WHO/RHR/14.15

WHO recommendations for augmentation of labour:

Evidence base

World Health Organization

WHO recommendations for augmentation of labour
Evidence base

WHO/RHR/14.15

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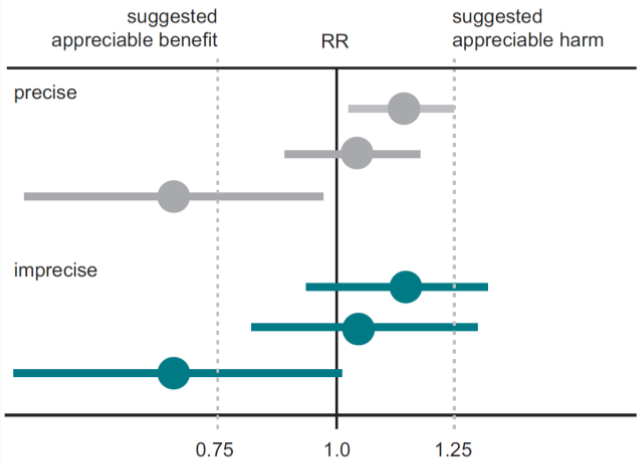
Standard criteria for grading of evidence

Box 1. Standard criteria for grading of evidence[1]

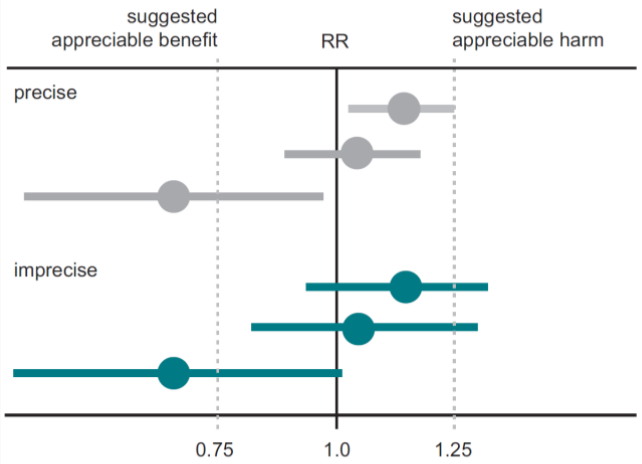
Domain	Grade	Characteristic
STUDY DESIGN	0	All randomized controlled trials
	–2	All observational studies
STUDY DESIGN LIMITATIONS	0	Most of the pooled effect provided by studies, with low risk of bias ("A")
	–1	Most of the pooled effect provided by studies with moderate (“B”) or high (“C”) risk of bias. Studies with high risk of bias weighs <40%
	–2	Most of the pooled effect provided by studies with moderate (“B”) or high (“C”) risk of bias. Studies with high risk of bias weighs ≥40%
	Note:	Low risk of bias (no limitations or minor limitations) –“A” Moderate risk of bias (serious limitations or potentially very serious limitations including unclear concealment of allocation or serious limitations, excluding limitations on randomization or concealment of allocation) –“B” High risk of bias (Limitations for randomization, concealment of allocation, including small blocked randomization (<10) or other very serious, crucial methodological limitations) –“C”
INCONSISTENCY	0	No severe heterogeneity (I^2<60% or $\chi^2 \geq 0.1$)
	–1	Severe, non-explained, heterogeneity (I2≥ 60% or $\chi^2 < 0.1$) If heterogeneity could be caused by publication bias or imprecision due to small studies, downgrade only for publication bias or imprecision (i.e. the same weakness should not be downgraded twice)
INDIRECTNESS	0	No indirectness
	–1	Presence of indirect comparison, population, intervention, comparator, or outcome.

1 Adapted from: Schünemann H, Brozek J, Oxman A, editors. GRADE handbook for grading quality of evidence and strength of recommendations. The GRADE Working Group. Available at: <http://ims.cochrane.org/revman/gradepro>. (This document is contained within the "Help" section of the GRADE profiler software version v.3.2.2.)

Box 1. (cont.) Standard criteria for grading of evidence

Domain	Grade	Characteristic
IMPRECISION	0	The confidence interval is precise according to the figure below. The total cumulative study population is not very small (i.e. sample size is more than 300 participants) and the total number of events is more than 30. 
	–1	One of the above-mentioned conditions is not fulfilled.
	–2	The two above-mentioned are not fulfilled.
	Note: If the total number of events is less than 30 and the total cumulative sample size is appropriately large (e.g. above 3000 patients, consider not downgrading the evidence). If there are no events in both intervention and control groups, the quality of evidence in the specific outcome should be regarded as very low.	
PUBLICATION BIAS	0	No evident asymmetry in the funnel plot or less than five studies to be plotted.
	–1	Evident asymmetry in funnel plot with at least five studies.

Box 1. (cont.) Standard criteria for grading of evidence

Domain	Grade	Characteristic
IMPRECISION	0	The confidence interval is precise according to the figure below. The total cumulative study population is not very small (i.e. sample size is more than 300 participants) and the total number of events is more than 30. 
	–1	One of the above-mentioned conditions is not fulfilled.
	–2	The two above-mentioned are not fulfilled.
	Note: If the total number of events is less than 30 and the total cumulative sample size is appropriately large (e.g. above 3000 patients, consider not downgrading the evidence). If there are no events in both intervention and control groups, the quality of evidence in the specific outcome should be regarded as very low.	
PUBLICATION BIAS	0	No evident asymmetry in the funnel plot or less than five studies to be plotted.
	–1	Evident asymmetry in funnel plot with at least five studies.

Note: All observational studies will start as “low” quality evidence but non-controlled studies (e.g. case series) will be further downgraded to “very low” quality.

GRADE[1] Tables

Table 1a. Partograph for monitoring the progress of labour (maternal outcomes)

Source: Lavender T, Hart A, Smyth RMD. Effect of partogram use on outcomes for women in spontaneous labour at term. Cochrane Database Syst Rev. 2013;(7):CD005461.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph (studies carried out in high- and low-resource settings)	No partograph (studies carried out in high- and low-resource settings)	Relative (95% CI)	Absolute		
Duration of first stage of labour (hours) – high-resource setting (better indicated by lower values)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	580	576	-	MD 0.8 higher (0.06 lower to 1.66 higher)	⊕⊕◯◯ LOW	CRITICAL
Caesarean section (overall)												
2	randomized trials	very serious[3]	no serious inconsistency	no serious indirectness	serious[4]	none	146/804 (18.2%)	173/786 (22%)	RR 0.64 (0.24 to 1.7)	79 fewer per 1000 (from 167 fewer to 154 more)	⊕◯◯◯ VERY LOW	IMPORTANT
Caesarean section (overall) – low-resource setting												
1	randomized trials	very serious[5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	21/224 (9.4%)	52/210 (24.8%)	RR 0.38 (0.24 to 0.61)	154 fewer per 1000 (from 97 fewer to 188 fewer)	⊕⊕◯◯ LOW	IMPORTANT
Caesarean section (overall) – high-resource setting												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	125/580 (21.6%)	121/576 (21%)	RR 1.03 (0.82 to 1.28)	6 more per 1000 (from 38 fewer to 59 more)	⊕⊕◯◯ LOW	IMPORTANT

[1] GRADE: Grading of Recommendations Assessment, Development and Evaluation (http://www.gradeworkinggroup.org/)

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph (studies carried out in high- and low-resource settings)	No partograph (studies carried out in high- and low-resource settings)	Relative (95% CI)	Absolute		
Duration of second stage of labour (hours) – high-resource setting (better indicated by lower values)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	580	576	-	MD 0 higher (0.21 lower to 0.21 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
Epidural analgesia – high-resource setting												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	532/580 (91.7%)	521/576 (90.5%)	RR 1.01 (0.98 to 1.05)	9 more per 1000 (from 18 fewer to 45 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Oxytocin augmentation – high-resource setting												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	423/580 (72.9%)	412/576 (71.5%)	RR 1.02 (0.95 to 1.1)	14 more per 1000 (from 36 fewer to 72 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Instrumental vaginal delivery												
2	randomized trials	serious[6]	no serious inconsistency	no serious indirectness	no serious imprecision	none	218/804 (27.1%)	214/786 (27.2%)	RR 1 (0.85 to 1.17)	0 fewer per 1000 (from 41 fewer to 46 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Instrumental vaginal delivery – low-resource setting												
1	randomized trials	very serious[5]	no serious inconsistency	no serious indirectness	serious[4]	none	45/224 (20.1%)	36/210 (17.1%)	RR 1.17 (0.79 to 1.74)	29 more per 1000 (from 36 fewer to 127 more)	⊕○○○ VERY LOW	IMPORTANT
Instrumental vaginal delivery – high-resource setting												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	173/580 (29.8%)	178/576 (30.9%)	RR 0.97 (0.81 to 1.15)	9 fewer per 1000 (from 59 fewer to 46 more)	⊕⊕⊕○ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph (studies carried out in high- and low-resource settings)	No partograph (studies carried out in high- and low-resource settings)	Relative (95% CI)	Absolute		
Artificial rupture of membranes performed												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	283/580 (48.8%)	284/576 (49.3%)	RR 0.99 (0.88 to 1.11)	5 fewer per 1000 (from 59 fewer to 54 more)	⊕⊕⊕○ MODERATE	IMPORTANT

[1] One study with design limitations.
[2] Wide confidence interval crossing the line of no effect and fails to exclude appreciable benefit for the control group.
[3] Most studies contributing data had design limitations, with more than 40% of weight from studies with serious design limitations.
[4] Wide confidence interval crossing the line of no effect.
[5] One study with serious design limitations.
[6] Most studies contributing data had design limitations, but with less than 40% of weight from studies with serious design limitations.

