295.08	125	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Fenix 2012	high risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	296	183.26	30	Oxytocin; 10 IU; by an intravenous infusion	493.3	183.26	30	NA	NA	NA	NA	NA	NA	NA	NA
Fu 2003	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; orally	212.25	75.02	76	Placebo or control; ; (Control)	242.89	87.01	80	NA	NA	NA	NA	NA	NA	NA	NA
Gavilanes 2015	high risk; elective caesarean section	Misoprostol; 400 mcg; sublingually	837	287	50	Oxytocin; 10 IU; by an intravenous infusion	829	417	50	NA	NA	NA	NA	NA	NA	NA	NA
Gulmezoglu 2001	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	332.8	274.6	9213	Oxytocin; 10 IU; Intramuscularly or by an intravenous bolus	289.7	262.1	9227	NA	NA	NA	NA	NA	NA	NA	NA
Gupta 2006	Both high and low risk; vaginal delivery	Misoprostol; 600 mcg; rectally	161.67	76.81	100	Oxytocin; 10 IU; Intramuscularly	150.97	69.14	100	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Hamm 2005	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 200 mcg plus 20 IU; sublingually plus by an intravenous infusion	749	173	173	Oxytocin; 20 IU; by an intravenous infusion	725	212	179	NA	NA	NA	NA	NA	NA	NA	NA
Harriott 2009	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	197	177	70	Misoprostol; 400 mcg; rectally	180.1	120	70	NA	NA	NA	NA	NA	NA	NA	NA
Hofmeyr 2011	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; sublingually plus intramuscularly	189	288.14	540	Oxytocin; 10 IU; Intramuscularly	199	290.54	549	NA	NA	NA	NA	NA	NA	NA	NA
Hoj 2005	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; sublingually	443	338.29	330	Placebo or control; ; (Placebo)	496	380.57	331	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Humera 2016	high risk; vaginal delivery	Misoprostol; 600 mcg; orally	195.1	94.25	50	Ergometrine; 200 mcg; by an intravenous bolus	172.8	79.65	50	NA	NA	NA	NA	NA	NA	NA	NA
Ibrahim 2017	high risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	278	36.9	30	Misoprostol; 600 mcg; sublingually	403	37.6	30	NA	NA	NA	NA	NA	NA	NA	NA
Ibrahim 2020	high risk; caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	424.75	20.4	80	Oxytocin; 10 IU; intravenous infusion	679.5	22.4	80	NA	NA	NA	NA	NA	NA	NA	NA
Jago 2007	both high and low risk; vaginal delivery	Ergometrine; 500 mcg; Intramuscularly	150.2	63.6	254	Oxytocin; 10 IU; by an intravenous bolus	171.9	81.6	256	NA	NA	NA	NA	NA	NA	NA	NA
Jain 2019	low risk; vaginal delivery	Oxytocin; 5 IU; by intravenous	334.5	14.1	24	Misoprostol; 400 mcg; rectally	346.13	11.9	24	Ergometrine; 0.2 mg ; Intramuscularly	246.87	13.4	24	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Jangsten 2011	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	535	414.5	810	Placebo or control; ; (Control)	680	486.7	821	NA	NA	NA	NA	NA	NA	NA	NA
Jirakulsawas 2000	unspecified; vaginal delivery	Misoprostol; 600 mcg; orally	490.5	109.8	70	Ergometrine; 200 mcg; Intramuscularly	484.71	120.1	70	NA	NA	NA	NA	NA	NA	NA	NA
Kabir 2015	both high and low risk; vaginal delivery	Carbetocin; 100 mcg; by an intravenous bolus	325	306	47	Oxytocin; 10 IU; Intramuscularly	389	366	47	NA	NA	NA	NA	NA	NA	NA	NA
Kang 2022	high risk; caesarean section	Carbetocin; 100 mcg; by intravenous bolus	370.3	8.46	440	Oxytocin; 30 IU; uterine injection plus intravenous infusion	386.6	9.57	401	NA	NA	NA	NA	NA	NA	NA	NA
