National Institute for Health and Care Excellence

Final

Inducing labour

GRADE tables for pharmacological and mechanical methods for induction of labour

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FInal

This supplement was developed by the National Guideline Alliance, which is a part of the Royal College of Obstetricians and Gynaecologists

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F1 – GRADE tables for perinatal death and maternal death and morbidity (uterine rupture) (pairwise analysis)

Table 1: Laminaria (dilapan) versus no treatment for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Laminaria (dilapan)	Control/ no treatment	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/12 (0%)	0/10 (0%)	Not estimable	0 more per 1000 (from 160 fewer to 160 more)3	VERY LOW	IMPORTANT

[1] High ROB in one domains, unclear in four domains
[2] OIS<300
[3] calculated from risk difference

Table 2: Vaginal PGE2 (tablet) versus placebo for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (tablet)	Control/ placebo	Relative (95% CI)	Absolute		
Perinatal death - Favourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/28 (0%)	0/28 (0%)	Not estimable	0 more per 1000 (from 70	VERY LOW	IMPORTANT

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (tablet)	Control/ placebo	Relative (95% CI)	Absolute		
										fewer to 70 more)3		

[1] High ROB in one domain, unclear in 5 domains
[2] OIS<300
[3] calculated from risk difference

Table 3: Vaginal PGE2 (tablet) versus vaginal PGE2 (pessary - slow release) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (tablet)	Control/ vaginal PGE2 (pessary - slow release)	Relative (95% CI)	Absolute		
Maternal death and morbidity												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	1/200 (0.5%)	0/200 (0%)	Peto OR 7.39 (0.15 to 372.38)	10 more per 1000 (from 10 fewer to 20 more)4	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[5]	none	0/100 (0%)	0/100 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)4	LOW	IMPORTANT
Maternal death and morbidity - Mixed												
1	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/100 (1%)	0/100 (0%)	Peto OR 7.39 (0.15 to 372.38)	10 more per 1000 (from 10 fewer to 40 more)4	VERY LOW	IMPORTANT

[1] Unclear ROB in all domains in one study
[2] i2=0%
[3] 95%CI crosses two MID boundaries
[4] calculated from risk difference
[5] OIS<300
[6] Unclear ROB in all domains

Table 4: Vaginal PGE2 (tablet) versus intracervical PGE2 for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (tablet)	Control/ Intracervical PGE2	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/26 (0%)	0/22 (0%)	Not estimable	0 more per 1000 (from 80 fewer to 80 more)3	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	0/26 (0%)	1/22 (4.5%)	Peto OR 0.11 (0 to 5.76)	40 fewer per 1000 (from 45 fewer to 170 more)	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in 3 domains
[2] OIS<300
[3] calculated from risk difference
[4] 95%CI crosses two MID boundaries

Table 5: Vaginal PGE2 (tablet) versus vaginal misoprostol (≥50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (tablet)	Control/ vaginal misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	2/143 (1.4%)	0/140 (0%)	Peto OR 7.26 (0.45 to 116.04)	10 more per 1000 (from 10 fewer to 40 more)4	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
2	randomised trials	very serious[5]	no serious inconsistency[2]	no serious indirectness	serious[6]	none	0/183 (0%)	0/180 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)4	VERY LOW	IMPORTANT

[1] High ROB in 2 domains in one study, unclear in at least one domain in both studies
[2] i2=0%
[3] 95%CI crosses two MID boundaries
[4] calculated from risk difference
[5] High ROB in 3 domains in one study, unclear in 3 domains in one study
[6] OIS<500 (>300)

Table 6: Vaginal PGE2 (tablet) versus IV oxytocin + amniotomy for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (tablet)	Control/ IV oxy+amniotomy	Relative (95% CI)	Absolute		
Perinatal death - Mixed												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/50 (0%)	0/50 (0%)	Not estimable	0 more per 1000 (from 40 fewer to 40 more)3	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in two domains
[2] OIS<300
[3] calculated from risk difference

Table 7: Vaginal PGE2 (tablet) versus Foley catheter for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (tablet)	Control/ Foley catheter	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
2	randomised trials	very serious [1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	0/102 (0%)	0/99 (0%)	Not estimable	0 more per 1000 (from 30 fewer to 30 more)4	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious [5]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/75 (0%)	0/72 (0%)	Not estimable	0 more per 1000 (from 30 fewer to 30 more)6	VERY LOW	IMPORTANT

[1] High ROB in one domain in each study, unclear in at least one domain in each study
[2] i2=0%
[3] OIS<300
[4] calculated from risk difference
[5] High ROB in one domain, unclear in 2 domains
[6] calculated from risk difference

Table 8: Vaginal PGE2 (tablet) versus laminaria (dilapan) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (tablet)	Control/ laminaria (dilapan)	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/40 (0%)	0/40 (0%)	Not estimable	0 more per 1000 (from 50 fewer to 509 more)3	VERY LOW	IMPORTANT

[1] Unclear ROB in 4 domains
[2] OIS<300
[3] calculated from risk difference

Table 9: Vaginal PGE2 (gel) versus placebo for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ placebo	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/15 (0%)	0/15 (0%)	Not estimable	0 more per 1000 (from 120 fewer to 120 more)3	VERY LOW	IMPORTANT

[1] Unclear ROB in 5 domains
[2] OIS<300
[3] calculated from risk difference

Table 10: Vaginal PGE2 (gel) versus vaginal PGE2 (pessary - slow release) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ vaginal PGE2 (pessary - slow release)	Relative (95% CI)	Absolute		
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/65 (0%)	0/65 (0%)	Not estimable	0 more per 1000 (from 30 fewer to 30 more)3	VERY LOW	IMPORTANT

[1] Unclear ROB in all domains
[2] OIS<300
[3] calculated from risk difference

Table 11: Vaginal PGE2 (gel) versus intracervical gel for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ intracervical gel	Relative (95% CI)	Absolute		
Perinatal death												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	0/102 (0%)	0/76 (0%)	Not estimable	0 more per 1000 (from 30 fewer to 30 more)4	VERY LOW	IMPORTANT
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[5]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/71 (0%)	0/39 (0%)	Not estimable	0 more per 1000 (from 40 fewer to 40 more)4	VERY LOW	IMPORTANT
Perinatal death - Not reported/ unclear cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ intracervical gel	Relative (95% CI)	Absolute		
1	randomised trials	serious[6]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/31 (0%)	0/37 (0%)	Not estimable	0 more per 1000 (from 60 fewer to 60 more)4	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[7]	no serious inconsistency	no serious indirectness	very serious[8]	none	0/125 (0%)	1/122 (0.82%)	Peto OR 0.13 (0 to 6.66)	7 fewer per 1000 (from 8 fewer to 44 more)	VERY LOW	IMPORTANT

[1] High ROB in one domain in 1 study, unclear in at least 3 domains per study
[2] i2=0%
[3] OIS<300
[4] calculated from risk difference
[5] Unclear ROB in 6 domains
[6] Unclear ROB in 3 domains
[7] High ROB in one domain, unclear in 3 domains
[8] 95%CI crosses two MID boundaries

Table 12: Vaginal PGE2 (gel) versus vaginal misoprostol (<50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ vaginal misoprostol (<50mcg)	Relative (95% CI)	Absolute		
Perinatal death												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	no serious imprecision	none	1/365 (0.27%)	2/272 (0.74%)	Not estimable	10 fewer per 1000 (from 20 fewer to 10 more)[3]	LOW	IMPORTANT

Quality assessment							Number of patients		Effect			
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ vaginal misoprostol (<50mcg)	Relative (95% CI)	Absolute	Quality	Importance
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[4]	no serious inconsistency	no serious indirectness	very serious[5]	none	1/193 (0.52%)	2/100 (2%)	Peto OR 0.23 (0.02 to 2.55)	15 fewer per 1000 (from 20 fewer to 29 more)	VERY LOW	IMPORTANT
Perinatal death - Mixed cervix												
1	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness	serious[7]	none	0/172 (0%)	0/172 (0%)	Not estimable	0 fewer per 1000 (from 10 more to 10 more)[3]	VERY LOW	IMPORTANT
Maternal death and morbidity												
3	randomised trials	very serious[8]	no serious inconsistency	no serious indirectness	no serious imprecision	none	1/703 (0.14%)	1/712 (0.14%)	Not estimable	0 fewer per 1000 (from 10 fewer to 10 more)[3]	LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
2	randomised trials	very serious[9]	no serious inconsistency[2]	no serious indirectness	no serious imprecision	none	1/531 (0.19%)10	1/540 (0.19%)10	Not estimable	0 fewer per 1000 (from 10 fewer to 10 more)[3]	VERY LOW	IMPORTANT
Maternal death and morbidity – Mixed cervix												
1	randomised trials	very serious[5]	no serious inconsistency	no serious indirectness	serious[6]	none	0/172 (0%)	0/172 (0%)	Not estimable	0 fewer per 1000 (from 10 more to 10 more)[3]	VERY LOW	IMPORTANT

[1] One study has a high ROB in one domain and unclear risk in one domain, another study has high ROB in two domains
[2] i2=0%
[3] Calculated from risk difference
[4] High ROB in one domain, unclear in one domain
[5] 95%CI crosses two MID boundaries
[6] High ROB in two domains
[7] OIS<500

[8] At least high ROB in one domain for each study; unclear in one domain in one study
[9] High ROB in one domain in one study, 3 in the other; unclear in one domain in one study
[10] Includes cases of uterine rupture

Table 13: Vaginal PGE2 (gel) versus vaginal misoprostol (≥50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ vaginal misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	0/240 (0%)	0/120 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)3	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in two domains
[2] OIS<500 (>300)
[3] calculated from risk difference

Table 14: Vaginal PGE2 (gel) versus oral misoprostol (<50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ oral misoprostol (<50mcg)	Relative (95% CI)	Absolute		
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/100 (0%)	0/100 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in 2 domains, unclear in 2 domains
[2] OIS<300
[3] calculated from risk difference

Table 15: Vaginal PGE2 (gel) versus oral misoprostol (≥50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ oral misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
Perinatal death - Mixed												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	no serious imprecision[3]	none	0/304 (0%)	0/302 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[4]	LOW	IMPORTANT
Maternal death and morbidity - Mixed cervix												
2	randomised trials	very serious[5]	no serious inconsistency[2]	no serious indirectness	no serious imprecision[3]	none	0/412 (0%)	0/257 (0%)	Not estimable	0 fewer per 1000 (from 10 more to 10 more)[4]	LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness	serious[7]	none	0/240 (0%)	0/120 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[4]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness	serious[7]	none	0/172 (0%)	0/167 (0%)	Not estimable	0 fewer per 1000 (from 10 more to 10 more)[4]	VERY LOW	IMPORTANT

[1] Unclear ROB in 3 domains in one study; high risk in 2 domains in the other study
[2] i2=0%
[3] OIS>500
[4] calculated from risk difference
[5] High ROB in one domain, unclear in 2 domains for one study, high ROB in two domains for the other study
[6] High ROB in one domain, unclear in 2 domains
[7] OIS<500

Table 16: Vaginal PGE2 (gel) versus titrated oral misoprostol solution for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ titrated oral misoprostol solution	Relative (95% CI)	Absolute		
Perinatal death												
3	randomised trials	very serious [1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	2/918 (0.22%)	1/813 (0.12%)	Peto OR 1.6 (0.16 to 15.98)	1 more per 1000 (from 1 fewer to 18 more)	VERY LOW	IMPORTANT
Perinatal death - Unfavourable cervix												
2	randomised trials	very serious [1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	1/569 (0.18%)	0/468 (0%)	Peto OR 4.64 (0.08 to 283.84)	0 more per 1000 (from 0 more to 10 more)[4]	VERY LOW	IMPORTANT
Perinatal death - Mixed cervix												
1	randomised trials	very serious [5]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/349 (0.29%)	1/345 (0.29%)	Peto OR 0.99 (0.06 to 15.84)	0 fewer per 1000 (from 3 fewer to 41 more)	VERY LOW	IMPORTANT
Maternal death and morbidity												
2	randomised trials	very serious [5,6]	no serious inconsistency[2]	no serious indirectness	no serious imprecision[7]	none	0/725 (0%)	0/711 (0%)	Not estimable	0 more per 1000 (from 0 more to 0 more)[4]	LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious [6]	no serious inconsistency	no serious indirectness	no serious imprecision[7]	none	0/376 (0%)	0/365 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[4]	LOW	IMPORTANT
Maternal death and morbidity - Mixed cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ titrated oral misoprostol solution	Relative (95% CI)	Absolute		
1	randomised trials	very serious [5]	no serious inconsistency	no serious indirectness	no serious imprecision[7]	none	0/349 (0%)	0/346 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[4]	LOW	IMPORTANT

[1] High ROB in one domain in 1 study, unclear in at least one domain in each study
[2] i2=0%
[3] 95%CI crosses two MID boundaries
[4] calculated from risk difference
[5] Unclear ROB in 3 domains
[6] Unclear ROB in 5 domains
[7] OIS>500