Table 1b. Partograph for monitoring the progress of labour (infant outcomes)

Source: Lavender T, Hart A, Smyth RMD. Effect of partogram use on outcomes for women in spontaneous labour at term. Cochrane Database Syst Rev. 2013;(7):CD005461.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph (studies carried out in high- and low-resource settings)	No partograph (studies carried out in high- and low-resource settings)	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	7/810 (0.9%)	9/786 (1.1%)	RR 0.77 (0.29 to 2.06)	3 fewer per 1000 (from 8 fewer to 12 more)	⊕○○○ VERY LOW	CRITICAL
Apgar score < 7 at 5 minutes – low-resource setting												
1	randomized trials	very serious[3]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/230 (0.4%)	2/210 (1%)	RR 0.46 (0.04 to 5)	5 fewer per 1000 (from 9 fewer to 38 more)	⊕○○○ VERY LOW	CRITICAL
Apgar score < 7 at 5 minutes – high-resource setting												
1	randomized trials	serious[4]	no serious inconsistency	no serious indirectness	very serious[2]	none	6/580 (1%)	7/576 (1.2%)	RR 0.85 (0.29 to 2.52)	2 fewer per 1000 (from 9 fewer to 18 more)	⊕○○○ VERY LOW	CRITICAL
Admission to special care nursery – high-resource setting												
1	randomized trials	serious[4]	no serious inconsistency	no serious indirectness	serious[5]	none	19/580 (3.3%)	20/576 (3.5%)	RR 0.94 (0.51 to 1.75)	2 fewer per 1000 (from 17 fewer to 26 more)	⊕⊕○○ LOW	IMPORTANT

[1] Studies contributing data had design limitations.
[2] Wide confidence interval crossing the line of no effect and few events.
[3] One study with design limitations.
[4] One study with serious design limitations.
[5] Wide confidence interval crossing the line of no effect.

Table 1c. Partograph for monitoring the progress of labour (maternal outcomes)

Source: Lavender T, Hart A, Smyth RMD. Effect of partogram use on outcomes for women in spontaneous labour at term. Cochrane Database Syst Rev. 2013;(7):CD005461.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph with 2-hour action line (studies carried out in a high-resource setting)	Partograph with 4-hour action line (studies carried out in a high-resource setting)	Relative (95% CI)	Absolute		
Serious maternal morbidity or death												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/1805 (0%)	0/1796 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Blood loss > 500 ml												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	240/1805 (13.3%)	224/1796 (12.5%)	RR 1.07 (0.9 to 1.26)	9 more per 1000 (from 12 fewer to 32 more)	⊕⊕○○ LOW	CRITICAL
Caesarean section (fetal distress)												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	51/1805 (2.8%)	39/1796 (2.2%)	RR 1.3 (0.86 to 1.96)	7 more per 1000 (from 3 fewer to 21 more)	⊕⊕○○ LOW	CRITICAL
Caesarean section (delay in labour)												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	120/1805 (6.6%)	122/1796 (6.8%)	RR 0.98 (0.77 to 1.25)	1 fewer per 1000 (from 16 fewer to 17 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Epidural use												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	599/1805 (33.2%)	574/1796 (32%)	RR 1.04 (0.95 to 1.14)	13 more per 1000 (from 16 fewer to 45 more)	⊕⊕⊕○ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph with 2-hour action line (studies carried out in a high-resource setting)	Partograph with 4-hour action line (studies carried out in a high-resource setting)	Relative (95% CI)	Absolute		
Oxytocin augmentation												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	840/1805 (46.5%)	736/1796 (41%)	RR 1.14 (1.05 to 1.22)	57 more per 1000 (from 20 more to 90 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Instrumental vaginal delivery												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	360/1805 (19.9%)	393/1796 (21.9%)	RR 0.91 (0.8 to 1.03)	20 fewer per 1000 (from 44 fewer to 7 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Caesarean section (overall)												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	171/1805 (9.5%)	161/1796 (9%)	RR 1.06 (0.85 to 1.32)	5 more per 1000 (from 13 fewer to 29 more)	⊕⊕○○ LOW	IMPORTANT

[1] Studies contributing data had design limitations.
[2] No events.
[3] Wide confidence interval crossing the line of no effect.

Table 1d. Partograph for monitoring the progress of labour (infant outcomes)

Source: Lavender T, Hart A, Smyth RMD. Effect of partogram use on outcomes for women in spontaneous labour at term. Cochrane Database Syst Rev. 2013;(7):CD005461.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph with 2-hour action line (studies carried out in a high-resource setting)	Partograph with 4-hour action line (studies carried out in a high-resource setting)	Relative (95% CI)	Absolute		
Serious neonatal morbidity or perinatal death												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/1805 (0%)	0/1796 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Apgar score < 7 at 5 minutes												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	28/1805 (1.6%)	34/1796 (1.9%)	RR 0.82 (0.5 to 1.35)	3 fewer per 1000 (from 9 fewer to 7 more)	⊕⊕○○ LOW	CRITICAL
Cord pH < 7.1												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	25/1805 (1.4%)	34/1796 (1.9%)	RR 0.73 (0.44 to 1.22)	5 fewer per 1000 (from 11 fewer to 4 more)	⊕⊕○○ LOW	CRITICAL
Admission to special care nursery												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	25/1805 (1.4%)	32/1796 (1.8%)	RR 0.78 (0.46 to 1.31)	4 fewer per 1000 (from 10 fewer to 6 more)	⊕⊕○○ LOW	IMPORTANT

[1] Studies contributing data had design limitations.
[2] No events.
[3] Wide confidence interval crossing the line of no effect.

Table 1e. Partograph for monitoring the progress of labour (maternal outcomes)

Source: Lavender T, Hart A, Smyth RMD. Effect of partogram use on outcomes for women in spontaneous labour at term. Cochrane Database Syst Rev. 2013;(7):CD005461.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph with 2-hour action line (study carried out in a high-resource setting)	Partograph with 3-hour action line (study carried out in a high-resource setting)	Relative (95% CI)	Absolute		
Serious maternal morbidity or death												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/315 (0%)	0/302 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Blood loss > 500 ml												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	39/315 (12.4%)	39/302 (12.9%)	RR 0.96 (0.63 to 1.45)	5 fewer per 1000 (from 48 fewer to 58 more)	⊕⊕○○ LOW	CRITICAL
Caesarean section (fetal distress)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	12/315 (3.8%)	12/302 (4%)	RR 0.96 (0.44 to 2.1)	2 fewer per 1000 (from 22 fewer to 44 more)	⊕○○○ VERY LOW	CRITICAL
Caesarean section (delay in labour)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	23/315 (7.3%)	31/302 (10.3%)	RR 0.71 (0.42 to 1.19)	30 fewer per 1000 (from 60 fewer to 20 more)	⊕⊕○○ LOW	IMPORTANT
Epidural use												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	120/315 (38.1%)	99/302 (32.8%)	RR 1.16 (0.94 to 1.44)	52 more per 1000 (from 20 fewer to 144 more)	⊕⊕○○ LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Partograph with 2-hour action line (study carried out in a high-resource setting)**	**Partograph with 3-hour action line (study carried out in a high-resource setting)**	**Relative (95% CI)**	**Absolute**		
Oxytocin augmentation												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	144/315 (45.7%)	136/302 (45%)	RR 1.02 (0.85 to 1.21)	9 more per 1000 (from 68 fewer to 95 more)	⊕⊕⊕◯ MODERATE	IMPORTANT
Instrumental vaginal delivery												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	66/315 (21%)	68/302 (22.5%)	RR 0.93 (0.69 to 1.26)	16 fewer per 1000 (from 70 fewer to 59 more)	⊕⊕◯◯ LOW	IMPORTANT
Caesarean section (overall)												
1	no methodology chosen					none	35/315 (11.1%)	43/302 (14.2%)	RR 0.78 (0.51 to 1.18)	31 fewer per 1000 (from 70 fewer to 26 more)		

[1] One study with design limitations.
[2] No events.
[3] Wide confidence interval crossing the line of no effect.
[4] Wide confidence interval crossing the line of no effect and few events.