Khurshid 2010	both high and low risk; vaginal delivery	Carboprost; 125 mcg; Intramuscularly	63.6	10.1	100	Ergometrine; 200 mcg; by an intraven	83.6	14.1	100	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
						ous bolus											
Koen 2016	high risk; both elective or emergency caesarean	Oxytocin; 12.5 IU; by an intravenous bolus + infusion	610	249	214	Ergometrine plus Oxytocin; 500 mcg plus 15 IU; intramuscularly plus by an intravenous infusion	590	245	202	NA	NA	NA	NA	NA	NA	NA	NA
Kumar 2016	both high and low risk; vaginal delivery	Carboprost; 125 mcg; Intramuscularly	170.2	197.41	100	Oxytocin; 10 IU; Intramuscularly	281.05	197.41	100	NA	NA	NA	NA	NA	NA	NA	NA
Kumar 2021	low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	329.01	9.4	40	Misoprostol; 600 mcg; rectally	332.41	11.49	40	NA	NA	NA	NA	NA	NA	NA	NA
Kumru 2005	high risk; both elective or emergency caesarean	Oxytocin; 10 IU; by an intravenous bolus + infusion	235.8	74.5	35	Ergometrine plus Oxytocin; 200 mcg plus 10 IU; by	165.8	55.4	20	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
						an intravenous bolus plus by intravenous bolus plus infusion											
Kundodyiwa 2001	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	354	99.25	243	Oxytocin; 10 IU; Intramuscularly	348	99.25	256	NA	NA	NA	NA	NA	NA	NA	NA
Kushtagi 2006	unspecified; vaginal delivery	Ergometrine; 200 mcg; by an intravenous bolus	214.1	110	107	Carboprost; 125 mcg; Intramuscularly	235.7	99.3	108	NA	NA	NA	NA	NA	NA	NA	NA
Lamont 2001	both high and low risk; both caesarean and vaginal delivery	Carboprost; 250 mcg; Intramuscularly	335.5	264.4	263	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	350.6	627.6	266	NA	NA	NA	NA	NA	NA	NA	NA
Lapaire 2006	high risk; elective caesarean section	Oxytocin; 25 IU; by an intravenous	970	560	25	Misoprostol plus Oxytocin; 800	1083	920	28	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
		bolus + infusion				mcg plus 5 IU; orally plus by an intravenous bolus											
Leung 2006	low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	232	122	150	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	249	175	150	NA	NA	NA	NA	NA	NA	NA	NA
Lokugamage 2001	high risk; both elective or emergency caesarean	Oxytocin; 10 IU; by an intravenous bolus	643	236.54	20	Misoprostol; 500 mcg; orally	667	236.54	20	NA	NA	NA	NA	NA	NA	NA	NA
Lui 2020	high risk; vaginal delivery	Carbetocin; 100 mcg; Intravenous infusion	329.1	13.34	314	Oxytocin; 10 IU; intravenous infusion	307.9	13.76	310	NA	NA	NA	NA	NA	NA	NA	NA
Lumbiganon 1999	both high and low risk;	Misoprostol; ≤ 600 mcg; orally	355.86	15.61	397	Oxytocin; 10 IU;	353	21.92	200	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
	vaginal delivery					Intramuscularly											
Maged 2016	high risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	337.73	118.77	100	Oxytocin; 5 IU; Intramuscularly	378	143.2	100	NA	NA	NA	NA	NA	NA	NA	NA
Maged 2017	high risk; both elective or emergency caesarean	Carbetocin; 100 mcg; by an intravenous bolus	578	178	150	Ergometrine plus Oxytocin; 200 mcg plus 5 IU; by an intravenous bolus	602	213	150	NA	NA	NA	NA	NA	NA	NA	NA