Table 17: Vaginal PGE2 (gel) versus IV oxytocin for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ IV oxytocin	Relative (95% CI)	Absolute		
Perinatal death - Mixed cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/25 (0%)	0/25 (0%)	Not estimable	0 more per 1000 (from 70 fewer to 70 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in 3 domains
[2] OIS<300
[3] calculated from risk difference

Table 18: Vaginal PGE2 (gel) versus IV oxytocin + amniotomy for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ IV oxy+ amniotomy	Relative (95% CI)	Absolute		
Perinatal death - Mixed cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	no serious imprecision[3]	none	0/322 (0%)	0/318 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[4]	LOW	IMPORTANT
Maternal death and morbidity - Mixed cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	0/165 (0%)	0/155 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[4]	VERY LOW	IMPORTANT

[1] High ROB in at least one domain, unclear in 2 domains
[2] i2=0%
[3] OIS>500
[4] calculated from risk difference
[5] OIS<500 (>300)

Table 19: Vaginal PGE2 (gel) versus oestrogens for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ oestrogens	Relative (95% CI)	Absolute		
Perinatal death - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/30 (0%)	0/30 (0%)	Not estimable	0 more per 1000 (from 60 fewer to 60 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in 2 domains, unclear in 2 domains
[2] OIS<300
[3] calculated from risk difference

Table 20: Vaginal PGE2 (gel) versus buccal/sublingual misoprostol for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ buccal/sublingual misoprostol	Relative (95% CI)	Absolute		
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/53 (0%)	0/53 (0%)	Not estimable	0 more per 1000 (from 40 fewer to 40 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in 2 domains
[2] OIS<300
[3] calculated from risk difference

Table 21: Vaginal PGE2 (gel) versus Foley catheter for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ Foley catheter	Relative (95% CI)	Absolute		
Perinatal death - Mixed cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/349 (0.29%)	1/171 (0.58%)	Peto OR 0.46 (0.02 to 8.81)	3 fewer per 1000 (from 6 fewer to 43 more)	VERY LOW	IMPORTANT
Maternal death and morbidity												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ Foley catheter	Relative (95% CI)	Absolute		
3	randomised trials	very serious[3]	no serious inconsistency[4]	no serious indirectness	very serious[2]	none	1/956 (0.1%)5	0/783 (0%)5	Peto OR 7.44 (0.15 to 375.14)	0 more per 1000 (from 0 more to 10 more)6	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
2	randomised trials	very serious[3]	no serious inconsistency[4]	no serious indirectness	very serious[2]	none	1/607 (0.16%)5	0/609 (0%)5	Peto OR 7.44 (0.15 to 375.14)	0 more per 1000 (from 0 more to 10 more)[6]	VERY LOW	IMPORTANT
Maternal death and morbidity - Mixed cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision[7]	none	0/349 (0%)	0/174 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[6]	LOW	IMPORTANT

[1] Unclear ROB in 3 domains
[2] 95%CI crosses two MID boundaries
[3] High ROB in one domain in two studies, unclear in at least one domain in all studies
[4] i2=0%
[5] includes cases of uterine rupture in one study
[6] calculated from risk difference
[7] OIS>500

Table 22: Vaginal PGE2 (pessary - slow release) versus placebo for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - slow release)	Control/ placebo	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - slow release)	Control/ placebo	Relative (95% CI)	Absolute		
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	0/134 (0%)	0/150 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[4]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[5]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/33 (0%)	0/36 (0%)	Not estimable	0 more per 1000 (from 50 fewer to 50 more)[4]	VERY LOW	IMPORTANT

[1] Unclear ROB in at least 4 domains per study
[2] i2=0%
[3] OIS<300
[4] calculated from risk difference
[5] Unclear ROB in 6 domains

Table 23: Vaginal PGE2 (pessary - slow release) versus vaginal misoprostol (<50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - slow release)	Control/ vaginal misoprostol (<50mcg)	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/39 (0%)	0/39 (0%)	Not estimable	0 more per 1000 (from 50 fewer to 50 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in one domain
[2] OIS<300
[3] calculated from risk difference

Table 24: Vaginal PGE2 (pessary - slow release) versus vaginal misoprostol (≥50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - slow release)	Control/ vaginal misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	0/95 (0%)	0/96 (0%)	Not estimable	0 more per 1000 (from 30 fewer to 30 more)[4]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/56 (0%)	0/56 (0%)	Not estimable	0 more per 1000 (from 30 fewer to 30 more)[5]	VERY LOW	IMPORTANT

[1] High ROB in one domain per study, unclear in at least one domain per study
[2] i2=0%
[3] OIS<300
[4] calculated from risk difference
[5] calculated from risk difference

Table 25: Vaginal PGE2 (pessary - slow release) versus titrated oral misoprostol solution for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - slow release)	Control/ titrated oral misoprostol solution	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - slow release)	Control/ titrated oral misoprostol solution	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/80 (1.3%)	1/80 (1.3%)	Peto OR 1 (0.06 to 16.13)	0 fewer per 1000 (from 12 fewer to 157 more)	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in one domain
[2] 95%CI crosses two MID boundaries

Table 26: Vaginal PGE2 (pessary - slow release) versus misoprostol insert (sustained release) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - slow release)	Control/ misoprostol insert (sustained release)	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
2	randomised trials	serious[1]	no serious inconsistency[2]	no serious indirectness	no serious imprecision[3]	none	0/1116 (0%)	0/1549 (0%)	Not estimable	0 more per 1000 (from 0 more to 0 more)[4]	MODERATE	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
2	randomised trials	serious[1]	no serious inconsistency[2]	no serious indirectness	no serious imprecision[3]	none	0/1116 (0%)	0/1549 (0%)	Not estimable	0 more per 1000 (from 0 more to 0 more)[4]	MODERATE	IMPORTANT

[1] Unclear ROB in at least one domain per study
[2] i2=0%

[3] OIS>500
[4] calculated from risk difference

Table 27: Vaginal PGE2 (pessary - slow release) versus IV oxytocin for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - slow release)	Control/ IV oxytocin	Relative (95% CI)	Absolute		
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/72 (0%)	0/72 (0%)	Not estimable	0 more per 1000 (from 30 fewer to 30 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in one domain
[2] OIS<300
[3] calculated from risk difference

Table 28: Vaginal PGE2 (pessary - slow release) versus Foley catheter for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - slow release)	Control/ Foley catheter	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	0/132 (0%)	0/265 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[3]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - slow release)	Control/ Foley catheter	Relative (95% CI)	Absolute		
1	randomised trials	serious[4]	no serious inconsistency	no serious indirectness	very serious[5]	none	0/119 (0%)	0/107 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in two domains
[2] OIS<500 (>300)
[3] calculated from risk difference
[4] High ROB in one domain, unclear in one domain
[5] OIS<300

Table 29: PGF2 gel versus placebo for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	PGF 2 gel	Control/ placebo	Relative (95% CI)	Absolute		
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/60 (0%)	0/30 (0%)	Not estimable	0 more per 1000 (from 50 fewer to 50 more)3	VERY LOW	IMPORTANT

[1] Unclear ROB in 5 domains
[2] OIS<300
[3] calculated from risk difference

Table 30: PGF2 gel versus IV oxytocin for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	PGF2 gel	Control/ IV oxytocin	Relative (95% CI)	Absolute		
Perinatal death - Mixed cervix												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	0/150 (0%)	0/150 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[3]	LOW	IMPORTANT
Maternal death and morbidity - Mixed cervix												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	very serious[4]	none	0/150 (0%)	0/146 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[3]	VERY LOW	IMPORTANT

[1] HIgh ROB in one domain, unclear in one domain
[2] OIS<500 (=300)
[3] calculated from risk difference
[4] OIS<300

Table 31: Intracervical PGE2 versus no treatment for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ no treatment	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	0/587 (0%)	2/578 (0.35%)	Peto OR 0.13 (0.01 to 2.11)	3 fewer per 1000 (from 3 fewer to 4 more)	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	0/587 (0%)	1/578 (0.17%)	Peto OR 0.13 (0 to 6.66)	2 fewer per 1000 (from 2	VERY LOW	IMPORTANT

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ no treatment	Relative (95% CI)	Absolute		
										fewer to 10 more)		

[1] High ROB in one domain per study, unclear in at least 2 domains per study
[2] i2=0%
[3] 95%CI crosses two MID boundaries

Table 32: Intracervical PGE2 versus placebo for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ placebo	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
2	randomised trials	very serious [1,2]	no serious inconsistency[3]	no serious indirectness	serious[4]	none	0/198 (0%)	0/112 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[5]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	0/174 (0%)	0/91 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[5]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in two domains
[2] Unclear ROB in 4 domains
[3] i2=0%
[4] OIS<500 (>300)
[5] calculated from risk difference
[6] OIS<300

Table 33: Intracervical PGE2 versus vaginal PGE2 (pessary - normal release) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ vaginal PGE2 (pessary - normal release)	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/64 (0%)	1/61 (1.6%)	Peto OR 0.13 (0 to 6.5)	14 fewer per 1000 (from 16 fewer to 81 more)	VERY LOW	IMPORTANT

[1] High ROB in two domains, unclear in two domains
[2] 95%CI crosses two MID boundaries

Table 34: Intracervical PGE2 versus vaginal misoprostol (<50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ vaginal misoprostol (<50mcg)	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	0/83 (0%)	0/86 (0%)	Not estimable	0 more per 1000 (from 30 fewer to 30 more)[4]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
3	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[5]	none	0/250 (0%)	1/250 (0.4%)	Peto OR 0.14 (0 to 6.82)	3 fewer per 1000 (from 4 fewer to 23 more)	VERY LOW	IMPORTANT

[1] High ROB in at least one domain per study, unclear in at least one domain per study
[2] i2=0%
[3] OIS<300

[4] calculated from risk difference
[5] 95%CI crosses two MID boundaries

Table 35: Intracervical PGE2 versus vaginal misoprostol (≥50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ vaginal misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
3	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	0/131 (0%)	2/134 (1.5%)	Peto OR 0.13 (0.01 to 2.07)	13 fewer per 1000 (from 15 fewer to 15 more)	VERY LOW	IMPORTANT
Maternal death and morbidity												
2	randomised trials	very serious[4]	no serious inconsistency[2]	no serious indirectness	very serious[5]	none	0/81 (0%)	0/85 (0%)	Not estimable	0 more per 1000 (from 30 fewer to 30 more)[6]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[4]	no serious inconsistency	no serious indirectness	very serious[5]	none	0/31 (0%)	0/35 (0%)	Not estimable	0 more per 1000 (from 60 fewer to 60 more)[6]	VERY LOW	IMPORTANT
Maternal death and morbidity - Not reported/ unclear cervix												
1	randomised trials	very serious[4]	no serious inconsistency	no serious indirectness	very serious[5]	none	0/50 (0%)	0/50 (0%)	Not estimable	0 more per 1000 (from 40 fewer to 40 more)[6]	VERY LOW	IMPORTANT

[1] High ROB in at least one domain per study, and/or unclear in at least 2 domains per study
[2] i2=0%
[3] 95%CI crosses two MID boundaries
[4] High ROB in one domain per study, unclear in at least 3 domains per study
[5] OIS<300
[6] calculated from risk difference

Table 36: Intracervical PGE2 versus oral misoprostol (≥50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ oral misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
PerinatalPerinatal death - Unfavourable cervix												
2	randomised trials	very serious[1,2]	no serious inconsistency[3]	no serious indirectness	serious[4]	none	0/195 (0%)	0/196 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[5]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	0/95 (0%)	0/96 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[5]	VERY LOW	IMPORTANT

[1] High ROB in two domains, unclear in one domain
[2] Unclear ROB in 6 domains
[3] i2=0%
[4] OIS<500 (>300)
[5] calculated from risk difference
[6] OIS<300

Table 37: Intracervical PGE2 versus IV oxytocin for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ IV oxytocin	Relative (95% CI)	Absolute		
Perinatal death												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ IV oxytocin	Relative (95% CI)	Absolute		
3	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	1/269 (0.37%)	0/259 (0%)	Peto OR 6.92 (0.14 to 349.34)	0 more per 1000 (from 10 fewer to 20 more)[4]	VERY LOW	IMPORTANT
Perinatal death - Unfavourable cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	1/219 (0.46%)	0/209 (0%)	Peto OR 6.92 (0.14 to 349.34)	0 more per 1000 (from 10 fewer to 20 more)[4]	VERY LOW	IMPORTANT
Perinatal death - Mixed cervix												
1	randomised trials	very serious[5]	no serious inconsistency	no serious indirectness	very serious[6]	none	0/50 (0%)	0/50 (0%)	Not estimable	0 more per 1000 (from 40 fewer to 40 more)[4]	VERY LOW	IMPORTANT

[1] High ROB on at least one domain per study, unclear in at least two domains per study
[2] i2=0%
[3] 95%CI crosses two MID boundaries
[4] calculated from risk difference
[5] High ROB in one domain, unclear in 3 domains
[6] OIS<300

Table 38: Intracervical PGE2 versus nitric oxide for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ nitric oxide	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Intracervical PGE2**	**Control/ nitric oxide**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/21 (0%)	0/21 (0%)	Not estimable	0 more per 1000 (from 90 fewer to 90 more)[3]	VERY LOW	IMPORTANT