Table 1f. Partograph for monitoring the progress of labour (infant outcomes)

Source: Lavender T, Hart A, Smyth RMD. Effect of partogram use on outcomes for women in spontaneous labour at term. Cochrane Database Syst Rev. 2013;(7):CD005461.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph with 2-hour action line (study carried out in a high-resource setting)	Partograph with 3-hour action line (study carried out in a high-resource setting)	Relative (95% CI)	Absolute		
Serious neonatal morbidity or perinatal death												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/315 (0%)	0/302 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Apgar score < 7 at 5 minutes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	6/315 (1.9%)	4/302 (1.3%)	RR 1.44 (0.41 to 5.05)	6 more per 1000 (from 8 fewer to 54 more)	⊕○○○ VERY LOW	CRITICAL
Cord pH < 7.1												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	2/315 (0.6%)	5/302 (1.7%)	RR 0.38 (0.07 to 1.96)	10 fewer per 1000 (from 15 fewer to 16 more)	⊕○○○ VERY LOW	CRITICAL
Admission to special care nursery												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	4/315 (1.3%)	1/302 (0.3%)	RR 3.83 (0.43 to 34.12)	9 more per 1000 (from 2 fewer to 110 more)		IMPORTANT

[1] One study with design limitations.

[2] No events.

[3] Wide confidence interval crossing the line of no effect and few events.

Table 1g. Partograph for monitoring the progress of labour (maternal outcomes)

Source: Lavender T, Hart A, Smyth RMD. Effect of partogram use on outcomes for women in spontaneous labour at term. Cochrane Database Syst Rev. 2013;(7):CD005461.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph with 3-hour action line (study carried out in a high-resource setting)	Partograph with 4-hour action line (study carried out in a high-resource setting)	Relative (95% CI)	Absolute		
Serious maternal morbidity or death												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/302 (0%)	0/311 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Blood loss > 500 ml												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	39/302 (12.9%)	39/311 (12.5%)	RR 1.03 (0.68 to 1.56)	4 more per 1000 (from 40 fewer to 70 more)	⊕⊕○○ LOW	CRITICAL
Caesarean section (fetal distress)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	12/302 (4%)	7/311 (2.3%)	RR 1.77 (0.7 to 4.42)	17 more per 1000 (from 7 fewer to 77 more)	⊕○○○ VERY LOW	CRITICAL
Caesarean section (delay in labour)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	31/302 (10.3%)	19/311 (6.1%)	RR 1.68 (0.97 to 2.91)	42 more per 1000 (from 2 fewer to 117 more)	⊕⊕○○ LOW	IMPORTANT
Epidural use												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	99/302 (32.8%)	101/311 (32.5%)	RR 1.01 (0.8 to 1.27)	3 more per 1000 (from 65 fewer to 88 more)	⊕⊕○○ LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph with 3-hour action line (study carried out in a high-resource setting)	Partograph with 4-hour action line (study carried out in a high-resource setting)	Relative (95% CI)	Absolute		
Oxytocin augmentation												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	136/302 (45%)	129/311 (41.5%)	RR 1.09 (0.91 to 1.3)	37 more per 1000 (from 37 fewer to 124 more)	⊕⊕◯◯ LOW	IMPORTANT
Instrumental vaginal delivery												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	68/302 (22.5%)	73/311 (23.5%)	RR 0.96 (0.72 to 1.28)	9 fewer per 1000 (from 66 fewer to 66 more)	⊕⊕◯◯ LOW	IMPORTANT
Caesarean section (overall)												
1	no methodology chosen					none	43/302 (14.2%)	26/311 (8.4%)	RR 1.7 (1.07 to 2.7)	59 more per 1000 (from 6 more to 142 more)		

[1] One study with design limitations.
[2] No events.
[3] Wide confidence interval crossing the line of no effect.
[4] Wide confidence interval crossing the line of no effect and few events.

Table 1h. Partograph for monitoring the progress of labour (infant outcomes)

Source: Lavender T, Hart A, Smyth RMD. Effect of partogram use on outcomes for women in spontaneous labour at term. Cochrane Database Syst Rev. 2013;(7):CD005461.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph with 3-hour action line (study carried out in a high-resource setting)	Partograph with 4-hour action line (study carried out in a high-resource setting)	Relative (95% CI)	Absolute		
Serious neonatal morbidity or perinatal death												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/302 (0%)	0/311 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Apgar score < 7 at 5 minutes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	4/302 (1.3%)	5/311 (1.6%)	RR 0.82 (0.22 to 3.04)	3 fewer per 1000 (from 13 fewer to 33 more)	⊕○○○ VERY LOW	CRITICAL
Cord pH < 7.1												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	5/302 (1.7%)	2/311 (0.64%)	RR 2.57 (0.5 to 13.17)	10 more per 1000 (from 3 fewer to 78 more)	⊕○○○ VERY LOW	CRITICAL
Admission to special care nursery												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/302 (0.3%)	2/311 (0.6%)	RR 0.51 (0.05 to 5.65)	3 fewer per 1000 (from 6 fewer to 30 more)	⊕○○○ VERY LOW	IMPORTANT

[1] One study with design limitations.

[2] No events.

[3] Wide confidence interval crossing the line of no effect and few events.

Table 1i. Partograph for monitoring the progress of labour (maternal outcomes)

Source: Lavender T, Hart A, Smyth RMD. Effect of partogram use on outcomes for women in spontaneous labour at term. Cochrane Database Syst Rev. 2013;(7):CD005461.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph with alert line only (study carried out in a low-resource setting)	Partograph with alert line only versus partograph with alert and action line (study carried out in a low-resource setting)	Relative (95% CI)	Absolute		
Caesarean section (overall)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	55/344 (16%)	82/350 (23.4%)	RR 0.68 (0.5 to 0.93)	75 fewer per 1000 (from 16 fewer to 117 fewer)	⊕⊕⊕○ MODERATE	IMPORTANT
Oxytocin augmentation												
1	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	77/344 (22.4%)	97/350 (27.7%)	RR 0.81 (0.62 to 1.05)	53 fewer per 1000 (from 105 fewer to 14 more)	⊕⊕○○ LOW	IMPORTANT
Instrumental vaginal delivery												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	70/344 (20.3%)	82/350 (23.4%)	RR 0.87 (0.66 to 1.15)	30 fewer per 1000 (from 80 fewer to 35 more)	⊕⊕○○ LOW	IMPORTANT

[1] One study with design limitations.
[2] Wide confidence interval crossing the line of no effect.
[3] No explanation was provided.

Table 1j. Partograph for monitoring the progress of labour (infant outcomes)

Source: Lavender T, Hart A, Smyth RMD. Effect of partogram use on outcomes for women in spontaneous labour at term. Cochrane Database Syst Rev. 2013;(7):CD005461.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph with alert line only (study carried out in a low-resource setting)	Partograph with alert line only versus partograph with alert and action line (study carried out in a low-resource setting)	Relative (95% CI)	Absolute		
Perinatal death												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	3/344 (0.9%)	0/350 (0%)	RR 7.12 (0.37 to 137.36)	-	⊕○○○ VERY LOW	CRITICAL
Apgar score < 7 at 5 minutes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	3/344 (0.9%)	0/350 (0%)	RR 7.12 (0.37 to 137.36)	-	⊕○○○ VERY LOW	CRITICAL

[1] One study with design limitations.

[2] Wide confidence interval crossing the line of no effect and few events.