Maged 2020	low risk; vaginal delivery	Carbetocin; 100 mcg; intravenous	292.2	3.79	75	misoprostol; 800 mcg; rectal	410.4	0.58	75	NA	NA	NA	NA	NA	NA	NA	NA
Malik 2018	low risk; vaginal delivery	Carboprost; 125 mcg; Intramuscularly	129	27.25	100	Ergometrine; 200 mcg; by an intravenous bolus	250	35.21	100	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Masse 2022	high risk; caesarean section	Ergometrine plus Oxytocin; 0.2 mg plus 30 IU; intramuscularly plus intravenous infusion	967	47.96	80	Oxytocin; 30 IU; intravenous infusion	1315	102.3	80	NA	NA	NA	NA	NA	NA	NA	NA
McDonagh 2022	high risk; caesarean section	Carbetocin; 20 mcg and 100 mcg; intravenous bolus	849.31	15.07	139	Oxytocin; 5.5 IU; Intravenous infusion	808.33	14.03	138	NA	NA	NA	NA	NA	NA	NA	NA
Mitchell 1993	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	187.2	140.42	228	Oxytocin; 5 IU; Intramuscularly	252.3	177.43	230	NA	NA	NA	NA	NA	NA	NA	NA
Mobeen 2011	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	337	226	514	Placebo or control; ; (Placebo)	366	262	558	NA	NA	NA	NA	NA	NA	NA	NA
Modi 2014	low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	223.2	122.53	25	Ergometrine; 200 mcg; by an	131	72.04	25	Carboprost; 125 mcg;	435	147.58	25	Misoprostol; 600 mcg; rectally	255.8	102.16	25

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
						intravenous bolus				Intramuscularly							
Mohamed 2015	high risk; elective caesarean section	Oxytocin; 5 IU; by an intravenous bolus	434.7	171.7	86	Carbetocin; 100 mcg; by an intravenous bolus	366.4	165	86	NA	NA	NA	NA	NA	NA	NA	NA
Moir 1979	low risk; vaginal delivery	Ergometrine; 500 mcg; by an intravenous bolus	201	50	44	Oxytocin; 10 IU; by an intravenous bolus	208	58	44	NA	NA	NA	NA	NA	NA	NA	NA
Moodie 1976	high risk; vaginal delivery	Ergometrine; 500 mcg; by an intravenous bolus	369	118	40	Oxytocin; 5 IU; by an intravenous bolus	391	129	40	NA	NA	NA	NA	NA	NA	NA	NA
Musa 2015	low risk; vaginal delivery	Misoprostol; 600 mcg; orally	325.85	164.72	100	Oxytocin; 10 IU; Intramuscularly	303.95	163.33	100	NA	NA	NA	NA	NA	NA	NA	NA
Nagaria 2006	both high and low risk; vaginal delivery	Carboprost; 125 mcg; Intramuscularly	74.86	27.16	100	Ergometrine; 200 mcg; by an	93.6	32.69	100	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
						intravenous bolus											
Nayak 2017	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; sublingually plus by an intravenous bolus	363.4	77.7	100	Oxytocin; 10 IU; by an intravenous infusion	481.3	116.6	100	NA	NA	NA	NA	NA	NA	NA	NA
Nellore 2006	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; rectally	245	158	60	Carboprost; 125 mcg; Intramuscularly	205	175	60	NA	NA	NA	NA	NA	NA	NA	NA
Ng 2001	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	296	160	1026	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	254	157	1032	NA	NA	NA	NA	NA	NA	NA	NA
Ng 2007	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	289	178	178	Ergometrine plus Oxytocin; 500 mcg plus 5	255	149	177	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
						IU; Intramuscularly											
Nihar 2022	high risk; both elective or emergency caesarean	Oxytocin; 10 IU; intravenous	278.8	3.2	50	ergometrine; 0.2 mg; intramuscularly	282	3.48	50	NA	NA	NA	NA	NA	NA	NA	NA