[1] Unclear ROB in 6 domains
[2] OIS<300
[3] calculated from risk difference

Table 39: Intracervical PGE2 versus Foley catheter for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ Foley catheter	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	9/200 (4.5%)	7/200 (3.5%)	Peto OR 1.3 (0.48 to 3.52)	10 more per 1000 (from 18 fewer to 78 more)	VERY LOW	IMPORTANT

1 High ROB in one domain, unclear in 3 domains
2 95%CI crosses two MID boundaries

Table 40: Intracervical PGE2 versus laminaria (dilapan) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ laminiaria (dilapan)	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/95 (0%)	1/90 (1.1%)	Peto OR 0.13 (0 to 6.46)	10 fewer per 1000 (from 11 fewer to 57 more)	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/95 (1.1%)4	0/95 (0%)[4]	Peto OR 7.39 (0.15 to 372.38)	10 more per 1000 (from 20 fewer to 40 more)[5]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in 2 domains
[2] 95%CI crosses two MID boundaries
[3] OIS<300
[4] includes cases of uterine rupture
[5] calculated from risk difference

Table 41: Vaginal PGE2 (pessary - normal release) versus placebo for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - normal release)	Control/ placebo	Relative (95% CI)	Absolute		
Perinatal death - Mixed cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/52 (1.9%)	0/32 (0%)	Peto OR 5.03 (0.09 to 284.68)	20 more per 1000 (from 40 fewer to 80 more)[3]	VERY LOW	IMPORTANT

[1] Unclear ROB in 6 domains
[2] 95%CI crosses two MID boundaries
[3] calculated from risk difference

Table 42: Vaginal PGE2 (pessary - normal release) versus titrated oral misoprostol solution for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - normal release)	Control/ titrated oral misoprostol solution	Relative (95% CI)	Absolute		
Perinatal death												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	1/274 (0.36%)	1/339 (0.29%)	Peto OR 1.74 (0.1 to 30.87)	2 more per 1000 (from 3 fewer to 81 more)	VERY LOW	IMPORTANT
Perinatal death - Unfavourable cervix												
1	randomised trials	serious[4]	no serious inconsistency	no serious indirectness	serious[5]	none	0/199 (0%)	0/212 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[6]	LOW	IMPORTANT
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[7]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/75 (1.3%)	1/127 (0.79%)	Peto OR 1.74 (0.1 to 30.87)	6 more per 1000 (from 7 fewer to 189 more)	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	serious[4]	no serious inconsistency	no serious indirectness	serious[5]	none	0/199 (0%)	0/212 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[6]	LOW	IMPORTANT

[1] High ROB in at least one domain per study, unclear in at least one domain per study
[2] i2=0%

[3] 95%CI crosses two MID boundaries
[4] High ROB in one domain, unclear in one domain
[5] OIS<500 (>300)
[6] calculated from risk difference
[7] High ROB in 2 domains, unclear in 2 domains

Table 43: Vaginal PGE2 (pessary - normal release) versus IV oxytocin for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - normal release)	Control/ IV oxytocin	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/80 (0%)	0/90 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in 3 domains, unclear in one domain
[2] OIS<300
[3] calculated from risk difference

Table 44: Vaginal PGE2 (pessary - normal release) versus IV oxytocin + amniotomy for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - normal release)	Control/ IV oxytocin + amniotomy	Relative (95% CI)	Absolute		
Maternal death and morbidity - Unfavourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - normal release)	Control/ IV oxytocin + amniotomy	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/34 (0%)	0/30 (0%)	Not estimable	0 more per 1000 (from 60 fewer to 60 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in one domain
[2] OIS<300
[3] calculated from risk difference

Table 45: Vaginal PGE2 (pessary - normal release) versus vaginal misoprostol (≥50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - normal release)	Control/ vaginal misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/75 (1.3%)	2/128 (1.6%)	Peto OR 0.86 (0.08 to 9.02)	2 fewer per 1000 (from 14 fewer to 110 more)	VERY LOW	IMPORTANT

[1] High ROB in two domains, unclear in two domains
[2] 95%CI crosses two MID boundaries

Table 46: Vaginal PGE2 (pessary - normal release) versus Foley catheter for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - normal release)	Control/ Foley catheter	Relative (95% CI)	Absolute		
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/34 (0%)	0/30 (0%)	Not estimable	0 more per 1000 (from 60 fewer to 60 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in one domain
[2] OIS<300
[3] calculated from risk difference

Table 47: Vaginal PGE2 (pessary - normal release) versus extra-amniotic PGE2/PGF2 for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - normal release)	Control/ extra-amniotic PGE2/PGF2	Relative (95% CI)	Absolute		
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/75 (1.3%)	1/76 (1.3%)	Peto OR 1.01 (0.06 to 16.35)	0 more per 1000 (from 12 fewer to 166 more)	VERY LOW	IMPORTANT

[1] High ROB in two domains, unclear in two domains
[2] 95%CI crosses two MID boundaries

Table 48: Vaginal misoprostol (<50mcg) versus no treatment for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg)	Control/ no treatment	Relative (95% CI)	Absolute		
Perinatal death - Mixed cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/38 (0%)	1/39 (2.6%)	Peto OR 0.14 (0 to 7)	22 fewer per 1000 (from 26 fewer to 130 more)	VERY LOW	IMPORTANT

[1] High ROB in two domains, unclear in 3 domains
[2] 95%CI crosses two MID boundaries

Table 49: Vaginal misoprostol (<50mcg) versus placebo for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg)	Control/ placebo	Relative (95% CI)	Absolute		
Maternal death and morbidity - Unfavourable cervix												
2	randomised trials	no serious risk of bias	no serious inconsistency[1]	no serious indirectness	serious[2]	none	0/238 (0%)	0/113 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[3]	MODERATE	IMPORTANT

[1] i2=0%
[2] OIS<500 (>300)
[3] calculated from risk difference

Table 50: Vaginal misoprostol (<50mcg) versus vaginal misoprostol (≥50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg)	Control/ vaginal misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	0/79 (0%)	1/83 (1.2%)	Peto OR 0.15 (0 to 7.33)	10 fewer per 1000 (from 12 fewer to 70 more)	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
5	randomised trials	very serious[4]	serious[5]	no serious indirectness	very serious[3]	none	1/259 (0.39%)[6]	1/261 (0.38%)[6]	Peto OR 0.98 (0.06 to 15.71)	0 fewer per 1000 (from 4 fewer to 53 more)	VERY LOW	IMPORTANT

[1] High ROB in one domains per study, unclear in at least one domain per study
[2] i2=0%
[3] 95%CI crosses two MID boundaries
[4] High ROB in in at least one domain in more than half studies, and unclear in at least one domain in all studies
[5] i2=49%
[6] includes cases of uterine rupture in one study

Table 51: Vaginal misoprostol (<50mcg) versus oral misoprostol (≥50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg)	Control/ oral misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	1/210 (0.48%)	0/210 (0%)	Peto OR 7.39 (0.15 to 372.38)	0 more per 1000 (from 20	VERY LOW	IMPORTANT

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg)	Control/ oral misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
										fewer to 20 more)[4]		
Perinatal death - Mixed cervix												
1	randomised trials	very serious[5]	no serious inconsistency	no serious indirectness	serious[6]	none	0/172 (0%)	0/167 (0%)	Not estimable	0 fewer per 1000 (from 10 fewer to 10 more)[4]	VERY LOW	IMPORTANT
Perinatal death - Unfavourable cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	1/210 (0.48%)	0/210 (0%)	Peto OR 7.39 (0.15 to 372.38)	0 more per 1000 (from 20 fewer to 20 more)[4]	VERY LOW	IMPORTANT
Maternal death and morbidity - Mixed cervix												
1	randomised trials	very serious[5]	no serious inconsistency	no serious indirectness	serious6	none	0/172 (0%)	0/167 (0%)	Not estimable	0 fewer per 1000 (from 10 more to 10 more)[4]	VERY LOW	IMPORTANT

[1] High ROB in at least one domain per study, unclear in at least 3 domain per study
[2] i2=0%
[3] 95%CI crosses two MID boundaries
[4] calculated from risk difference
[5] High ROB in two domains
[6] OIS<500
[7] High ROB in two domains, unclear in 3 domains
[8] OIS<300

Table 52: Vaginal misoprostol (<50mcg) versus titrated oral misoprostol solution for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg)	Control/ titrated oral misoprostol solution	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
3	randomised trials	serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	2/308 (0.65%)	0/217 (0%)	Peto OR 5.71 (0.33 to 97.72)	10 more per 1000 (from 10 fewer to 20 more)[4]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
2	randomised trials	serious[5]	no serious inconsistency[2]	no serious indirectness	very serious[6]	none	0/115 (0%)	0/114 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[4]	VERY LOW	IMPORTANT

[1] High ROB in one domain in one study, unclear in at least one domain per study
[2] i2=0%
[3] 95%CI crosses two MID boundaries
[4] calculated from risk difference
[5] Unclear ROB in at least one domain per study
[6] OIS<300

Table 53: Vaginal misoprostol (<50mcg) versus Foley catheter for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg)	Control/ Foley catheter	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg)	Control/ Foley catheter	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/60 (0%)	0/61 (0%)	Not estimable	0 more per 1000 (from 30 fewer to 30 more)[3]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
7	randomised trials	very serious[4]	no serious inconsistency[5]	no serious indirectness	no serious imprecision[6]	none	0/622 (0%)	0/605 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[3]	LOW	IMPORTANT

[1] High ROB in one domain, unclear in one domain
[2] OIS<300
[3] calculated from risk difference
[4] High ROB in one domain in 6/7 studies, unclear in at least one domain in all studies
[5] i2=0%
[6] OIS>500

Table 54: Vaginal misoprostol (<50mcg) versus buccal/sublingual misoprostol for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg)	Control/ buccal /sublingual misoprostol	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg)	Control/ buccal /sublingual misoprostol	Relative (95% CI)	Absolute		
2	randomised trials	very serious [1]	no serious inconsistency [2]	no serious indirectness	very serious[3]	none	0/150 (0%)	0/148 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[4]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
2	randomised trials	very serious [5]	no serious inconsistency [2]	no serious indirectness	serious[6]	none	0/252 (0%)	0/246 (0%)	Not estimable	0 fewer per 1000 (from 10 more to 10 more)[4]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in 4 domains in one study, and high ROB in one domain in another study
[2] i2=0%
[3] OIS<300
[4] calculated from risk difference
[5] High ROB in one domain
[6] OIS<500

Table 55: Vaginal misoprostol (≥50mcg) versus no treatment for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (≥50mcg)	Control/ no treatment	Relative (95% CI)	Absolute		
Perinatal death												
2	randomised trials	very serious [1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	1/156 (0.64%)	1/357 (0.28%)	Peto OR 1.79 (0.09 to 34.63)	2 more per 1000 (from 3	VERY LOW	IMPORTANT

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (≥50mcg)	Control/ no treatment	Relative (95% CI)	Absolute		
										fewer to 86 more)		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[4]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/56 (1.8%)	0/57 (0%)	Peto OR 7.52 (0.15 to 379.15)	0 more per 1000 (from 20 fewer to 20 more)[5]	VERY LOW	IMPORTANT
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/100 (0%)	1/300 (0.33%)	Peto OR 0.26 (0 to 24.36)	2 fewer per 1000 (from 3 fewer to 72 more)	VERY LOW	IMPORTANT

[1] High ROB in one domain per study, unclear in at least 3 domains per study
[2] i2=17%
[3] 95%CI crosses two MID boundaries
[4] High ROB in one domain, unclear in 3 domains
[5] calculated from risk difference
[6] High ROB in one domain, unclear in 4 domains

Table 56: Vaginal misoprostol (≥50mcg) versus oral misoprostol (≥50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (≥50mcg)	Control/ oral misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
Perinatal death												
4	randomised trials	very serious [1,2]	no serious inconsistency[3]	no serious indirectness	very serious[4]	none	1/305 (0.33%)	0/313 (0%)	Peto OR 7.39 (0.15 to 372.38)	0 more per 1000 (from 10 fewer to 20 more)[5]	VERY LOW	IMPORTANT
Perinatal death - Unfavourable cervix												
3	randomised trials	very serious [2]	no serious inconsistency[3]	no serious indirectness	very serious[4]	none	1/235 (0.43%)	0/243 (0%)	Peto OR 7.39 (0.15 to 372.38)	0 more per 1000 (from 10 fewer to 20 more)[5]	VERY LOW	IMPORTANT
Perinatal death - Mixed cervix												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	very serious[6]	none	0/70 (0%)	0/70 (0%)	Not estimable	0 more per 1000 (from 30 fewer to 30 more)[5]	VERY LOW	IMPORTANT
Maternal death and morbidity												
5	randomised trials	very serious [7]	no serious inconsistency[3]	no serious indirectness	very serious[4]	none	0/823 (0%)	1/815 (0.12%)	Peto OR 0.13 (0 to 6.61)	1 fewer per 1000 (from 1 fewer to 7 more)	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
3	randomised trials	very serious [8]	no serious inconsistency[3]	no serious indirectness	no serious imprecision[9]	none	0/689 (0%)	0/683 (0%)	Not estimable	0 more per 1000 (from 0	LOW	IMPORTANT