Table 1k. Partograph for monitoring the progress of labour (maternal outcomes)

Source: Lavender T, Hart A, Smyth RMD. Effect of partogram use on outcomes for women in spontaneous labour at term. Cochrane Database Syst Rev. 2013;(7):CD005461.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Earlier intervention (combined analysis for trials in high- and low-resource settings)	Later intervention (combined analysis for trials in high- and low-resource settings)	Relative (95% CI)	Absolute		
Caesarean section (overall) – all settings												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	226/2149 (10.5%)	243/2146 (11.3%)	RR 0.94 (0.67 to 1.31)	7 fewer per 1000 (from 37 fewer to 35 more)	⊕⊕◯◯ LOW	IMPORTANT
Caesarean section (overall) – low-resource setting												
1	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	55/344 (16%)	82/350 (23.4%)	RR 0.68 (0.5 to 0.93)	75 fewer per 1000 (from 16 fewer to 117 fewer)	⊕⊕⊕◯ MODERATE	IMPORTANT
Caesarean section (overall) – high-resource setting												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	171/1805 (9.5%)	161/1796 (9%)	RR 1.06 (0.85 to 1.32)	5 more per 1000 (from 13 fewer to 29 more)	⊕⊕◯◯ LOW	IMPORTANT
Instrumental delivery – all settings												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	430/2149 (20%)	475/2146 (22.1%)	RR 0.9 (0.8 to 1.02)	22 fewer per 1000 (from 44 fewer to 4 more)	⊕⊕◯◯ LOW	IMPORTANT
Instrumental delivery – low-resource setting												
1	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	serious[2]	none	70/344 (20.3%)	82/350 (23.4%)	RR 0.87 (0.66 to 1.15)	30 fewer per 1000 (from 80 fewer to 35 more)	⊕⊕◯◯ LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Earlier intervention (combined analysis for trials in high- and low-resource settings)	Later intervention (combined analysis for trials in high- and low-resource settings)	Relative (95% CI)	Absolute		
Instrumental delivery – high-resource setting												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	360/1805 (19.9%)	393/1796 (21.9%)	RR 0.91 (0.8 to 1.03)	20 fewer per 1000 (from 44 fewer to 7 more)	⊕⊕◯◯ LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] Wide confidence interval crossing the line of no effect.
[3] One study with design limitations.

Table 1l. Partograph for monitoring the progress of labour (infant outcomes)

Source: Lavender T, Hart A, Smyth RMD. Effect of partogram use on outcomes for women in spontaneous labour at term. Cochrane Database Syst Rev. 2013;(7):CD005461.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Earlier intervention (combined analysis for trials in high- and low-resource settings)	Later intervention (combined analysis for trials in high- and low-resource settings)	Relative (95% CI)	Absolute		
Apgar score low at 5 or 10 minutes												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	31/2149 (1.4%)	34/2146 (1.6%)	RR 0.95 (0.48 to 1.86)	1 fewer per 1000 (from 8 fewer to 14 more)	⊕⊕◯◯ LOW	CRITICAL
Apgar score low at 5 or 10 minutes – low-resource setting												
1	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[4]	none	3/344 (0.9%)	0/350 (0%)	RR 7.12 (0.37 to 137.36)	-	⊕◯◯◯ VERY LOW	CRITICAL
Apgar score low at 5 or 10 minutes – high-resource setting												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	28/1805 (1.6%)	34/1796 (1.9%)	RR 0.82 (0.5 to 1.35)	3 fewer per 1000 (from 9 fewer to 7 more)	⊕⊕◯◯ LOW	CRITICAL

[1] Most studies contributing data had design limitations.
[2] Wide confidence interval crossing the line of no effect.
[3] One study with design limitations.
[4] Wide confidence interval crossing the line of no effect and few events.

Table 1m. Partograph for monitoring the progress of labour (maternal outcomes)

Source: Lavender T, Hart A, Smyth RMD. Effect of partogram use on outcomes for women in spontaneous labour at term. Cochrane Database Syst Rev. 2013;(7):CD005461.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph with latent phase	Partograph without latent phase	Relative (95% CI)	Absolute		
Caesarean section (fetal distress)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	65/350 (18.6%)	15/393 (3.8%)	RR 4.87 (2.83 to 8.37)	148 more per 1000 (from 70 more to 281 more)	⊕⊕⊕○ MODERATE	CRITICAL
Caesarean section (delay in labour)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12/350 (3.4%)	10/393 (2.5%)	RR 1.35 (0.59 to 3.08)	9 more per 1000 (from 10 fewer to 53 more)	⊕○○○ VERY LOW	IMPORTANT
Caesarean section (overall)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	83/350 (23.7%)	38/393 (9.7%)	RR 2.45 (1.72 to 3.5)	140 more per 1000 (from 70 more to 242 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Oxytocin augmentation												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	126/350 (36%)	65/393 (16.5%)	RR 2.18 (1.67 to 2.83)	195 more per 1000 (from 111 more to 303 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Instrumental vaginal delivery												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	24/350 (6.9%)	26/393 (6.6%)	RR 1.04 (0.61 to 1.77)	3 more per 1000 (from 26 fewer to 51 more)	⊕⊕○○ LOW	IMPORTANT

[1] One study with design limitations.
[2] Wide confidence interval crossing the line of no effect and few events.
[3] Wide confidence interval crossing the line of no effect.

Table 1n. Partograph for monitoring the progress of labour (infant outcomes)

Source: Lavender T, Hart A, Smyth RMD. Effect of partogram use on outcomes for women in spontaneous labour at term. Cochrane Database Syst Rev. 2013;(7):CD005461.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Partograph with latent phase	Partograph without latent phase	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	4/350 (1.1%)	6/393 (1.5%)	RR 0.75 (0.21 to 2.63)	4 fewer per 1000 (from 12 fewer to 25 more)	⊕○○○ VERY LOW	CRITICAL
Admission to special care nursery												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	69/350 (19.7%)	42/393 (10.7%)	RR 1.84 (1.29 to 2.63)	90 more per 1000 (from 31 more to 174 more)	⊕⊕⊕○ MODERATE	IMPORTANT

[1] One study with design limitations.
[2] Wide confidence interval crossing the line of no effect and few events.

Table 2a. Routine vaginal examination for assessing the progress of labour (maternal outcomes)

Source: Downe S, Gill GML, Dahlen, Dahlen HG, Singata M. Routine vaginal examinations for assessing progress of labour to improve outcomes for women and babies at term. Cochrane Database Syst Rev. 2013;(7):CD010088.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal examination	Rectal examination	Relative (95% CI)	Absolute		
Caesarean section												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/154 (0.6%)	3/153 (2%)	RR 0.33 (0.03 to 3.15)	13 fewer per 1000 (from 19 fewer to 42 more)	⊕○○○ VERY LOW	IMPORTANT
Spontaneous vaginal birth												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	135/154 (87.7%)	137/153 (89.5%)	RR 0.98 (0.9 to 1.06)	18 fewer per 1000 (from 90 fewer to 54 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Operative vaginal birth												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	18/154 (11.7%)	13/153 (8.5%)	RR 1.38 (0.7 to 2.71)	32 more per 1000 (from 25 fewer to 145 more)	⊕⊕○○ LOW	IMPORTANT
Augmentation of labour												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	27/154 (17.5%)	26/153 (17%)	RR 1.03 (0.63 to 1.68)	5 more per 1000 (from 63 fewer to 116 more)	⊕⊕○○ LOW	IMPORTANT
Maternal infection with unknown treatment (not pre-specified)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	8/154 (5.2%)	16/153 (10.5%)	RR 0.5 (0.22 to 1.13)	52 fewer per 1000 (from 82 fewer to 14 more)	⊕○○○ VERY LOW	IMPORTANT
Very uncomfortable (not pre-specified)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	17/151 (11.3%)	41/152 (27%)	RR 0.42 (0.25 to 0.7)	156 fewer per 1000 (from 81 fewer to 202 fewer)	⊕⊕⊕○ MODERATE	IMPORTANT

[1] One trial with design limitations.

[2] Wide confidence interval crossing the line of no effect and few events.

[3] Wide confidence interval crossing the line of no effect.

Table 2b. Routine vaginal examination for assessing the progress of labour (infant outcomes)

Source: Downe S, Gill GML, Dahlen, Dahlen HG, Singata M. Routine vaginal examinations for assessing progress of labour to improve outcomes for women and babies at term. Cochrane Database Syst Rev. 2013;(7):CD010088.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal examination	Rectal examination	Relative (95% CI)	Absolute		
Perinatal mortality												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/154 (0.6%)	1/153 (0.7%)	RR 0.99 (0.06 to 15.74)	0 fewer per 1000 (from 6 fewer to 96 more)	⊕○○○ VERY LOW	CRITICAL
Neonatal infection requiring antibiotics (primary outcome)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/154 (0%)	1/153 (0.7%)	RR 0.33 (0.01 to 8.07)	4 fewer per 1000 (from 6 fewer to 46 more)	⊕○○○ VERY LOW	CRITICAL
Admission to neonatal intensive care unit												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	8/154 (5.2%)	6/153 (3.9%)	RR 1.32 (0.47 to 3.73)	13 more per 1000 (from 21 fewer to 107 more)	⊕○○○ VERY LOW	IMPORTANT
Infant infection with unknown treatment (not pre-specified)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	2/154 (1.3%)	2/153 (1.3%)	RR 0.99 (0.14 to 6.96)	0 fewer per 1000 (from 11 fewer to 78 more)	⊕○○○ VERY LOW	IMPORTANT

[1] One trial with design limitations.