Nirmala 2009	high risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	244	114	60	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	343	143	60	NA	NA	NA	NA	NA	NA	NA	NA
Nordstrom 1997	both high and low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	409	345	513	Placebo or control; ; (Placebo)	527	412	487	NA	NA	NA	NA	NA	NA	NA	NA
Nuamsiri 2016	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 200 mcg plus 20 IU; by an intravenous bolus + infusion	145	74.13	162	Oxytocin; 20 IU; by an intravenous infusion	150	74.13	161	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Oboro 2003	low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	339	18.9	249	Misoprostol; 600 mcg; orally	341	19.3	247	NA	NA	NA	NA	NA	NA	NA	NA
Ogunbode 1979	both high and low risk; vaginal delivery	Ergometrine; 200 mcg or 500 mcg; Intramuscularly	96.04	54.18	96	Ergometrine plus Oxytocin; 500 mcg plus plus 5 IU; Intramuscularly	75.94	33.18	48	NA	NA	NA	NA	NA	NA	NA	NA
Orji 2008	both high and low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	245.66	77.6	297	Ergometrine; 250 mcg; by an intravenous bolus	246.58	95.43	303	NA	NA	NA	NA	NA	NA	NA	NA
Othman 2016	high risk; elective caesarean section	Misoprostol; 400 mcg; sublingually	490.75	159.9	60	Oxytocin; 20 IU; by an intravenous infusion	601.08	299.49	50	NA	NA	NA	NA	NA	NA	NA	NA
Ottun 2022	low risk; vaginal delivery	Oxytocin; 10 IU;	274.6	5.33	517	Misoprostol plus Oxytocin; 200	229.7	4.75	519	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
		Intramuscularly				mcg plus 10 IU; sublingually and intramuscular											
Owonikoko 2011	high risk; both elective or emergency caesarean	Oxytocin; 20 IU; by an intravenous infusion	650	251	50	Misoprostol; 400 mcg; sublingually	667	213	50	NA	NA	NA	NA	NA	NA	NA	NA
Parsons 2006	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	150	74.1	225	Misoprostol; 800 mcg; orally	150	74.1	225	NA	NA	NA	NA	NA	NA	NA	NA
Parsons 2007	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	186.5	230.1	224	Misoprostol; 800 mcg; rectally	163.5	106.7	217	NA	NA	NA	NA	NA	NA	NA	NA
Patil 2013	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; orally	211	172	99	Ergometrine; 200 mcg; by an intravenous bolus	178	137	99	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Patil 2016	both high and low risk; vaginal delivery	Oxytocin; 10 IU; Intramuscularly	281.05	84.83	100	Carboprost; 125 mcg; Intramuscularly	170.2	50.2	100	NA	NA	NA	NA	NA	NA	NA	NA
Penaranda 2002	both high and low risk; vaginal delivery	Misoprostol; 50 mcg; sublingually	389	271	25	Oxytocin; 16mIU/min; by an intravenous infusion	467	427.5	25	Ergometrine; 200 mcg; Intramuscularly	546.8	338.5	25	NA	NA	NA	NA
Perez-Rumbos 2017	both high and low risk; vaginal delivery	Misoprostol; 600 mcg; rectally	171.1	69.9	195	Oxytocin; 20 IU; Intramuscularly	288.1	173.2	197	NA	NA	NA	NA	NA	NA	NA	NA
Poeschmann 1991	low risk; vaginal delivery	Oxytocin; 5 IU; Intramuscularly	374	279	28	Carboprost; 500 mcg; Intramuscularly	324	302	22	Placebo or control; ; (Placebo)	548	376	24	NA	NA	NA	NA
Quibel 2016	both high and low risk; vaginal delivery	Misoprostol plus Oxytocin; 400 mcg plus 10 IU; orally plus by an	150	122.31	806	Oxytocin; 10 IU; by an intravenous bolus	150	111.19	797	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