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (≥50mcg)	Control/ oral misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
										more to 0 more)5		
Maternal death and morbidity - Mixed cervix												
2	randomised trials	serious [10]	no serious inconsistency[3]	no serious indirectness	very serious[4]	none	0/134 (0%)	1/132 (0.76%)	Peto OR 0.13 (0 to 6.61)	7 fewer per 1000 (from 8 fewer to 40 more)	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in one domain
[2] Unclear ROB in at least 4 domains per study
[3] i2=0%
[4] 95%CI crosses two MID boundaries
[5] calculated from risk difference
[6] OIS<300
[7] High ROB in at least one domain in 4/5 studies, unclear in at least one domain in all studies
[8] High ROB in at least one domain in 2/3 studies, unclear in at least two domain in all studies
[9] OIS>500
[10] High ROB in one domain in one study, unclear in one domain per study

Table 57: Vaginal misoprostol (≥50mcg) versus titrated oral misoprostol solution for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (≥50mcg)	Control/ titrated oral misoprostol solution	Relative (95% CI)	Absolute		
Perinatal death - Not reported/ unclear cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	2/193 (1%)	1/196 (0.51%)	Peto OR 1.94 (0.2 to 18.84)	5 more per 1000 (from 4	VERY LOW	IMPORTANT

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (≥50mcg)	Control/ titrated oral misoprostol solution	Relative (95% CI)	Absolute		
										fewer to 83 more)		
Maternal death and morbidity - Not reported/ unclear cervix												
1	randomised trials	serious[4]	no serious inconsistency	no serious indirectness	very serious[5]	none	0/65 (0%)	0/69 (0%)	Not estimable	0 more per 1000 (from 30 fewer to 30 more)[6]	VERY LOW	IMPORTANT

[1] High ROB in at least one domain in each study, unclear in at least one domain in each study
[2] i2=0%
[3] 95%CI crosses two MID boundaries
[4] High ROB in one domain, unclear in one domain
[5] OIS<300
[6] calculated from risk difference

Table 58: Vaginal misoprostol (≥50mcg) versus IV oxytocin for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (≥50mcg)	Control/ IV oxytocin	Relative (95% CI)	Absolute		
Perinatal death												
5	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	3/266 (1.1%)	2/260 (0.77%)	Peto OR 1.25 (0.2 to 7.73)	2 more per 1000 (from 6 fewer to 49 more)	VERY LOW	IMPORTANT
Perinatal death - Unfavourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (≥50mcg)	Control/ IV oxytocin	Relative (95% CI)	Absolute		
3	randomised trials	very serious [4]	no serious inconsistency[2]	no serious indirectness	very serious[5]	none	0/132 (0%)	0/132 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[6]	VERY LOW	IMPORTANT
Perinatal death - Not reported/ unclear cervix												
2	randomised trials	very serious [7]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	3/134 (2.2%)	2/128 (1.6%)	Peto OR 1.25 (0.2 to 7.73)	4 more per 1000 (from 12 fewer to 94 more)	VERY LOW	IMPORTANT
Maternal death and morbidity												
5	randomised trials	very serious [1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	1/216 (0.46%)8	0/211 (0%)8	Peto OR 6.19 (0.12 to 317.97)	0 more per 1000 (from 20 fewer to 30 more)[6]	VERY LOW	
Maternal death and morbidity - Unfavourable cervix												
4	randomised trials	very serious [1]	no serious inconsistency[2]	no serious indirectness	serious[9]	none	0/182 (0%)	0/183 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[6]	VERY LOW	IMPORTANT
Maternal death and morbidity - Not reported/ unclear cervix												
1	randomised trials	very serious [10]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/34 (2.9%)8	0/28 (0%)8	Peto OR 6.19 (0.12 to 317.97)	30 more per 1000 (from 50 fewer to 110 more)[6]	VERY LOW	IMPORTANT

[1] High ROB in 2 domain in 2 studies (1 domain in others), unclear in at least one domain per study
[2] i2=0%
[3] 95%CI cross two MID boundaries

[4] High ROB in at least one domain per study (2 domains in 2/3 studies), unclear in at least one domain per study
[5] OIS<300
[6] calculated from risk difference
[7] High ROB in one domain per study, unclear in at least 2 domains per study
[8] includes cases of uterine rupture in one study
[9] OIS<500 (>300)
[10] High ROB in one domain, unclear in two domains

Table 59: Vaginal misoprostol (≥50mcg) versus Foley catheter for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (≥50mcg)	Control/ Foley catheter	Relative (95% CI)	Absolute		
Perinatal death												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	0/150 (0%)	0/146 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[4]	VERY LOW	IMPORTANT
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[5]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/50 (0%)	0/46 (0%)	Not estimable	0 more per 1000 (from 40 fewer to 40 more)[4]	VERY LOW	IMPORTANT
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/100 (0%)	0/100 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[4]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[5]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/50 (0%)	0/46 (0%)	Not estimable	0 more per 1000 (from 40 fewer to 40 more)[4]	VERY LOW	IMPORTANT

[1] High ROB in one domain per study, unclear in at least 2 domains
[2] i2=0%

[3] OIS<300
[4] calculated from risk difference
[5] High ROB in one domain, unclear in 2 domains
[6] High ROB in one domain, unclear in 4 domains

Table 60: Vaginal misoprostol (≥50mcg) versus extra-amniotic PGE2/PGF2 for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (≥50mcg)	Control/ extra-amniotic PGE2/PGF2	Relative (95% CI)	Absolute		
Perinatal death												
2	randomised trials	very serious [1,2]	no serious inconsistency[3]	no serious indirectness	very serious[4]	none	3/204 (1.5%)	2/152 (1.3%)	Peto OR 1.1 (0.18 to 6.65)	1 more per 1000 (from 11 fewer to 68 more)	VERY LOW	IMPORTANT
Perinatal death - Mixed cervix												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	very serious[4]	none	1/76 (1.3%)	1/76 (1.3%)	Peto OR 1 (0.06 to 16.14)	0 fewer per 1000 (from 12 fewer to 164 more)	VERY LOW	IMPORTANT
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious [2]	no serious inconsistency	no serious indirectness	very serious[4]	none	2/128 (1.6%)	1/76 (1.3%)	Peto OR 1.18 (0.11 to 12.45)	2 more per 1000 (from 12 fewer to 129 more)	VERY LOW	IMPORTANT
Maternal death and morbidity - Mixed cervix												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	very serious[5]	none	0/76 (0%)	0/76 (0%)	Not estimable	0 more per 1000 (from 30 fewer to 30 more)[6]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in one domain
[2] High ROB in 2 domains, unclear in 2 domains

[3] i2=0%
[4] 95%CI crosses two MID boundaries
[5] OIS<300
[6] calculated from risk difference

Table 61: Vaginal misoprostol (≥50mcg) versus nitric oxide for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (≥50mcg)	Control/ nitric oxide	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/23 (0%)	0/21 (0%)	Not estimable	0 more per 1000 (from 80 fewer to 80 more)[3]	VERY LOW	IMPORTANT

[1] Unclear ROB in 6/7 domains
[2] OIS<300
[3] calculated from risk difference

Table 62: Oral misoprostol (<50mcg) versus oral misoprostol (≥50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oral misoprostol (<50mcg)	Control/ oral misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/23 (0%)	0/29 (0%)	Not estimable	0 more per 1000 (from 70 fewer to 70 more)[3]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oral misoprostol (<50mcg)	Control/ oral misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/23 (0%)	0/29 (0%)	Not estimable	0 more per 1000 (from 70 fewer to 70 more)[3]	VERY LOW	IMPORTANT

[1] Unclear in 4 domains
[2] OIS<300
[3] calculated from risk difference

Table 63: Oral misoprostol (<50mcg) versus titrated oral misoprostol solution for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Oral misoprostol (<50mcg)**	**Control/ titrated oral misoprostol solution**	**Relative (95% CI)**	**Absolute**		
Perinatal death - Unfavourable cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	0/148 (0%)	0/148 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[4]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/75 (0%)	0/75 (0%)	Not estimable	0 more per 1000 (from 30 fewer to 30 more)[4]	VERY LOW	IMPORTANT

[1] High ROB in 3 domains
[2] i2=0%

[3]OIS<300
[4]calculated from risk difference

Table 64: Oral misoprostol (<50mcg) versus Foley catheter for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oral misoprostol (<50mcg)	Control/ Foley catheter	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	6/302 (2%)	5/300 (1.7%)	Peto OR 1.19 (0.36 to 3.94)	3 more per 1000 (from 11 fewer to 46 more)	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision[3]	none	0/302 (0%)	0/300 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[4]	LOW	IMPORTANT

[1] High ROB in two domains
[2] 95%CI crosses two MID boundaries
[3] OIS>500
[4] calculated from risk difference

Table 65: Oral misoprostol (≥50mcg) versus titrated oral misoprostol solution for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oral misoprostol (≥50mcg)	Control/ titrated oral misoprostol solution	Relative (95% CI)	Absolute		
Maternal death and morbidity - Unfavourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oral misoprostol (≥50mcg)	Control/ titrated oral misoprostol solution	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/32 (0%)	0/32 (0%)	Not estimable	0 more per 1000 (from 60 fewer to 60 more)[3]	VERY LOW	IMPORTANT

[1] Unclear ROB in 3 domains
[2] OIS<300
[3] calculated from risk difference

Table 66: Oral misoprostol (≥50mcg) versus Foley catheter for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oral misoprostol (≥50mcg)	Control/ Foley catheter	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	1/1015 (0.1%)	4/1010 (0.4%)	Peto OR 0.3 (0.05 to 1.73)	3 fewer per 1000 (from 4 fewer to 3 more)	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	no serious imprecision[4]	none	0/1015 (0%)	0/1010 (0%)	Not estimable	0 more per 1000 (from 0 more to 0 more)[5]	LOW	IMPORTANT

[1] High ROB in two domains per study
[2] i2=0%
[3] 95%CI crosses two MID boundaries

[4] OIS>500
[5] calculated from risk difference

Table 67: Titrated oral misoprostol solution versus extra-amniotic PGE2/PGF2 for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Titrated oral misoprostol solution	Control/ extra-amniotic PGE2/PGF2	Relative (95% CI)	Absolute		
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/127 (0.79%)	1/76 (1.3%)	Peto OR 0.58 (0.03 to 10.3)	5 fewer per 1000 (from 13 fewer to 108 more)	VERY LOW	IMPORTANT

[1] High ROB in two domains, unclear in two domains
[2] 95%CI crosses two MID boundaries

Table 68: Titrated oral misoprostol solution versus IV oxytocin for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Titrated oral misoprostol solution	Control/ IV oxytocin	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/128 (0%)	0/128 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[3]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/128 (0%)	0/128 (0%)	Not estimable	0 more per 1000 (from	VERY LOW	IMPORTANT

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Titrated oral misoprostol solution	Control/ IV oxytocin	Relative (95% CI)	Absolute		
										20 fewer to 20 more)[3]		

[1] High ROB in two domains, unclear in 4 domains
[2] OIS<300
[3] calculated from risk difference

Table 69: Titrated oral misoprostol solution versus Foley catheter for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Titrated oral misoprostol solution	Control/ Foley catheter	Relative (95% CI)	Absolute		
Perinatal death - Mixed cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/345 (0.29%)	1/171 (0.58%)	Peto OR 0.47 (0.02 to 8.89)	3 fewer per 1000 (from 6 fewer to 44 more)	VERY LOW	IMPORTANT
Maternal death and morbidity - Mixed cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision[3]	none	0/346 (0%)	0/174 (0%)	Not estimable	0 more per 1000 (from 10 fewer to 10 more)[4]	LOW	IMPORTANT

[1] Unclear ROB in 3 domains
[2] 95%CI crosses two MID boundaries
[3] OIS>500
[4] calculated from risk difference

Table 70: IV oxytocin versus no treatment for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ no treatment	Relative (95% CI)	Absolute		
Perinatal death												
3	randomised trials	very serious [1,2,3]	no serious inconsistency[4]	no serious indirectness	serious[5]	none	1/145 (0.69%)	1/345 (0.29%)	Not estimable	0 fewer per 1000 (from 20 fewer to 20 more)[6]	VERY LOW	IMPORTANT
Perinatal death - Favourable cervix												
1	randomised trials	very serious[3]	no serious inconsistency	no serious indirectness	very serious[7]	none	0/25 (0%)	0/25 (0%)	Not estimable	0 fewer per 1000 (from 70 more to 70 more)[6]	VERY LOW	IMPORTANT
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[8]	none	1/20 (5%)	0/20 (0%)	Peto OR 7.39 (0.15 to 372.38)	0 more per 1000 (from 20 fewer to 20 more)[6]	VERY LOW	IMPORTANT
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[8]	none	0/100 (0%)	1/300 (0.33%)	Peto OR 0.26 (0 to 24.36)	2 fewer per 1000 (from 3 fewer to 72 more)	VERY LOW	IMPORTANT
Maternal death and morbidity - Favourable cervix												
1	randomised trials	very serious[3]	no serious inconsistency	no serious indirectness	very serious[7]	none	0/25 (0%)	0/25 (0%)	Not estimable	0 fewer per 1000 (from 70 more to 70 more)[6]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in 4 domains
[2] High ROB in 4 domains, unclear in 2 domains
[3] High ROB in one domain, unclear in one domain
[4] i2=0%
[5] OIS<500