[2] Wide confidence interval crossing the line of no effect and few events.

Table 2c. Routine vaginal examination for assessing the progress of labour (maternal outcomes)

Source: Downe S, Gill GML, Dahlen, Dahlen HG, Singata M. Routine vaginal examinations for assessing progress of labour to improve outcomes for women and babies at term. Cochrane Database Syst Rev. 2013;(7):CD010088.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vaginal examinations 2 hourly	Vaginal examinations 4 hourly	Relative (95% CI)	Absolute		
Duration of labour (minutes) (primary outcome) (better indicated by lower values)												
1	randomized trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	55	54	-	MD 6 lower (88.7 lower to 76.7 higher)	⊕○○○ VERY LOW	CRITICAL
Caesarean section												
1	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[2]	none	10/75 (13.3%)	13/75 (17.3%)	RR 0.77 (0.36 to 1.64)	40 fewer per 1000 (from 111 fewer to 111 more)	⊕○○○ VERY LOW	IMPORTANT
Spontaneous vaginal birth												
1	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	52/75 (69.3%)	53/75 (70.7%)	RR 0.98 (0.8 to 1.21)	14 fewer per 1000 (from 141 fewer to 148 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Epidural for pain relief												
1	randomized trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	11/55 (20%)	14/54 (25.9%)	RR 0.77 (0.39 to 1.55)	60 fewer per 1000 (from 158 fewer to 143 more)	⊕○○○ VERY LOW	IMPORTANT
Operative vaginal birth												
1	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[2]	none	13/75 (17.3%)	9/75 (12%)	RR 1.44 (0.66 to 3.17)	53 more per 1000 (from 41 fewer to 260 more)	⊕○○○ VERY LOW	IMPORTANT
Augmentation of labour												
1	randomized trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	21/55 (38.2%)	20/54 (37%)	RR 1.03 (0.64 to 1.67)	11 more per 1000 (from 133 fewer to 248 more)	⊕○○○ VERY LOW	IMPORTANT

[1] One trial with serious design limitations.
[2] Wide confidence interval crossing the line of no effect and small sample size.
[3] One trial with serious design limitations (ITT data used in this analysis).

Table 3a. Package of care for active management of labour for prevention of delay in the first stage of labour (maternal outcomes)

Source: Brown HC, Paranjothy S, Dowswell T, Thomas J. Package of care for active management in labour for reducing caesarean section rates in low-risk women. Cochrane Database Syst Rev. 2008;(4):CD004907.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Active management of labour	Routine care	Relative (95% CI)	Absolute		
Duration of labour (hours from admission to delivery) (better indicated by lower values)												
4	randomized trials	serious[1]	serious[2]	no serious indirectness	no serious imprecision	none	1055	1376	-	MD 1.27 lower (2.19 to 0.36 lower)	⊕⊕○○ LOW	CRITICAL
Postpartum haemorrhage (blood loss > 500 ml)												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	57/741 (7.7%)	63/763 (8.3%)	RR 0.93 (0.67 to 1.31)	6 fewer per 1000 (from 27 fewer to 26 more)	⊕⊕○○ LOW	CRITICAL
Duration of first stage of labour (hours) (better indicated by lower values)												
4	randomized trials	serious[1]	serious[4]	no serious indirectness	no serious imprecision	none	1055	1376	-	MD 1.56 lower (2.17 to 0.96 lower)	⊕⊕○○ LOW	CRITICAL
Caesarean section rate – all women												
7	randomized trials	very serious[5]	no serious inconsistency	no serious indirectness	no serious imprecision	none	343/2573 (13.3%)	416/2817 (14.8%)	RR 0.88 (0.77 to 1.01)	18 fewer per 1000 (from 34 fewer to 1 more)	⊕⊕○○ LOW	IMPORTANT
Caesarean section rate – all women (Frigoletto [1995] study women eligible in labour)												
7	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	220/2242 (9.8%)	307/2496 (12.3%)	RR 0.82 (0.69 to 0.97)	22 fewer per 1000 (from 4 fewer to 38 fewer)	⊕⊕⊕○ MODERATE	IMPORTANT
Caesarean section rate (sensitivity analysis: Frigoletto [1995] study excluded)												
6	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	146/1564 (9.3%)	240/1911 (12.6%)	RR 0.77 (0.63 to 0.94)	29 fewer per 1000 (from 8 fewer to 46 fewer)	⊕⊕⊕○ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Active management of labour	Routine care	Relative (95% CI)	Absolute		
Duration of second stage (hours) (better indicated by lower values)												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	1207	1530	-	MD 0.02 lower (0.06 lower to 0.02 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
Maternal infection (various definitions)												
5	randomized trials	serious[1]	serious[6]	no serious indirectness	serious[3]	none	131/1412 (9.3%)	152/1757 (8.7%)	RR 1.14 (0.65 to 1.98)	12 more per 1000 (from 30 fewer to 85 more)	⊕○○○ VERY LOW	IMPORTANT
Number of women having epidural analgesia												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	575/1023 (56.2%)	553/1044 (53%)	RR 1.06 (0.98 to 1.14)	32 more per 1000 (from 11 fewer to 74 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Assisted vaginal delivery rates												
6	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	309/1564 (19.8%)	360/1911 (18.8%)	RR 0.99 (0.87 to 1.14)	2 fewer per 1000 (from 24 fewer to 26 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Prolonged labour (> 12 hours)												
6	randomized trials	serious[1]	serious[7]	no serious indirectness	no serious imprecision	none	163/1481 (11%)	412/1761 (23.4%)	RR 0.47 (0.32 to 0.69)	124 fewer per 1000 (from 73 fewer to 159 fewer)	⊕⊕○○ LOW	IMPORTANT
Overall satisfaction with care												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	190/243 (78.2%)	169/225 (75.1%)	RR 1.04 (0.94 to 1.15)	30 more per 1000 (from 45 fewer to 113 more)	⊕⊕○○ LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] Statistical heterogeneity (I^2 = 92%). Considerable variation in size of effect.
[3] Wide confidence interval crossing the line of no effect.
[4] Statistical heterogeneity (I^2 = 84%). Considerable variation in size of effect.
[5] Most studies contributing data had design limitations, with more than 40% of weight from a study with serious design limitations.
[6] Statistical heterogeneity (I^2 = 80%). Considerable variation in size of effect.
[7] Statistical heterogeneity (I^2 = 75%). Considerable variation in size of effect.

Table 3b. Package of care for active management of labour for prevention of delay in the first stage of labour (infant outcomes)

Source: Brown HC, Paranjothy S, Dowswell T, Thomas J. Package of care for active management in labour for reducing caesarean section rates in low-risk women. Cochrane Database Syst Rev. 2008;(4):CD004907.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Active management of labour	Routine care	Relative (95% CI)	Absolute		
Low APGAR score at 5 minutes												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	47/1244 (3.8%)	43/1271 (3.4%)	RR 1.12 (0.76 to 1.64)	4 more per 1000 (from 8 fewer to 22 more)	⊕⊕○○ LOW	CRITICAL
Admission to special care (various definitions)												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	35/1023 (3.4%)	39/1044 (3.7%)	RR 0.92 (0.59 to 1.43)	3 fewer per 1000 (from 15 fewer to 16 more)	⊕⊕○○ LOW	IMPORTANT
Meconium staining												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	79/1023 (7.7%)	100/1353 (7.4%)	RR 0.93 (0.7 to 1.24)	5 fewer per 1000 (from 22 fewer to 18 more)	⊕⊕○○ LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] Wide confidence interval crossing the line of no effect.