		intravenous bolus															
Rajaei 2014	both high and low risk; vaginal delivery	Oxytocin; 20 IU; by an intravenous infusion	182.4	101.3	200	Misoprostol; 400 mcg; orally	157	84.9	200	NA	NA	NA	NA	NA	NA	NA	NA
Rashid 2009	both high and low risk; vaginal delivery	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	245.74	135.86	340	Oxytocin; 10 IU; by an intravenous infusion	248.41	124.03	346	NA	NA	NA	NA	NA	NA	NA	NA
Reddy 2001	high risk; vaginal delivery	Ergometrine; 200 mcg; by an intravenous bolus	202	84	40	Carboprost; 250 mcg; Intramuscularly	113	127	40	NA	NA	NA	NA	NA	NA	NA	NA
Rogers 1998	low risk; vaginal delivery	Ergometrine plus Oxytocin; unspecified ; Intramuscularly	268.5	246.14	748	Placebo or control; ; (Control)	336.5	243.23	764	NA	NA	NA	NA	NA	NA	NA	NA
Rossel and 2013	high risk; elective caesarean section	Oxytocin; 5 IU; Intravenous bolus	841	556	26	Carbetocin; 100 mcg; Intraven	579	623	25	Placebo or control; ; (Placebo)	853	518	25	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
						ous bolus											
Sadiq 2011	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous bolus	388.04	177.3	900	Misoprostol; 600 mcg; orally	327.68	118.5	900	NA	NA	NA	NA	NA	NA	NA	NA
Shady 2019	low risk; vaginal delivery	Oxytocin; 10 IU; intravenous	451.25	16.5	120	misoprostol; 600 mcg; buccal	644.02	22.4	120	NA	NA	NA	NA	NA	NA	NA	NA
Shaheen 2019	low risk; vaginal delivery	Oxytocin; 10 IU; intramuscular	303.5	21.89	106	Misoprostol; 600 mcg; sublingually	271.3	20.03	106	NA	NA	NA	NA	NA	NA	NA	NA
Shrestha 2011	low risk; vaginal delivery	Misoprostol; 1000 mcg; rectally	156.7	124.2	100	Oxytocin; 10 IU; Intramuscularly	132.3	91.8	100	NA	NA	NA	NA	NA	NA	NA	NA
Singh 2009	low risk; vaginal delivery	Misoprostol; 400 or 600 mcg; sublingually	111.15	70.41	150	Oxytocin; 5 IU; by an intravenous bolus	154.73	161.95	75	Ergometrine; 200 mcg; by an intravenous bolus	223.48	161.95	75	NA	NA	NA	NA
Sitaula 2017	high risk; elective	Misoprostol plus Oxytocin;	326.9	116.2	100	Oxytocin; 20 IU; by an	397.7	110.1	100	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
	caesarean section	400 mcg plus 20 IU; rectally plus by an intravenous infusion				intravenous infusion											
Soltan 2007	both high and low risk; vaginal delivery	Ergometrine; 200 mcg; Intramuscularly	149.3	6.38	266	Misoprostol; ≤600 mcg; sublingually	143	6.75	271	Misoprostol; >600 mcg to ≤800 mcg; sublingually	131.2	5.61	269	Misoprostol; >800 mcg to ≤1000 mcg; sublingually	128	4.02	278
Sood 2012	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intravenous infusion	595	108	90	Oxytocin; 20 IU; by an intravenous infusion	651	118	84	NA	NA	NA	NA	NA	NA	NA	NA
Su 2009	low risk; vaginal delivery	Carbetocin; 100 mcg; Intramuscularly	217.4	99.2	185	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	223.1	76.3	185	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Supe 2016	both high and low risk; vaginal delivery	Misoprostol ; 800 mcg; rectally	124.4	34.71	50	Ergometrine; 200 mcg; Intramuscularly	152.2	49.29	50	Carboprost; 125 mcg; Intramuscularly	153.8	43.46	50	Placebo or control; ; (Control)	167.4	52.95	50
Surbeck 1999	both high and low risk; vaginal delivery	Misoprostol ; 600 mcg; orally	345	108.57	31	Placebo or control; ; (Placebo)	417	151.02	34	NA	NA	NA	NA	NA	NA	NA	NA