[6] calculated from risk difference
[7] OIS<300
[8] 95%CI crosses two MID boundaries

Table 71: IV oxytocin versus amniotomy for induction of labour

Quality assessment							Number of patients		Effect			
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ amniotomy	Relative (95% CI)	Absolute	Quality	Importance
Perinatal death - Mixed cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/113 (0%)	0/110 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in 3 domains, unclear in one domain
[2] OIS<300
[3] calculated from risk difference

Table 72: IV oxytocin versus mifepristone for induction of labour

Quality assessment							Number of patients		Effect			
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ mifepristone	Relative (95% CI)	Absolute	Quality	Importance
Perinatal death - Unfavourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/34 (0%)	0/34 (0%)	Not estimable	0 more per 1000 (from 60 fewer to 60 more)[3]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ mifepristone	Relative (95% CI)	Absolute		
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/34 (0%)	0/34 (0%)	Not estimable	0 more per 1000 (from 60 fewer to 60 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in 2 domains
[2] OIS<300
[3] calculated from risk difference

Table 73: IV oxytocin versus IV prostaglandin for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ IV prostaglandin	Relative (95% CI)	Absolute		
Perinatal death - Mixed cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	0/127 (0%)	1/135 (0.74%)	Peto OR 0.15 (0 to 7.33)	6 fewer per 1000 (from 7 fewer to 44 more)	VERY LOW	IMPORTANT
Maternal death and morbidity - Mixed cervix												
1	randomised trials	very serious[4]	no serious inconsistency	no serious indirectness	very serious[5]	none	0/107 (0%)	0/115 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[6]	VERY LOW	IMPORTANT

[1] High ROB in one domain in 1/2 studies, unclear in at least two domains in all studies
[2] i2=0%
[3] 95%CI crosses two MID boundaries
[4] High ROB in one domain, unclear in 2 domains
[5] OIS<300
[6] calculated from risk difference

Table 74: IV oxytocin versus oral prostaglandins for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ oral prostaglandins	Relative (95% CI)	Absolute		
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/50 (2%)	0/54 (0%)	Peto OR 8 (0.16 to 404.57)	20 more per 1000 (from 30 fewer to 70 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in 3 domains
[2] 95%CI crosses two MID boundaries
[3] calculated from risk difference

Table 75: IV oxytocin versus buccal/sublingual misoprostol for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ buccal/sublingual misoprostol	Relative (95% CI)	Absolute		
Maternal death and morbidity - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/50 (0%)	0/45 (0%)	Not estimable	0 more per 1000 (from 40 fewer to 40 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in all others (as could not be assessed)
[2] OIS<300
[3] calculated from risk difference

Table 76: IV oxytocin versus Foley catheter for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ Foley catheter	Relative (95% CI)	Absolute		
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/100 (0%)	0/100 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in 4 domains
[2] OIS<300
[3] calculated from risk difference

Table 77: IV oxytocin + amniotomy versus no treatment for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin+amnio	Control/ no treatment	Relative (95% CI)	Absolute		
Perinatal death												
2	randomised trials	very serious[1,2]	no serious inconsistency3	no serious indirectness	very serious[4]	none	1/202 (0.5%)	1/203 (0.49%)	Peto OR 1 (0.06 to 16.13)	0 fewer per 1000 (from 5 fewer to 69 more)	VERY LOW	IMPORTANT
Perinatal death - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	0/124 (0%)	0/125 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[6]	VERY LOW	IMPORTANT
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[4]	none	1/78 (1.3%)	1/78 (1.3%)	Peto OR 1 (0.06 to 16.13)	0 fewer per 1000 (from	VERY LOW	IMPORTANT

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin+amnio	Control/ no treatment	Relative (95% CI)	Absolute		
										12 fewer to 160 more)		
Maternal death and morbidity - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	0/124 (0%)	0/125 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[6]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in 3 domains
[2] High ROB in 3 domains, unclear in 2 domains
[3] i2=0%
[4] 95%CI crosses two MID boundaries
[5] OIS<300
[6] calculated from risk difference

Table 78: IV oxytocin + amniotomy versus oral prostaglandins for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin+amnio	Control/ oral prostaglandins	Relative (95% CI)	Absolute		
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/50 (0%)	0/54 (0%)	Not estimable	0 more per 1000 (from 40 fewer to 40 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in 3 domains
[2] OIS<300
[3] calculated from risk difference

Table 79: IV oxytocin + amniotomy versus IV oxytocin for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin+amnio	Control/ IV oxytocin	Relative (95% CI)	Absolute		
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/50 (2%)	0/50 (0%)	Peto OR 7.39 (0.15 to 372.38)	20 more per 1000 (from 30 fewer to 70 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in 3 domains
[2] 95%CI crosses two MID boundaries
[3] calculated from risk difference

Table 80: IV oxytocin + amniotomy versus amniotomy for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin+amnio	Control/ amniotomy	Relative (95% CI)	Absolute		
Perinatal death - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/50 (0%)	0/50 (0%)	Not estimable	0 more per 1000 (from 40 fewer to 40 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in 4 domains
[2] OIS<300
[3] calculated from risk difference

Table 81: IV oxytocin + amniotomy versus Foley catheter for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin+amnio	Control/ Foley catheter	Relative (95% CI)	Absolute		
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/30 (0%)	0/30 (0%)	Not estimable	0 more per 1000 (from 60 fewer to 60 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in one domain
[2] OIS<300
[3] calculated from risk difference

Table 82: Oral prostaglandins versus no treatment for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oral prostaglandins	Control/ no treatment	Relative (95% CI)	Absolute		
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/34 (0%)	0/38 (0%)	Not estimable	0 more per 1000 (from 50 fewer to 50 more)[3]	VERY LOW	IMPORTANT

[1] Unclear ROB in 4 domains
[2] OIS<300
[3] calculated from risk difference

Table 83: Foley catheter versus no treatment for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Foley catheter	Control/ no treatment	Relative (95% CI)	Absolute		
Perinatal death - Not reported/ unclear cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/100 (0%)	1/300 (0.33%)	Peto OR 0.26 (0 to 24.36)	2 fewer per 1000 (from 3 fewer to 72 more)	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in 4 domains
[2] 95%CI crosses two MID boundaries

Table 84: Foley catheter versus extra-amniotic PGE2/PGF2 for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Foley catheter	Control/ extra-amniotic PGE2/PGF2	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
2	randomised trials	serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	3/91 (3.3%)	3/96 (3.1%)	Peto OR 1.07 (0.21 to 5.43)	2 more per 1000 (from 25 fewer to 118 more)	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	serious[4]	no serious inconsistency	no serious indirectness	very serious[5]	none	0/81 (0%)	0/81 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[6]	VERY LOW	IMPORTANT

[1] Unclear ROB in 2 and 3 domains per study
[2] i2=0%
[3] 95%CI crosses two MID boundaries

[4] Unclear ROB in 2 domains
[5] OIS<300
[6] calculated from risk difference

Table 85: Nitric oxide versus placebo for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Nitric oxide	Control/ placebo	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
2	randomised trials	very serious [1]	no serious inconsistency[2]	no serious indirectness	very serious3	none	3/855 (0.35 %)	0/857 (0%)	Peto OR 7.48 (0.78 to 72)	0 more per 1000 (from 0 more to 10 more)[4]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
2	randomised trials	very serious [5]	no serious inconsistency[2]	no serious indirectness	no serious imprecision[6]	none	0/714 (0%)	0/718 (0%)	Not estimable	0 more per 1000 (from 0 more to 0 more)[4]	LOW	IMPORTANT

[1] High ROB in one domain in each study, unclear in one domain in one study
[2] i2=0%
[3] 95%CI crosses two MID boundaries
[4] calculated from risk difference
[5] High ROB in one domain in one study, unclear in three domains in one study
[6] OIS>500

Table 86: Mifepristone versus placebo for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Mifepristone	Control/ placebo	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Mifepristone	Control/ placebo	Relative (95% CI)	Absolute		
2	randomised trials	serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	1/74 (1.4%)	0/62 (0%)	Peto OR 7.39 (0.15 to 372.38)	20 more per 1000 (from 40 fewer to 70 more)[4]	VERY LOW	IMPORTANT
Maternal death and morbidity - Unfavourable cervix												
1	randomised trials	serious[5]	no serious inconsistency	no serious indirectness	very serious[3]	none	3/289 (1%)6	0/57 (0%)6	Peto OR 3.33 (0.16 to 71.07)	10 more per 1000 (from 20 fewer to 40 more)[4]	VERY LOW	IMPORTANT

[1] Unclear ROB in at least one domain per study
[2] i2=0%
[3] 95%CI crosses two MID boundaries
[4] calculated from risk difference
[5] Unclear ROB in two domains
[6] includes cases of uterine rupture

Table 87: Relaxin versus placebo for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Relaxin	Control/ placebo	Relative (95% CI)	Absolute		
Perinatal death												
3	randomised trials	serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	0/131 (0%)	0/77 (0%)	Not estimable	0 more per 1000 (from 40 fewer to 40 more)[4]	VERY LOW	IMPORTANT
Perinatal death - Favourable cervix												
1	randomised trials	very serious[5]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/18 (0%)	0/22 (0%)	Not estimable	0 more per 1000 (from 90 fewer to 90 more)[4]	VERY LOW	IMPORTANT

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Relaxin	Control/ placebo	Relative (95% CI)	Absolute		
Perinatal death - Unfavourable cervix												
2	randomised trials	serious [6]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	0/113 (0%)	0/55 (0%)	Not estimable	0 fewer per 1000 (from 40 fewer to 40 more)[4]	VERY LOW	IMPORTANT

[1] Unclear ROB in at least one domain in two studies
[2] i2=0%
[3] OIS<300
[4] calculated from risk difference
[5] Unclear ROB in 3 domains
[6] Unclear ROB in 2 domains in 1 study only

Table 88: Titrated (low dose) oral misoprostol solution vs sustained release misoprostol insert

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Titrated oral misoprostol solution vs sustained release misoprostol insert	Control / placebo	Relative (95% CI)	Absolute		
Perinatal death – Unfavourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/99 (0%)	0/97 (0%)	Not estimable	0 fewer per 1000 (from 20 more to 20 more)	VERY LOW	IMPORTANT

[1] High bias in 2 domains
[2] OIS<300
[3] Calculated from risk difference

F2 – GRADE tables for maternal satisfaction (pairwise analysis)

Table 89: Vaginal PGE2 (tablet) versus vaginal PGE2 (pessary, slow release) for Induction of labour

Quality assessment							Number of patients		Effect			
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (tablet) versus vaginal PGE2 (pessary, slow release)	Control	Relative (95% CI)	Absolute	Quality	Importance
Satisfactory												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[1]	none	44/70 (62.9%)	61/75 (81.3%)	RR 0.77 (0.63 to 0.95)	187 fewer per 1000 (from 41 fewer to 301 fewer)	MODERATE	IMPORTANT

[1] Crosses lower boundary of default MIDs (0.8 to 1.25)

Table 90: Vaginal PGE2 (tablet) versus IV oxytocin + amniotomy for Induction of labour

Quality assessment							Number of patients		Effect			
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (tablet) versus IV oxytocin + amniotomy	Control	Relative (95% CI)	Absolute	Quality	Importance
Reaction unfavourable												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	0/50 (0%)	26/50 (52%)	Peto OR 0.07 (0.03 to 0.17)2	450 fewer per 1000 (from 364 fewer to 489 fewer)	LOW	IMPORTANT
Acceptance of method (positively rated)												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (tablet) versus IV oxytocin + amniotomy	Control	Relative (95% CI)	Absolute		
1	randomised trials	very serious[3]	no serious inconsistency	no serious indirectness	serious[4]	none	63/101 (62.4%)	77/99 (77.8%)	RR 0.8 (0.67 to 0.96)	156 fewer per 1000 (from 31 fewer to 257 fewer)	VERY LOW	IMPORTANT

[1] High ROB in one domain (performance bias) and unclear in three domains (selection biases and reporting bias)
[2] Peto OR due to zero cases in one group
[3] High ROB in 3 domains (selection biases and performance bias) and unclear in one domain (reporting bias)
[4] Crosses lower boundary of default MIDs (0.8 to 1.25)

Table 91: Vaginal PGE2 (tablet) versus double balloon catheter for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (tablet) versus double balloon catheter	Control	Relative (95% CI)	Absolute		
Overall satisfaction (0-5) (Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	54	33	-	MD 0.2 lower (0.83 lower to 0.43 higher)	VERY LOW	IMPORTANT
Would recommend												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	36/52 (69.2%)	22/31 (71%)	RR 0.98 (0.73 to 1.3)	14 fewer per 1000 (from 192 fewer to 213 more)	VERY LOW	IMPORTANT