Table 4a. Early amniotomy and early oxytocin for prevention of delay in the first stage of labour (maternal outcomes)

Source: Wei S, Wo BL, Qi HP, Xu H, Luo ZC, Roy C, Fraser WD. Early amniotomy and early oxytocin for prevention of, or therapy for, delay in first stage spontaneous labour compared with routine care. Cochrane Database Syst Rev. 2013;(8):CD006794.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early amniotomy and early oxytocin	Routine care	Relative (95% CI)	Absolute		
Duration of labour (hours from admission in labour) – prevention (better indicated by lower values)												
7	randomized trials	serious[1]	serious[2]	no serious indirectness	no serious imprecision	none	2185	2490	-	MD 1.11 lower (1.82 to 0.41 lower)	⊕⊕○○ LOW	CRITICAL
Postpartum haemorrhage (blood loss > 500 ml) – prevention												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	100/1390 (7.2%)	111/1284 (8.6%)	RR 0.83 (0.65 to 1.08)	15 fewer per 1000 (from 30 fewer to 7 more)	⊕⊕○○ LOW	CRITICAL
Duration of first stage of labour (hours) – prevention (better indicated by lower values)												
4	randomized trials	serious[1]	serious[4]	no serious indirectness	no serious imprecision	none	1055	1376	-	MD 1.57 lower (2.15 to 1 lower)	⊕⊕○○ LOW	CRITICAL
Caesarean section rate – prevention												
11	randomized trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	411/3762 (10.9%)	497/3991 (12.5%)	RR 0.87 (0.77 to 0.99)	16 fewer per 1000 (from 1 fewer to 29 fewer)	⊕⊕○○ LOW	IMPORTANT
Hyperstimulation of labour – prevention												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	24/421 (5.7%)	18/432 (4.2%)	RR 1.37 (0.76 to 2.46)	15 more per 1000 (from 10 fewer to 61 more)	⊕⊕○○ LOW	IMPORTANT
Spontaneous vaginal birth – prevention												
9	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	1677/2703 (62%)	1708/3035 (56.3%)	RR 1.01 (0.97 to 1.05)	6 more per 1000 (from 17 fewer to 28 more)	⊕⊕⊕○ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early amniotomy and early oxytocin	Routine care	Relative (95% CI)	Absolute		
Satisfied with labour experience – prevention												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	1120/1232 (90.9%)	1079/1204 (89.6%)	RR 1.02 (0.99 to 1.04)	18 more per 1000 (from 9 fewer to 36 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Postpartum fever or infection – prevention												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	94/1244 (7.6%)	139/1580 (8.8%)	RR 0.88 (0.66 to 1.16)	11 fewer per 1000 (from 30 fewer to 14 more)	⊕⊕○○ LOW	IMPORTANT
Maternal blood transfusion – prevention												
3	randomized trials	serious[1]	serious[6]	no serious indirectness	very serious[5]	none	12/1490 (0.8%)	5/1487 (0.3%)	RR 1.84 (0.32 to 10.48)	3 more per 1000 (from 2 fewer to 32 more)	⊕○○○ VERY LOW	IMPORTANT

[1] Most of the pooled effect was provided by studies with design limitations.
[2] Statistical heterogeneity (I^2 = 94%). Although the direction of effect was the same, the effect size varied considerably between studies.
[3] Wide confidence interval crossing the line of no effect.
[4] Statistical heterogeneity (I^2 > 60%). Direction of effect consistent but size of effect variable.
[5] Wide confidence interval crossing the line of no effect and failed to exclude appreciable harm.
[6] Statistical heterogeneity (I^2 = 49%). Considerable variation in size and direction of effect.

Table 4b. Early amniotomy and early oxytocin for prevention of delay in the first stage of labour (infant outcomes)

Source: Wei S, Wo BL, Qi HP, Xu H, Luo ZC, Roy C, Fraser WD. Early amniotomy and early oxytocin for prevention of, or therapy for, delay in first stage spontaneous labour compared with routine care. Cochrane Database Syst Rev. 2013;(8):CD006794.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early amniotomy and early oxytocin	Routine care	Relative (95% CI)	Absolute		
Serious morbidity (seizure/neurological abnormalities) – prevention												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	5/1336 (0.4%)	6/1330 (0.5%)	RR 0.83 (0.25 to 2.71)	1 fewer per 1000 (from 3 fewer to 8 more)	⊕○○○ VERY LOW	CRITICAL
Apgar score < 7 at 5 minutes – prevention												
6	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	57/2231 (2.6%)	53/2248 (2.4%)	RR 1.1 (0.77 to 1.55)	2 more per 1000 (from 5 fewer to 13 more)	⊕⊕○○ LOW	CRITICAL
Acidosis as defined abnormal arterial cord pH (pH < 7.10 or 7.20) – prevention												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	22/703 (3.1%)	20/713 (2.8%)	RR 1.11 (0.61 to 2.02)	3 more per 1000 (from 11 fewer to 29 more)	⊕⊕○○ LOW	CRITICAL
Admission to special care nursery – prevention												
6	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	154/2231 (6.9%)	139/2248 (6.2%)	RR 1.13 (0.91 to 1.41)	8 more per 1000 (from 6 fewer to 25 more)	⊕⊕○○ LOW	IMPORTANT
Jaundice or hyperbilirubinemia – prevention												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	34/1108 (3.1%)	31/1111 (2.8%)	RR 1.1 (0.68 to 1.77)	3 more per 1000 (from 9 fewer to 21 more)	⊕⊕○○ LOW	IMPORTANT
Fetal distress – prevention												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	13/541 (2.4%)	11/558 (2%)	RR 1.22 (0.55 to 2.69)	4 more per 1000 (from 9 fewer to 33 more)	⊕○○○ VERY LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early amniotomy and early oxytocin	Routine care	Relative (95% CI)	Absolute		
Suboptimal or abnormal fetal heart tracing – prevention												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	3/351 (0.9%)	6/354 (1.7%)	RR 0.5 (0.13 to 2)	8 fewer per 1000 (from 15 fewer to 17 more)	⊕◯◯◯ VERY LOW	NOT IMPORTANT

[1] Most studies contributing data had design limitations.
[2] Wide confidence interval crossing the line of no effect, few events and failed to exclude appreciable harm or benefit.
[3] Wide confidence interval crossing the line of no effect.

Table 4c. Early amniotomy and early oxytocin for prevention of delay in the first stage of labour (maternal and infant outcomes)

Source: Wei S, Wo BL, Qi HP, Xu H, Luo ZC, Roy C, Fraser WD. Early amniotomy and early oxytocin for prevention of, or therapy for, delay in first stage spontaneous labour compared with routine care. Cochrane Database Syst Rev. 2013;(8):CD006794.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early amniotomy and early oxytocin (without active management of labour trials)	Routine care	Relative (95% CI)	Absolute		
Caesarean section rate												
7	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	173/2282 (7.6%)	252/2603 (9.7%)	RR 0.84 (0.7 to 1.01)	15 fewer per 1000 (from 29 fewer to 1 more)	⊕⊕○○ LOW	IMPORTANT
								14.1%		23 fewer per 1000 (from 42 fewer to 1 more)		
Duration of labour (hours from admission in labour) (better indicated by lower values)												
5	randomized trials	serious[1]	serious[3]	no serious indirectness	no serious imprecision	none	1764	2058	-	MD 0.81 lower (1.36 to 0.25 lower)	⊕⊕○○ LOW	CRITICAL
Spontaneous vaginal birth												
7	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	1589/2282 (69.6%)	1788/2603 (68.7%)	RR 1.02 (0.98 to 1.06)	14 more per 1000 (from 14 fewer to 41 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Instrumental vaginal delivery (forceps or vacuum, or both)												
7	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	521/2282 (22.8%)	563/2603 (21.6%)	RR 1 (0.9 to 1.11)	0 fewer per 1000 (from 22 fewer to 24 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Duration of first stage of labour (hours) (better indicated by lower values)												
2	randomized trials	serious[1]	serious[3]	no serious indirectness	no serious imprecision	none	634	944	-	MD 1.27 lower (2.08 to 0.47 lower)	⊕⊕○○ LOW	CRITICAL

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early amniotomy and early oxytocin (without active management of labour trials)	Routine care	Relative (95% CI)	Absolute		
Use of epidural analgesia												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	1179/1887 (62.5%)	1117/1888 (59.2%)	RR 1.04 (0.98 to 1.1)	24 more per 1000 (from 12 fewer to 59 more)	⊕⊕⊕◯ MODERATE	IMPORTANT
Postpartum haemorrhage (blood loss > 500 ml)												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	91/969 (9.4%)	95/852 (11.2%)	RR 0.88 (0.6 to 1.28)	13 fewer per 1000 (from 45 fewer to 31 more)	⊕⊕◯◯ LOW	CRITICAL
Maternal blood transfusion												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	12/1490 (0.8%)	5/1487 (0.3%)	RR 1.84 (0.32 to 10.48)	3 more per 1000 (from 2 fewer to 32 more)	⊕◯◯◯ VERY LOW	IMPORTANT
Postpartum fever or infection												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	42/823 (5.1%)	79/1148 (6.9%)	RR 0.87 (0.48 to 1.58)	9 fewer per 1000 (from 36 fewer to 40 more)	⊕⊕◯◯ LOW	IMPORTANT
Satisfied with labour experience												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	1120/1232 (90.9%)	1079/1204 (89.6%)	RR 1.02 (0.99 to 1.04)	18 more per 1000 (from 9 fewer to 35 more)	⊕⊕⊕◯ MODERATE	IMPORTANT
Apgar score < 7 at 5 minutes												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	17/1810 (0.9%)	15/1816 (0.8%)	RR 1.13 (0.57 to 2.22)	1 more per 1000 (from 4 fewer to 10 more)	⊕◯◯◯ VERY LOW	CRITICAL