Sweed 2018	high risk; caesarean section	oxytocin; 5 IU; intravenous	641.7	9.32	212	Misoprostol plus Oxytocin; 400 mcg plus 5IU; rectal or sublingual plus intravenous	407.65	6.57	424	NA	NA	NA	NA	NA	NA	NA	NA
Taheripanah 2017	high risk; emergency caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	430.68	118	110	Oxytocin; 30 IU; by an intravenous infusion	552.6	156	110	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Tewatia 2014	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous infusion	114.3	26.8	50	Misoprostol; 600 mcg; sublingually	149.5	30.8	50	NA	NA	NA	NA	NA	NA	NA	NA
Thilaganathan 1993	low risk; vaginal delivery	Placebo or control; ; (Control)	200	148.26	90	Ergometrine plus Oxytocin; 500 mcg plus 5 IU; Intramuscularly	200	74.13	103	NA	NA	NA	NA	NA	NA	NA	NA
Ugwu 2014	high risk; both elective or emergency caesarean	Misoprostol plus Oxytocin; 400 mcg plus 20 IU; sublingually plus by an intravenous infusion	451.3	204	60	Oxytocin; 20 IU; by an intravenous infusion	551.2	192	60	NA	NA	NA	NA	NA	NA	NA	NA
Vagge 2014	low risk; vaginal delivery	Oxytocin; 10 IU; by an intravenous infusion	340.72	89.58	100	Misoprostol; 800 mcg; rectally	321.72	87.78	100	NA	NA	NA	NA	NA	NA	NA	NA
Van Der	low risk; vaginal delivery	carbetocin; 100 mcg;	533.77	3.09	1909	Ergometrine plus oxytocin ; 500	518.52	3.04	1914	Oxytocin; 10 IU;	531.02	3.13	1894	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Nelson 2021		intramuscularly				mcg plus 5 IU; intramuscularly				Intramuscularly							
van Selm 1995	high risk; vaginal delivery	Ergometrine plus Oxytocin; 200 mcg plus 5 IU; Intramuscularly	717	685	36	Carboprost; 500 mcg; Intramuscularly	568	457	33	NA	NA	NA	NA	NA	NA	NA	NA
Verma 2006	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	137.57	72.8	100	Ergometrine; 200 mcg; Intramuscularly	125.79	72.8	100	NA	NA	NA	NA	NA	NA	NA	NA
Vimala 2004	low risk; vaginal delivery	Misoprostol; 400 mcg; sublingually	185	56	60	Ergometrine; 200 mcg; by an intravenous bolus	170	42	60	NA	NA	NA	NA	NA	NA	NA	NA
Vimala 2006	high risk; both elective or emergency caesarean	Misoprostol; 400 mcg; sublingually	819	236	50	Oxytocin; 20 IU; by an intravenous infusion	974	285	50	NA	NA	NA	NA	NA	NA	NA	NA

Study	PPH risk and mode of birth	Arm 1, intervention; dose; route	Arm 1 mean	Arm 1 SD	Arm 1 total	Arm 2, intervention; dose; route	Arm 2 mean	Arm 2 SD	Arm 2 total	Arm 3, intervention; dose; route	Arm 3 mean	Arm 3 SD	Arm 3 total	Arm 4, intervention; dose; route	Arm 4 mean	Arm 4 SD	Arm 4 total
Walley 2000	low risk; vaginal delivery	Misoprostol; 400 mcg; orally	190	78	202	Oxytocin; 10 IU; Intramuscularly	187	91	196	NA	NA	NA	NA	NA	NA	NA	NA
Whigham 2016	high risk; emergency caesarean section	Carbetocin; 100 mcg; by an intravenous bolus	586	245.1	59	Oxytocin; 5 IU; by an intravenous bolus	561	245.1	53	NA	NA	NA	NA	NA	NA	NA	NA
Yesmin 2022	high risk; caesarean section	Carbetocin; 100 mcg; intravenous bolus	363.3	18.99	32	Oxytocin; 10 IU; intravenous bolus	441.3	37.05	32	NA	NA	NA	NA	NA	NA	NA	NA
Zachariah 2006	both high and low risk; vaginal delivery	Misoprostol; 400 mcg; orally	192.5	131	730	Oxytocin; 10 IU; Intramuscularly	183	130	617	Ergometrine; 200 mcg; by an intravenous bolus	188	138	676	NA	NA	NA	NA