[1] High ROB in one domain (performance bias) and unclear in one domain (reporting bias)
[2] Crosses lower boundary for calculated MID: SD in "control" (double balloon catheter) group = 1.5; MID: +/-0.75
[3] Crosses upper and lower boundary for default MIDs (0.8 to 1.25)

Table 92: Vaginal PGE2 (pessary, normal release) versus no treatment for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary, normal release) versus no treatment	Control	Relative (95% CI)	Absolute		
Satisfied with management (pleased)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	97/195 (49.7%)	110/207 (53.1%)	RR 0.94 (0.77 to 1.13)	32 fewer per 1000 (from 122 fewer to 69 more)	VERY LOW	IMPORTANT

[1] High ROB in four domains (selection biases, attrition bias, other bias) and unclear in three domains (performance bias, detection bias, reporting bias)
[2] Crosses lower boundary for default MIDs (0.8 to 1.25)

Table 93: Vaginal PGE2 (pessary, normal release) versus IV oxytocin for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary, normal release) versus IV oxytocin	Control	Relative (95% CI)	Absolute		
Unsatisfactory												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	1/47 (2.1%)	7/45 (15.6%)	RR 0.14 (0.02 to 1.07)	134 fewer per 1000 (from 152 fewer to 11 more)	VERY LOW	IMPORTANT

[1] High ROB in two domains (allocation concealment, performance bias) and unclear in two domains (random sequence generation, reporting bias)
[2] Crosses lower boundary for default MIDs (0.8 to 1.25)

Table 94: Vaginal PGE2 (pessary, normal release) versus Foley catheter for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary, normal release) versus Foley catheter	Control	Relative (95% CI)	Absolute		
Acceptable/recommendable												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness[2]	no serious imprecision	none	35/39 (89.7%)	30/32 (93.8%)	RR 0.96 (0.83 to 1.1)	38 fewer per 1000 (from 159 fewer to 94 more)	LOW	IMPORTANT

[1] High ROB in one domain (performance bias) and unclear in 2 domains (random sequence generation, reporting bias)
[2] Includes EASI with Foley catheter

Table 95: Vaginal PGE2 (pessary, slow release) versus Foley catheter for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary, slow release) versus Foley catheter	Control	Relative (95% CI)	Absolute		
Satisfaction (Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	26	26	-	MD 0.08 lower (0.76 lower to 0.6 higher)	VERY LOW	IMPORTANT

[1] High ROB in one domain (performance bias) and unclear in one domain (allocation concealment)
[2] Crosses lower boundary for calculated MID: SD of "control" (Foley) group = 1.3; MID = +/-0.65

Table 96: Vaginal PGE2 (gel) versus vaginal misoprostol (<50mcg) for Induction of labour

Quality assessment							Number of patients		Effect			
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel) versus vaginal misoprostol (<50mcg)	Control	Relative (95% CI)	Absolute	Quality	Importance
Would choose same method again												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	serious[3]	none	266/425 (62.6%)	287/430 (66.7%)	RR 0.94 (0.85 to 1.03)	40 fewer per 1000 (from 100 fewer to 20 more)	VERY LOW	IMPORTANT

[1] High ROB in three domains (performance, detection, attrition bias) in one study and high risk of bias in two domains (performance and other) in the other study
[2] i2=0%
[3] Crosses upper boundary for default MIDs (0.8 to 1.25)

Table 97: Vaginal PGE2 (gel) versus oral misoprostol (≥50mcg) for Induction of labour

Quality assessment							Number of patients		Effect			
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel) versus oral misoprostol (≥50mcg)	Control	Relative (95% CI)	Absolute	Quality	Importance
Would choose same method again												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	102/139 (73.4%)	112/145 (77.2%)	RR 0.95 (0.83 to 1.09)	39 fewer per 1000 (from 131 fewer to 70 more)	LOW	IMPORTANT

[1] High risk of bias in two domains (performance and other)

Table 98: Vaginal PGE2 (gel) versus nitric oxide for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel) versus nitric oxide	Control	Relative (95% CI)	Absolute		
Happiness with cervical ripening treatment (VAS 0-10) (Better indicated by higher values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[1]	none	194	193	-	MD 1.2 lower (1.78 to 0.62 lower)	MODERATE	IMPORTANT

[1] Crosses lower boundary of calculated MID: SD in "control" (nitric oxide) group = 2.7; MID=+/-1.35

Table 99: Vaginal PGE2 (gel) versus Foley catheter for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel) versus Foley catheter	Control	Relative (95% CI)	Absolute		
Would choose again (always or most times)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	19/45 (42.2%)	31/48 (64.6%)	RR 0.65 (0.44 to 0.98)	226 fewer per 1000 (from 13 fewer to 362 fewer)	LOW	IMPORTANT

[1] High ROB in one domain (performance bias)
[2] Crosses lower boundary for default MIDs (0.8 to 1.25)

Table 100: Intracervical PGE2 versus IV oxytocin for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2 versus IV oxytocin	Control	Relative (95% CI)	Absolute		
Acceptable method (recommendable, acceptable)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	33/49 (67.3%)	41/49 (83.7%)	RR 0.8 (0.64 to 1.01)	167 fewer per 1000 (from 301 fewer to 8 more)	VERY LOW	IMPORTANT

[1] High ROB in four domains (selection biases, performance and detection bias) and unclear in one domain (other bias)
[2] Crosses lower boundary for default MIDs (0.8 to 1.25)

Table 101: Intracervical PGE2 versus IV oxytocin + amniotomy for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2 versus IV oxytocin + amniotomy	Control	Relative (95% CI)	Absolute		
Unfavourable reaction												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/27 (3.7%)	1/27 (3.7%)	RR 1 (0.07 to 15.18)	0 fewer per 1000 (from 34 fewer to 525 more)	VERY LOW	IMPORTANT

[1] High ROB in one domain (performance bias) and unclear in four domains (selection biases, reporting and other bias)
[2] Crosses upper and lower boundaries for default MIDs (0.8 to 1.25)

Table 102: Vaginal misoprostol (<50mcg) versus oral misoprostol (>50mcg) for Induction of labour

Quality assessment							Number of patients		Effect			
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg) versus oral misoprostol (>50mcg)	Control	Relative (95% CI)	Absolute	Quality	Importance
Perceived as acceptable												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	108/139 (77.7%)	112/145 (77.2%)	RR 0.99 (0.88 to 1.13)	8 fewer per 1000 (from 93 fewer to 100 more)	LOW	IMPORTANT

[1] High risk of bias in two domains (performance and other)

Table 103: Vaginal misoprostol (>50mcg) versus oral misoprostol (≥50mcg) for Induction of labour

Quality assessment							Number of patients		Effect			
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (>50mcg) versus oral misoprostol (>50mcg)	Control	Relative (95% CI)	Absolute	Quality	Importance
Perceived as acceptable												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	61/70 (87.1%)	53/70 (75.7%)	RR 1.15 (0.98 to 1.35)	114 more per 1000 (from 15 fewer to 265 more)	VERY LOW	IMPORTANT
Satisfied with method (women who answered satisfied – dichotomous outcome options – satisfied/not satisfied)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	56/70 (80%)	49/70	RR 1.14 (0.94 to 1.39)	98 more per 1000 (from 42	VERY LOW	IMPORTANT

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (>50mcg) versus oral misoprostol (>50mcg)	Control	Relative (95% CI)	Absolute		
								(70%)		fewer to 273 more)		
Satisfied with overall experience												
1	randomised trials	very serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	109/111 (98.2%)	91/93 (97.8%)	RR 1 (0.96 to 1.04)	0 fewer per 1000 (from 39 fewer to 39 more)	LOW	IMPORTANT
Dissatisfied with misoprostol												
1	randomised trials	very serious[3]	no serious inconsistency	no serious indirectness	serious[2]	none	16/111 (14.4%)	7/93 (7.5%)	RR 1.92 (0.82 to 4.46)	69 more per 1000 (from 14 fewer to 260 more)	VERY LOW	IMPORTANT
Satisfaction rate												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	72/81 (88.9%)	73/98 (74.5%)	RR 1.19 (1.04 to 1.37)	142 more per 1000 (from 30 more to 276 more)	VERY LOW	IMPORTANT

[1] High ROB in one domain (performance bias) and unclear in one domain (reporting bias)
[2] Crosses upper boundary for default MIDs (0.8 to 1.25)
[3] High ROB in two domains (performance and detection bias) and unclear in two domains (reporting and other bias)

Table 104: Vaginal misoprostol (<50mcg) versus buccal/sublingual misoprostol for Induction of labour

Quality assessment							Number of patients		Effect			
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg) versus buccal/sublingual misoprostol	Control	Relative (95% CI)	Absolute	Quality	Importance
Would use again												
2	randomised trials	very serious[1]	very serious[2]	no serious indirectness	no serious imprecision	none	74/217 (34.1%)	128/215 (59.5%)	RR 0.57 (0.46 to 0.71)	256 fewer per 1000 (from 173 fewer to 321 fewer)	LOW	IMPORTANT
Favourable view of induction												
2	randomised trials	very serious[1]	very serious[2]	no serious indirectness	serious[3]	none	106/221 (48%)	123/217 (56.7%)	RR 0.79 (0.51 to 1.23)	119 fewer per 1000 (from 278 fewer to 130 more)	VERY LOW	IMPORTANT
Satisfaction with the induction process (Better indicated by lower values)												
1	randomised trials	serious[4]	no serious inconsistency	no serious indirectness	serious[5]	none	240	240	-	MD 0.77 higher (0.32 to 1.23 higher)	LOW	IMPORTANT
Satisfaction with the induction process - Vaginal births (Better indicated by lower values)												
1	randomised trials	serious[4]	no serious inconsistency	no serious indirectness	no serious imprecision[6]	none	160	169	-	MD 0.4 higher (0.18 lower to 0.98 higher)	MODERATE	IMPORTANT
Satisfaction with the induction process - Caesarean births (Better indicated by lower values)												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg) versus buccal/sublingual misoprostol	Control	Relative (95% CI)	Absolute		
1	randomised trials	very serious[4]	no serious inconsistency	no serious indirectness	serious[7]	none	80	71	-	MD 1.4 higher (0.65 to 2.15 higher)	VERY LOW	IMPORTANT
Satisfaction with the induction process - Caesarean births (Better indicated by lower values)												
1	randomised trials	very serious[4]	no serious inconsistency	no serious indirectness	serious[7]	none	80	71	-	MD 1.4 higher (0.65 to 2.15 higher)	VERY LOW	IMPORTANT

[1] High ROB in one domain (performance bias) and unclear in one domain (reporting bias)
[2] I^2>80% (random effects model)
[3]Crosses lower boundary for default MID (0.8 to 1.25)
[4] Unclear ROB in one domain (reporting bias)
[5] crosses upper boundary of calculated MID: SD in "control" (buccal) group = 2.05; MID=+/-1.025
[6] SD in "control" (buccal) group=2.4; MID=+/-1.2
[7] crosses upper boundary for calculated MID: SD in "control" (buccal) group=1.7; MID=+/-0.85

Table 105: Vaginal misoprostol (<50mcg) versus Foley catheter for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg) versus Foley catheter	Control	Relative (95% CI)	Absolute		
Satisfaction (range of scores: 0-5; Better indicated by higher values)												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg) versus Foley catheter	Control	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	46	54	-	MD 0.02 higher (0.036 lower to 0.076 higher)[3]	VERY LOW	IMPORTANT

[1] High ROB in two domains (performance and other bias) and unclear in one domain (reporting bias)
[2] No SD available, imprecision assessed using optimal information size (OIS): N<300 per arm
[3] p=0.488 (ns); back calculated using mean, N, p-value

Table 106: Oral misoprostol versus Foley catheter for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oral misoprostol versus Foley catheter	Control	Relative (95% CI)	Absolute		
Would use again - Oral misoprostol <50mcg												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	250/302 (82.8%)	216/300 (72%)	RR 1.15 (1.05 to 1.25)	108 more per 1000 (from 36 more to 180 more)	LOW	IMPORTANT
Satisfied with procedure - Oral misoprostol >50mcg												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	166/273 (60.8%)	136/229 (59.4%)	RR 1.02 (0.89 to 1.18)	12 more per 1000 (from 65 fewer to 107 more)	LOW	IMPORTANT

[1] High ROB in two domains (performance and other bias)

Table 107: IV oxytocin + amniotomy versus amniotomy for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin + amniotomy versus amniotomy	Control	Relative (95% CI)	Absolute		
Satisfactory experience of IoL (satisfied/dissatisfied/neither)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	36/39 (92.3%)	27/36 (75%)	RR 1.23 (1 to 1.52)	173 more per 1000 (from 0 more to 390 more)	LOW	IMPORTANT
Would have it again (yes/no/no response)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	26/39 (66.7%)	23/36 (63.9%)	RR 1.04 (0.75 to 1.45)	26 more per 1000 (from 160 fewer to 288 more)	LOW	IMPORTANT
Satisfaction with birth process (range of scores: 1-10; Better indicated by higher values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	105	101	-	MD 0 higher (0 to 0 higher)[4]	LOW	IMPORTANT