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early amniotomy and early oxytocin (without active management of labour trials)	Routine care	Relative (95% CI)	Absolute		
Acidosis as defined abnormal arterial cord pH (pH < 7.10 or 7.20)												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	20/503 (4%)	18/508 (3.5%)	RR 1.12 (0.6 to 2.1)	4 more per 1000 (from 14 fewer to 39 more)	⊕○○○ VERY LOW	IMPORTANT
Suboptimal or abnormal fetal heart												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	3/351 (0.9%)	6/354 (1.7%)	RR 0.5 (0.13 to 2)	8 fewer per 1000 (from 15 fewer to 17 more)	⊕○○○ VERY LOW	IMPORTANT
Fetal distress												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	4/320 (1.3%)	4/331 (1.2%)	RR 1.03 (0.26 to 4.1)	0 more per 1000 (from 9 fewer to 37 more)	⊕○○○ VERY LOW	IMPORTANT
Admission to special care nursery												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	113/1810 (6.2%)	99/1816 (5.5%)	RR 1.15 (0.89 to 1.5)	8 more per 1000 (from 6 fewer to 27 more)	⊕⊕○○ LOW	IMPORTANT
Seizure/neurological abnormalities												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	5/1336 (0.4%)	6/1330 (0.5%)	RR 0.83 (0.25 to 2.71)	1 fewer per 1000 (from 3 fewer to 8 more)	⊕○○○ VERY LOW	CRITICAL
Jaundice or hyperbilirubinemia												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	34/1108 (3.1%)	31/1111 (2.8%)	RR 1.1 (0.68 to 1.77)	3 more per 1000 (from 9 fewer to 21 more)	⊕⊕○○ LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] Wide confidence interval crossing the line of no effect.
[3] Statistical heterogeneity (I^2 > 70%). Considerable variation in size of effect.
[4] Wide confidence interval crossing the line of no effect and few events.

Table 5a. Oxytocin for prevention of delay in labour in women under epidural analgesia (maternal outcomes)

Source: Costley PL, East CE. Oxytocin augmentation of labour in women with epidural analgesia for reducing operative deliveries. Cochrane Database Syst Rev. 2013;(7):CD009241.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oxytocin	Placebo	Relative (95% CI)	Absolute		
Postpartum haemorrhage												
2	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[1]	none	24/154 (15.6%)	27/165 (16.4%)	RR 0.96 (0.58 to 1.59)	7 fewer per 1000 (from 69 fewer to 97 more)	⊕⊕⊕○ MODERATE	CRITICAL
Caesarean section – all												
2	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	10/154 (6.5%)	11/165 (6.7%)	RR 0.95 (0.42 to 2.12)	3 fewer per 1000 (from 39 fewer to 75 more)	⊕⊕○○ LOW	IMPORTANT
Caesarean section – cervical dilatation < 10 cm												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	8/46 (17.4%)	7/47 (14.9%)	RR 1.17 (0.46 to 2.96)	25 more per 1000 (from 80 fewer to 292 more)	⊕⊕○○ LOW	IMPORTANT
Caesarean section – cervical dilatation 10 cm												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	2/108 (1.9%)	4/118 (3.4%)	RR 0.55 (0.1 to 2.92)	15 fewer per 1000 (from 31 fewer to 65 more)	⊕⊕○○ LOW	IMPORTANT
Uterine hyperstimulation												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	52/108 (48.1%)	43/118 (36.4%)	RR 1.32 (0.97 to 1.8)	117 more per 1000 (from 11 fewer to 292 more)	⊕⊕○○ LOW	IMPORTANT
Instrumental deliveries (all)												
2	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[1]	none	78/154 (50.6%)	95/165 (57.6%)	RR 0.88 (0.72 to 1.08)	69 fewer per 1000 (from 161 fewer to 46 more)	⊕⊕⊕○ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oxytocin	Placebo	Relative (95% CI)	Absolute		
Instrumental deliveries – cervical dilatation < 10 cm												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	26/46 (56.5%)	28/47 (59.6%)	RR 0.95 (0.67 to 1.34)	30 fewer per 1000 (from 197 fewer to 203 more)	⊕⊕◯◯ LOW	IMPORTANT
Instrumental deliveries – cervical dilatation 10 cm												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	52/108 (48.1%)	67/118 (56.8%)	RR 0.85 (0.66 to 1.09)	85 fewer per 1000 (from 193 fewer to 51 more)	⊕⊕◯◯ LOW	IMPORTANT
Combined operative deliveries												
2	randomized trials	no serious risk of bias	serious[4]	no serious indirectness	serious[1]	none	88/154 (57.1%)	99/165 (60%)	RR 1.01 (0.68 to 1.5)	6 more per 1000 (from 192 fewer to 300 more)	⊕⊕◯◯ LOW	IMPORTANT

[1] Wide confidence interval crossing the line of no effect.
[2] Wide confidence interval crossing the line of no effect and few events.
[3] Wide confidence interval crossing the line of no effect and small sample size.
[4] Statistical heterogeneity (I^2=77%). Direction of effect different in the two studies.

Table 5b. Oxytocin for women under epidural analgesia (infant outcomes)

Source: Costley PL, East CE. Oxytocin augmentation of labour in women with epidural analgesia for reducing operative deliveries. Cochrane Database Syst Rev. 2013;(7):CD009241.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Oxytocin	Placebo	Relative (95% CI)	Absolute		
Apgar score < 4 at 5 minutes												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[1]	none	0/108 (0%)	0/118 (0%)	not pooled	not pooled	⊕⊕○○ LOW	CRITICAL
Apgar score < 7 at 5 minutes												
2	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	1/154 (0.6%)	0/165 (0%)	RR 3.06 (0.13 to 73.33)	-	⊕⊕○○ LOW	CRITICAL
Admission to neonatal intensive care unit												
2	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	4/154 (2.6%)	4/165 (2.4%)	RR 1.07 (0.29 to 3.93)	2 more per 1000 (from 17 fewer to 71 more)	⊕⊕○○ LOW	IMPORTANT

[1] No events.

[2] Wide confidence interval crossing the line of no effect and few events.

Table 6a. The use of routine amniotomy (alone) for prevention of delay in the first stage of labour (maternal outcomes)

Source: Smyth RMD, Markham C, Dowswell T. Amniotomy for shortening spontaneous labour. Cochrane Database Syst Rev. 2013;(6):CD006167.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy (normal progression at randomization)	No amniotomy	Relative (95% CI)	Absolute		
Maternal mortality												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/872 (0.1%)	0/868 (0%)	RR 3.01 (0.12 to 73.61)	-	⊕○○○ VERY LOW	CRITICAL
Postpartum haemorrhage												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	4/985 (0.4%)	8/837 (1%)	RR 0.46 (0.14 to 1.5)	5 fewer per 1000 (from 8 fewer to 5 more)	⊕○○○ VERY LOW	CRITICAL
Postpartum haemorrhage – primiparous and multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/645 (0.2%)	4/487 (0.8%)	RR 0.19 (0.02 to 1.68)	7 fewer per 1000 (from 8 fewer to 6 more)	⊕○○○ VERY LOW	CRITICAL
Postpartum haemorrhage – primiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/74 (1.4%)	2/83 (2.4%)	RR 0.56 (0.05 to 6.06)	11 fewer per 1000 (from 23 fewer to 122 more)	⊕○○○ VERY LOW	CRITICAL
Postpartum haemorrhage – multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	2/266 (0.8%)	2/267 (0.7%)	RR 1 (0.14 to 7.07)	0 fewer per 1000 (from 6 fewer to 45 more)	⊕○○○ VERY LOW	CRITICAL
Duration of first stage of labour (minutes) (better indicated by lower values)												
5	randomized trials	serious[1]	very serious[3]	no serious indirectness	serious[4]	none	578	549	-	MD 20.43 lower (95.93 lower to 55.06 higher)	⊕○○○ VERY LOW	CRITICAL