[1] High ROB in one domain (performance bias)
[2] Crosses upper boundary for default MIDs (0.8 to 1.25)
[3] OIS<300
[4] p=0.36 (ns); back calculated using MD, N, p-value

Table 108: Nitric oxide versus placebo for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Nitric oxide versus placebo	Control	Relative (95% CI)	Absolute		
Would recommend												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Nitric oxide versus placebo	Control	Relative (95% CI)	Absolute		
2	randomised trials	very serious[1]	very serious[2]	no serious indirectness	serious[3]	none	428/619 (69.1%)	498/623 (79.9%)	RR 0.92 (0.73 to 1.15)4	64 fewer per 1000 (from 216 fewer to 120 more)	VERY LOW	IMPORTANT
Satisfied (extremely, very, moderately, a little)												
1	randomised trials	serious[5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	418/525 (79.6%)	415/524 (79.2%)	RR 1.01 (0.95 to 1.07)	8 more per 1000 (from 40 fewer to 55 more)	MODERATE	IMPORTANT
Would have same treatment again (1=definitely, 10=def not) (Better indicated by lower values)												
1	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness	serious[7]	none	177	173	-	MD 0.62 higher (0.1 to 1.14 higher)	VERY LOW	IMPORTANT
Recommend to a friend (1=definitely, 10=def not) (Better indicated by lower values)												
1	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness	no serious imprecision[8]	none	177	173	-	MD 0.41 higher (0.06 lower to 0.88 higher)	LOW	IMPORTANT

[1] High ROB in one domain in one study (other bias) and unclear in one domain of one study (detection bias)
[2] i2=95% (random effects model)
[3] Crosses lower boundary for default MIDs (0.8 to 1.25)
[4] Random effects model (fixed effect i2=95%, RR=0.87 [95%CI 0.81, 0.92])
[5] High ROB in one domain (other bias)
[6] High ROB in one domain (attrition bias) and unclear in one domain (detection bias)
[7] crosses upper boundary of calculated MID: SD in placebo group = 2.19; MID=+/-1.09
[8] SD in placebo group =2.07; MID=+/-1.35

Table 109: Foley catheter versus hyaluronidase for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Foley catheter versus hyaluronidase	Control	Relative (95% CI)	Absolute		
Satisfaction with method												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	56/70 (80%)	49/70 (70%)	RR 1.14 (0.94 to 1.39)	98 more per 1000 (from 42 fewer to 273 more)	VERY LOW	IMPORTANT

[1] High ROB in one domain (performance bias) and unclear in one domain (reporting bias)
[2] Crosses upper boundary for default MIDs (0.8 to 1.25)

Table 110: Foley catheter versus double balloon catheter for Induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Foley catheter versus double balloon catheter	Control	Relative (95% CI)	Absolute		
Satisfaction (0-10) (Better indicated by higher values)												
3	randomised trials	very serious[1]	serious[2]	no serious indirectness[3]	no serious imprecision[4]	none	253	199	-	MD 0.22 lower (0.95 lower to 0.51 higher)	VERY LOW	IMPORTANT

[1] High and unclear ROB in all 3 studies over multiple domains
[2] i2=52% (random effects model)
[3] includes EASI with Foley and Cook's catheter in two studies (Mei-Dan 2012; Mei-Dan 2014)
[4] SD in "control" (Cook's catheter) group = 2.66; MID=+/-1.33

Table 111: Titrated (low dose) oral misoprostol solution vs sustained release misoprostol insert

Quality assessment							Number of patients		Effect			
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (>50mcg) versus oral misoprostol (>50mcg)	Control	Relative (95% CI)	Absolute	Quality	Importance
Satisfaction with delivery experience (VAS 0-10) (Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	99	97	-	MD 0.20 lower (0.86 lower to 0.46 higher)	VERY LOW	IMPORTANT

[1] High ROB in two domains (performance and other bias)
[2] SD in "control" (oral misoprostol>50mcg) group = 2.30; (MID=+/-1.15

F3 – GRADE tables for subgroup analysis of women with a Bishop score >6 ('favourable cervix') (pairwise analysis)

Table 112: Vaginal PGE2 (tablet) versus placebo for induction of labour

Quality assessment							Number of patients		Effect			
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (tablet)	Control/ placebo	Relative (95% CI)	Absolute	Quality	Importance
Hyperstimulation with FHR - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/28 (0%)	0/28 (0%)	Not estimable	0 more per 1000 (from 70 fewer to 70 more)[3]	VERY LOW	CRITICAL
Caesarean - Favourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (tablet)	Control/ placebo	Relative (95% CI)	Absolute		
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[4]	none	5/28 (17.9%)	3/28 (10.7%)	RR 1.67 (0.44 to 6.31)	72 more per 1000 (from 60 fewer to 569 more)	VERY LOW	CRITICAL

[1] High ROB in 1 domain, unclear in 5 domains
[2] OIS<300
[3] calculated from risk difference
[4] 95%CI crosses two MID boundaries

Table 113: Vaginal PGE2 (gel) versus amniotomy for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ amniotomy	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	5/130 (3.8%)	6/130 (4.6%)	RR 0.83 (0.26 to 2.66)	8 fewer per 1000 (from 34 fewer to 77 more)	VERY LOW	CRITICAL
Instrumental delivery - Favourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	19/130 (14.6%)	17/130 (13.1%)	RR 1.12 (0.61 to 2.05)	16 more per 1000 (from 51 fewer to 137 more)	VERY LOW	IMPORTANT
NICU admission - Favourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Vaginal PGE2 (gel)**	**Control/ amniotomy**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	6/130 (4.6%)	7/130 (5.4%)	RR 0.86 (0.3 to 2.48)	8 fewer per 1000 (from 38 fewer to 80 more)	VERY LOW	IMPORTANT
Epidural - Favourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[3]	none	9/130 (6.9%)	17/130 (13.1%)	RR 0.53 (0.24 to 1.14)	61 fewer per 1000 (from 99 fewer to 18 more)	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in two domains
[2] 95%CI crosses two MID boundaries
[3] 95%CI crosses one MID boundary

Table 114: Vaginal PGE2 (gel) versus IV oxytocin +amniotomy for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ IV oxytocin +amniotomy	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	3/25 (12%)	5/25 (20%)	RR 0.6 (0.16 to 2.25)	80 fewer per 1000 (from 168 fewer to 250 more)	VERY LOW	CRITICAL

[1] High ROB in one domain, unclear in two domains
[2] 95%CI crosses two MID boundaries

Table 115: Vaginal PGE2 (gel) versus oestrogens for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (gel)	Control/ oestrogens	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	7/30 (23.3%)	8/30 (26.7%)	RR 0.88 (0.36 to 2.11)	32 fewer per 1000 (from 171 fewer to 296 more)	VERY LOW	CRITICAL
Epidural - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	24/30 (80%)	24/30 (80%)	RR 1 (0.78 to 1.29)	0 fewer per 1000 (from 176 fewer to 232 more)	VERY LOW	IMPORTANT

[1] High ROB in two domains, unclear in two domains
[2] 95%CI crosses two MID boundaries

Table 116: Intracervical PGE2 versus vaginal misoprostol (≥50mcg) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ vaginal misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
Hyperstimulation with FHR - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious2	none	0/60 (0%)	0/60 (0%)	Not estimable	0 more per 1000 (from	VERY LOW	CRITICAL

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ vaginal misoprostol (≥50mcg)	Relative (95% CI)	Absolute		
										30 fewer to 30 more)[3]		
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	9/60 (15%)	16/60 (26.7%)	RR 0.56 (0.27 to 1.17)	117 fewer per 1000 (from 195 fewer to 45 more)	VERY LOW	CRITICAL

[1] Unclear ROB in three domains
[2] OIS<300
[3] calculated from risk difference
[4] 95%CI crosses one MID boundary

Table 117: Intracervical PGE2 versus IV oxytocin +amniotomy for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ IV oxytocin +amniotomy	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	4/30 (13.3%)	1/30 (3.3%)	RR 4 (0.47 to 33.73)	100 more per 1000 (from 18 fewer to 1000 more)	VERY LOW	CRITICAL
Instrumental delivery - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	6/30 (20%)	10/30 (33.3%)	RR 0.6 (0.25 to 1.44)	133 fewer per 1000 (from 250	VERY LOW	IMPORTANT

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intracervical PGE2	Control/ IV oxytocin +amniotomy	Relative (95% CI)	Absolute		
										fewer to 147 more)		

[1] High ROB in one domain, unclear in four domains
[2] 95%CI crosses two MID boundaries

Table 118: Vaginal PGE2 (pessary - normal release) versus IV oxytocin for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal PGE2 (pessary - normal release)	Control/ IV oxytocin	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	3/94 (3.2%)	6/89 (6.7%)	RR 0.47 (0.12 to 1.86)	36 fewer per 1000 (from 59 fewer to 58 more)	VERY LOW	CRITICAL
Instrumental delivery - Favourable cervix												
2	randomised trials	very serious[1]	no serious inconsistency[2]	no serious indirectness	very serious[3]	none	16/94 (17%)	10/89 (11.2%)	RR 1.55 (0.76 to 3.2)	62 more per 1000 (from 27 fewer to 247 more)	VERY LOW	IMPORTANT

[1] High ROB in two domains per study, unclear in two domains per study
[2] i2=0%
[3] 95%CI crosses two MID boundaries

Table 119: Vaginal misoprostol (<50mcg) versus IV oxytocin for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (<50mcg)	Control/ IV oxytocin	Relative (95% CI)	Absolute		
Hyperstimulation with FHR - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	2/53 (3.8%)	4/53 (7.5%)	RR 0.5 (0.1 to 2.61)	38 fewer per 1000 (from 68 fewer to 122 more)	VERY LOW	CRITICAL
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	11/53 (20.8%)	21/53 (39.6%)	RR 0.52 (0.28 to 0.98)	190 fewer per 1000 (from 8 fewer to 285 fewer)	VERY LOW	CRITICAL

[1] High ROB in one domain, unclear in five domains
[2] 95%CI crosses two MID boundaries
[3] 95%CI crosses one MID boundary

Table 120: Vaginal misoprostol (≥50mcg) versus IV oxytocin for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (≥50mcg)	Control/ IV oxytocin	Relative (95% CI)	Absolute		
Instrumental delivery - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	6/70 (8.6%)	12/70 (17.1%)	RR 0.5 (0.2 to 1.26)	86 fewer per 1000 (from 137 fewer to 45 more)	VERY LOW	IMPORTANT
Caesarean - Favourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal misoprostol (≥50mcg)	Control/ IV oxytocin	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	5/70 (7.1%)	14/70 (20%)	RR 0.36 (0.14 to 0.94)	128 fewer per 1000 (from 12 fewer to 172 fewer)	VERY LOW	CRITICAL

[1] High ROB in three domains, unclear in two domains
[2] 95%CI crosses two MID boundaries
[3] 95%CI crosses one MID boundary

Table 121: Oral misoprostol (≥50mcg) versus IV oxytocin for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oral misoprostol (≥50mcg)	Control/ IV oxytocin	Relative (95% CI)	Absolute		
No vaginal birth in 24 hours - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	20/110 (18.2%)	10/88 (11.4%)	RR 1.6 (0.79 to 3.24)	68 more per 1000 (from 24 fewer to 255 more)	VERY LOW	CRITICAL
Hyperstimulation with FHR - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	7/110 (6.4%)	0/88 (0%)	Peto OR 6.4 (1.41 to 29.1)	60 more per 1000 (from 10 more to 110 more)[3]	LOW	CRITICAL
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	9/110 (8.2%)	8/88 (9.1%)	RR 0.9 (0.36 to 2.24)	9 fewer per 1000 (from	VERY LOW	CRITICAL

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oral misoprostol (≥50mcg)	Control/ IV oxytocin	Relative (95% CI)	Absolute		
										58 fewer to 113 more)		
Instrumental delivery - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	5/110 (4.5%)	3/88 (3.4%)	RR 1.33 (0.33 to 5.43)	11 more per 1000 (from 23 fewer to 151 more)	VERY LOW	IMPORTANT
NICU admission - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	11/110 (10%)	10/88 (11.4%)	RR 0.88 (0.39 to 1.98)	14 fewer per 1000 (from 69 fewer to 111 more)	VERY LOW	IMPORTANT

[1] High ROB in two domains, unclear in two domains
[2] 95%CI crosses two MID boundaries
[3] calculated from risk difference

Table 122: Amniotomy versus no treatment for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy	Control/ no treatment	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	4/10 (40%)	0/10 (0%)	Peto OR 10.75 (1.27 to 91)	400 more per 1000 (from 80 more to 720 more)[2]	LOW	CRITICAL

[1] High ROB in three domains, unclear in one domain
[2] calculated from risk difference

Table 123: Amniotomy versus IV oxytocin +amniotomy for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy	Control/ IV oxytocin +amniotomy	Relative (95% CI)	Absolute		
Hyperstimulation with FHR changes - Favourable cervix												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[1]	none	0/101 (0%)	0/105 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[2]	LOW	CRITICAL
Caesarean - Favourable cervix												
4	randomised trials	very serious[3]	no serious inconsistency[4]	no serious indirectness	very serious[5]	none	29/311 (9.3%)	23/314 (7.3%)	RR 1.27 (0.76 to 2.09)	20 more per 1000 (from 18 fewer to 80 more)	VERY LOW	CRITICAL
Instrumental delivery - Favourable cervix												
3	randomised trials	very serious[3]	very serious[6]	no serious indirectness	very serious[5]	none	37/213 (17.4%)	48/180 (26.7%)	RR 0.60 (0.24 to 1.5)7	107 fewer per 1000 (from 203 fewer to 133 more)	VERY LOW	IMPORTANT
NICU admission - Favourable cervix												
2	randomised trials	serious[8]	no serious inconsistency[4]	no serious indirectness	very serious[5]	none	0/163 (0%)	3/166 (1.8%)	Peto OR 0.13 (0.01 to 1.3)	16 fewer per 1000 (from 18 fewer to 5 more)	VERY LOW	IMPORTANT
Epidural - Favourable cervix												
3	randomised trials	very serious[3]	very serious[9]	no serious indirectness	very serious[5]	none	94/213 (44.1%)	85/216 (39.4%)	RR 1.29 (0.61 to 2.7)7	114 more per 1000 (from 153 fewer to 669 more)	VERY LOW	IMPORTANT

[1] OIS<300
[2] calculated from risk difference

[3] High ROB in one or more domain in more than one study, unclear in one or more domain in more than one study
[4] i2=0%
[5] 95%CI crosses two MID boundaries
[6] i2=75% (random effects model)
[7] random effects model
[8] High ROB in one domain in one study
[9] i2=93% (random effects model)

Table 124: Amniotomy versus Foley catheter for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy	Control/ Foley catheter	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	4/10 (40%)	1/10 (10%)	RR 4 (0.54 to 29.8)	300 more per 1000 (from 46 fewer to 1000 more)	VERY LOW	CRITICAL

[1] High ROB in three domain, unclear in one domain
[2] 95%CI crosses two MID boundaries

Table 125: Amniotomy versus laminaria (dilapan) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy	Control/ laminaria (dilapan)	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy	Control/ laminaria (dilapan)	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	4/10 (40%)	3/10 (30%)	RR 1.33 (0.4 to 4.49)	99 more per 1000 (from 180 fewer to 1000 more)	VERY LOW	CRITICAL

[1] High ROB in three domains, unclear in one domain
[2] 95%CI crosses two MID boundaries

Table 126: IV oxytocin +amniotomy versus no treatment for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin +amniotomy	Control/ no treatment	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	33/124 (26.6%)	27/125 (21.6%)	RR 1.23 (0.79 to 1.92)	50 more per 1000 (from 45 fewer to 199 more)	VERY LOW	CRITICAL
NICU admission - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/124 (0.81%)	0/125 (0%)	Peto OR 7.45 (0.15 to 375.41)	10 more per 1000 (from 10 fewer to 30 more)[3]	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in three domains
[2] 95%CI crosses two MID boundaries
[3] calculated from risk difference

Table 127: IV oxytocin +amniotomy versus oral prostaglandins for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin +amniotomy	Control/ oral prostaglandins	Relative (95% CI)	Absolute		
Hyperstimulation with FHR changes - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/92 (0%)	0/69 (0%)	Not estimable	0 more per 1000 (from 20 fewer to 20 more)[3]	VERY LOW	CRITICAL
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	6/92 (6.5%)	7/69 (10.1%)	RR 0.64 (0.23 to 1.83)	37 fewer per 1000 (from 78 fewer to 84 more)	VERY LOW	CRITICAL
Instrumental delivery - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	23/92 (25%)	11/69 (15.9%)	RR 1.57 (0.82 to 3)	91 more per 1000 (from 29 fewer to 319 more)	VERY LOW	IMPORTANT

[1] High ROB in three domains, unclear in one domain
[2] OIS<300
[3] calculated from risk difference
[4] 95%CI crosses two MID boundaries
[5] 95%CI crosses one MID boundary

Table 128: IV oxytocin +amniotomy versus buccal/sublingual misoprostol for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin +amniotomy	Control/ buccal/sublingual misoprostol	Relative (95% CI)	Absolute		
No vaginal birth in 24 hours - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	4/25 (16%)	10/25 (40%)	RR 0.4 (0.14 to 1.11)	240 fewer per 1000 (from 344 fewer to 44 more)	VERY LOW	CRITICAL
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	4/25 (16%)	3/25 (12%)	RR 1.33 (0.33 to 5.36)	40 more per 1000 (from 80 fewer to 523 more)	VERY LOW	CRITICAL
Instrumental delivery - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	4/25 (16%)	5/25 (20%)	RR 0.8 (0.24 to 2.64)	40 fewer per 1000 (from 152 fewer to 328 more)	VERY LOW	IMPORTANT
NICU admission - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	0/25 (0%)	0/25 (0%)	Not estimable	0 more per 1000 (from 70 fewer to 70 more)[5]	VERY LOW	IMPORTANT
Epidural - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	5/25 (20%)	6/25 (24%)	RR 0.83 (0.29 to 2.38)	41 fewer per 1000 (from 170 fewer to 331 more)	VERY LOW	IMPORTANT

[1] High ROB in one domain, unclear in one domain
[2] 95%CI crosses one MID boundary
[3] 95%CI crosses two MID boundaries
[4] OIS<300
[5] calculated from risk difference

Table 129: IV oxytocin versus amniotomy for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ amniotomy	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	3/10 (30%)	4/10 (40%)	RR 0.75 (0.22 to 2.52)	100 fewer per 1000 (from 312 fewer to 608 more)	VERY LOW	CRITICAL

[1] High ROB in three domains, unclear in one domain
[2] 95%CI crosses two MID boundaries

Table 130: IV oxytocin versus no treatment for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ no treatment	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
2	randomised trials	very serious [1]	no serious inconsistency[2]	no serious indirectness	very serious [3,4]	none	5/35 (14.3%)	1/35 (2.9%)	Peto OR 4.21 (0.8 to 22.21)	82 more per 1000 (from 6 fewer to 367 more)	VERY LOW	CRITICAL

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ no treatment	Relative (95% CI)	Absolute		
Instrumental delivery - Favourable cervix												
1	randomised trials	very serious[4]	no serious inconsistency	no serious indirectness	very serious[3]	none	5/25 (20%)	4/25 (16%)	Not estimable	4 fewer per 1000 (from 17 fewer to 25 more)[5]	VERY LOW	CRITICAL
NICU admission - Favourable cervix												
1	randomised trials	very serious[4]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/25 (0%)	0/25 (0%)	Not estimable	0 fewer per 1000 (from 70 more to 70 more)[5]	VERY LOW	CRITICAL

[1] High ROB in two domains in one study, high ROB in one domain and unclear in one domain in one study
[2] i2=0%
[3] 95%CI crosses two MID boundaries
[4] OIS<300
[5] High ROB in one domain, unclear in one domain
[6] Calculated from risk difference

Table 131: IV oxytocin versus IV oxytocin + amniotomy for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ IV oxytocin +amniotomy	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	6/72 (8.3%)	7/71 (9.9%)	RR 0.85 (0.3 to 2.39)	15 fewer per 1000 (from 69 fewer to 137 more)	VERY LOW	CRITICAL
Instrumental delivery - Favourable cervix												

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ IV oxytocin +amniotomy	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	9/72 (12.5%)	9/71 (12.7%)	RR 0.99 (0.42 to 2.34)	1 fewer per 1000 (from 74 fewer to 170 more)	VERY LOW	IMPORTANT
Epidural - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	63/72 (87.5%)	66/71 (93%)	RR 0.94 (0.84 to 1.05)	56 fewer per 1000 (from 149 fewer to 46 more)	LOW	IMPORTANT

[1] High ROB in one domain, unclear in two domains
[2] 95%CI crosses two MID boundaries

Table 132: IV oxytocin versus buccal/sublingual misoprostol for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ buccal/sublingual misoprostol	Relative (95% CI)	Absolute		
No vaginal birth in 24 hours - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12/50 (24%)	12/45 (26.7%)	RR 0.9 (0.45 to 1.8)	27 fewer per 1000 (from 147 fewer to 213 more)	VERY LOW	CRITICAL
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12/50 (24%)	10/45 (22.2%)	RR 1.08 (0.52 to 2.26)	18 more per 1000 (from 107 fewer	VERY LOW	CRITICAL

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ buccal/sublingual misoprostol	Relative (95% CI)	Absolute		
										to 280 more)		

[1] High ROB in one domain, no information for remaining domains so assessed as unclear
[2] 95%CI crosses two MID boundaries

Table 133: IV oxytocin versus Foley catheter for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ Foley catheter	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	3/10 (30%)	1/10 (10%)	RR 3 (0.37 to 24.17)	200 more per 1000 (from 63 fewer to 1000 more)	VERY LOW	CRITICAL

[1] High ROB in three domains, unclear in one domain
[2] 95%CI crosses two MID boundaries

Table 134: IV oxytocin versus laminaria (dilapan) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	IV oxytocin	Control/ laminaria (dilapan)	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	3/10 (30%)	3/10 (30%)	RR 1 (0.26 to 3.81)	0 fewer per 1000 (from 222 fewer to 843 more)	VERY LOW	CRITICAL

[1] High ROB in three domains, unclear in one domain
[2] 95%CI crosses two MID boundaries

Table 135: Foley catheter versus no treatment for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Foley catheter	Control/ no treatment	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/10 (10%)	0/10 (0%)	Peto OR 7.39 (0.15 to 372.38)	100 more per 1000 (from 140 fewer to 340 more)[3]	VERY LOW	CRITICAL

[1] High ROB in three domains, unclear in one domain
[2] 95% CI crosses two MID boundaries
[3] calculated from risk difference

Table 136: Foley catheter versus laminaria (dilapan) for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Foley catheter	Control/ laminaria (dilapan)	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/10 (10%)	3/10 (30%)	RR 0.33 (0.04 to 2.69)	201 fewer per 1000 (from 288 fewer to 507 more)	VERY LOW	CRITICAL

[1] High ROB in three domains, unclear in one domain
[2] 95% CI crosses two MID boundaries

Table 137: Relaxin versus placebo for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Relaxin	Control/ placebo	Relative (95% CI)	Absolute		
Hyperstimulation with FHR changes - Favourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/18 (0%)	0/22 (0%)	Not estimable	0 more per 1000 (from 90 fewer to 90 more)[3]	VERY LOW	CRITICAL
Caesarean - Favourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[4]	none	2/18 (11.1 %)	4/22 (18.2%)	RR 0.61 (0.13 to 2.96)	71 fewer per 1000 (from 158 fewer to 356 more)	VERY LOW	CRITICAL
Instrumental delivery - Favourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[4]	none	6/18 (33.3 %)	6/22 (27.3%)	RR 1.22 (0.48 to 3.14)	60 more per 1000 (from 142	VERY LOW	IMPORTANT

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Relaxin	Control/ placebo	Relative (95% CI)	Absolute		
										fewer to 584 more)		
Epidural - Favourable cervix												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[4]	none	8/18 (44.4 %)	10/22 (45.5%)	RR 0.98 (0.49 to 1.95)	9 fewer per 1000 (from 232 fewer to 432 more)	VERY LOW	IMPORTANT

[1] Unclear ROB in 3 domains
[2] OIS<300
[3] calculated from risk difference
[4] 95%CI crosses 2 MID boundaries

Table 138: Laminaria (dilapan) versus no treatment for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Laminaria (dilapan)	Control/ no treatment	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	3/10 (30%)	0/10 (0%)	Peto OR 9.35 (0.85 to 102.3)	300 more per 1000 (from 0 more to 600 more)[3]	VERY LOW	CRITICAL

[1] High ROB in 3 domains, and unclear in 1 domain
[2] 95%CI crosses upper MID
[3] calculated from risk difference

Table 139: Corticosteroids versus no treatment for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Corticosteroids	Control/ no treatment	Relative (95% CI)	Absolute		
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/32 (3.1%)	5/33 (15.2%)	RR 0.21 (0.03 to 1.67)	120 fewer per 1000 (from 147 fewer to 102 more)	VERY LOW	CRITICAL

[1] Unclear ROB in 3 domains
[2] 95%CI crosses two MID boundaries

Table 140: Corticosteroids versus placebo for induction of labour

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Corticosteroids	Control/ placebo	Relative (95% CI)	Absolute		
Hyperstimulation with FHR - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/33 (0%)	0/33 (0%)	Not estimable	0 more per 1000 (from 60 fewer to 60 more)[3]	VERY LOW	CRITICAL
Caesarean - Favourable cervix												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	10/61 (16.4%)	14/61 (23%)	RR 0.71 (0.34 to 1.48)	67 fewer per 1000 (from	VERY LOW	CRITICAL

Quality assessment							Number of patients		Effect		Quality	Importance
Number of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Corticosteroids	Control/ placebo	Relative (95% CI)	Absolute		
										151 fewer to 110 more)		

[1] Unclear in 3 domains
[2] OIS<300
[3] calculated from risk difference
[4] 95%CI crosses 2 MIDs