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy (normal progression at randomization)	No amniotomy	Relative (95% CI)	Absolute		
Duration of first stage of labour (minutes) – primiparous women (better indicated by lower values)												
4	randomized trials	serious[1]	very serious[3]	no serious indirectness	serious[5]	none	190	189	-	MD 57.93 lower (152.66 lower to 36.8 higher)	⊕○○○ VERY LOW	CRITICAL
Duration of first stage of labour (minutes) – multiparous women (better indicated by lower values)												
3	randomized trials	serious[1]	very serious[3]	no serious indirectness	serious[4]	none	205	181	-	MD 23.1 higher (50.89 lower to 97.09 higher)	⊕○○○ VERY LOW	CRITICAL
Duration of first stage of labour (minutes) – primiparous and multiparous women (better indicated by lower values)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	183	179	-	MD 18 lower (67.54 lower to 31.54 higher)	⊕⊕○○ LOW	CRITICAL
Caesarean section												
9	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	137/2620 (5.2%)	103/2401 (4.3%)	RR 1.27 (0.99 to 1.63)	12 more per 1000 (from 0 fewer to 27 more)	⊕⊕○○ LOW	IMPORTANT
Caesarean section – primiparous women												
6	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	108/1381 (7.8%)	90/1293 (7%)	RR 1.15 (0.88 to 1.51)	10 more per 1000 (from 8 fewer to 35 more)	⊕⊕○○ LOW	IMPORTANT
								4.7%		7 more per 1000 (from 6 fewer to 24 more)		
Caesarean section – multiparous women												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12/795 (1.5%)	6/678 (0.9%)	RR 1.76 (0.65 to 4.76)	7 more per 1000 (from 3 fewer to 33 more)	⊕○○○ VERY LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy (normal progression at randomization)	No amniotomy	Relative (95% CI)	Absolute		
Caesarean section – primiparous and multiparous women												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	17/444 (3.8%)	7/430 (1.6%)	RR 2.36 (0.99 to 5.63)	22 more per 1000 (from 0 fewer to 75 more)	⊕○○○ VERY LOW	IMPORTANT
Dysfunctional labour												
3	randomized trials	serious[1]	serious[6]	no serious indirectness	no serious imprecision	none	227/842 (27%)	358/853 (42%)	RR 0.6 (0.44 to 0.82)	168 fewer per 1000 (from 76 fewer to 235 fewer)	⊕⊕○○ LOW	IMPORTANT
								44.9%		180 fewer per 1000 (from 81 fewer to 251 fewer)		
Dysfunctional labour – primiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	22/74 (29.7%)	50/83 (60.2%)	RR 0.49 (0.33 to 0.73)	307 fewer per 1000 (from 163 fewer to 404 fewer)	⊕⊕⊕○ MODERATE	IMPORTANT
Dysfunctional labour – multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	36/266 (13.5%)	83/267 (31.1%)	RR 0.44 (0.31 to 0.62)	174 fewer per 1000 (from 118 fewer to 214 fewer)	⊕⊕⊕○ MODERATE	IMPORTANT
Dysfunctional labour – primiparous and multiparous women												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	169/502 (33.7%)	225/503 (44.7%)	RR 0.75 (0.64 to 0.88)	112 fewer per 1000 (from 54 fewer to 161 fewer)	⊕⊕⊕○ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy (normal progression at randomization)	No amniotomy	Relative (95% CI)	Absolute		
Duration of second stage (minutes) (better indicated by lower values)												
8	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	968	959	-	MD 1.33 lower (2.92 lower to 0.26 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
Duration of second stage (minutes) – primiparous women (better indicated by lower values)												
7	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	319	334	-	MD 5.43 lower (9.98 to 0.89 lower)	⊕⊕⊕○ MODERATE	IMPORTANT
Duration of second stage (minutes) – multiparous women (better indicated by lower values)												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	471	448	-	MD 1.19 lower (2.92 lower to 0.53 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
Duration of second stage (minutes) – primiparous and multiparous women (better indicated by lower values)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	178	177	-	MD 0.6 higher (2.46 lower to 3.66 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
Cord prolapse												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/802 (0.1%)	1/813 (0.1%)	RR 1 (0.14 to 7.1)	0 fewer per 1000 (from 1 fewer to 8 more)	⊕○○○ VERY LOW	IMPORTANT
Cord prolapse – primiparous and multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/462 (0%)	1/463 (0.2%)	RR 0.33 (0.01 to 8.18)	1 fewer per 1000 (from 2 fewer to 16 more)	⊕○○○ VERY LOW	IMPORTANT
Cord prolapse – primiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[7]	none	0/74 (0%)	0/83 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy (normal progression at randomization)	No amniotomy	Relative (95% CI)	Absolute		
Cord prolapse – multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/266 (0.4%)	0/267 (0%)	RR 3.01 (0.12 to 73.59)	Value?-	⊕○○○ VERY LOW	IMPORTANT
Caesarean section for fetal distress												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	6/340 (1.8%)	2/350 (0.6%)	RR 3.21 (0.66 to 15.6)	13 more per 1000 (from 2 fewer to 83 more)	⊕○○○ VERY LOW	CRITICAL
Caesarean section for fetal distress – primiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	4/74 (5.4%)	1/83 (1.2%)	RR 4.49 (0.51 to 39.25)	42 more per 1000 (from 6 fewer to 461 more)	⊕○○○ VERY LOW	CRITICAL
Caesarean section for fetal distress – multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	2/266 (0.8%)	1/267 (0.4%)	RR 2.01 (0.18 to 22.01)	4 more per 1000 (from 3 fewer to 79 more)	⊕○○○ VERY LOW	CRITICAL
Caesarean section for prolonged labour												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/340 (0.3%)	3/350 (0.9%)	RR 0.45 (0.07 to 3.03)	5 fewer per 1000 (from 8 fewer to 17 more)	⊕○○○ VERY LOW	IMPORTANT
Caesarean section for prolonged labour – primiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/74 (0%)	1/83 (1.2%)	RR 0.37 (0.02 to 9.03)	8 fewer per 1000 (from 12 fewer to 97 more)	⊕○○○ VERY LOW	IMPORTANT
Caesarean section for prolonged labour – multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/266 (0.4%)	2/267 (0.7%)	RR 0.5 (0.05 to 5.5)	4 fewer per 1000 (from 7 fewer to 34 more)	⊕○○○ VERY LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy (normal progression at randomization)	No amniotomy	Relative (95% CI)	Absolute		
Maternal infection												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	14/1119 (1.3%)	14/1031 (1.4%)	RR 0.88 (0.43 to 1.82)	2 fewer per 1000 (from 8 fewer to 11 more)	⊕⊕◯◯ LOW	IMPORTANT
Maternal infection – primiparous women												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	13/853 (1.5%)	14/764 (1.8%)	RR 0.81 (0.38 to 1.72)	3 fewer per 1000 (from 11 fewer to 13 more)	⊕⊕◯◯ LOW	IMPORTANT
Maternal infection – multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/266 (0.4%)	0/267 (0%)	RR 3.01 (0.12 to 73.59)	-	⊕◯◯◯ VERY LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] Wide confidence interval crossing the line of no effect and few events.
[3] Statistical heterogeneity (I^2 > 60%). Size and direction of effect inconsistent.
[4] Wide confidence interval crossing the line of no effect.
[5] Wide confidence interval crossing the line of no effect and failed to exclude appreciable benefit.
[6] Statistical heterogeneity (I^2 > 60%). Direction of effect consistent, size of effect varied.
[7] No events, no estimable data.

Table 6b. The use of routine amniotomy (alone) for prevention of delay in the first stage of labour (infant outcomes)

Source: Smyth RMD, Markham C, Dowswell T. Amniotomy for shortening spontaneous labour. Cochrane Database Syst Rev. 2013;(6):CD006167.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy (normal progression at randomization)	No amniotomy	Relative (95% CI)	Absolute		
Perinatal death												
8	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/1751 (0.1%)	0/1646 (0%)	RR 3.01 (0.12 to 73.59)	-	⊕○○○ VERY LOW	CRITICAL
Perinatal death – primiparous women												
7	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/1409 (0%)	0/1324 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Perinatal death – primiparous and multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/34 (0%)	0/30 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Perinatal death – multiparous women												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/308 (0.3%)	0/292 (0%)	RR 3.01 (0.12 to 73.59)	-	⊕○○○ VERY LOW	CRITICAL
Seizures (neonate)												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	2/2118 (0.1%)	2/1951 (0.1%)	RR 0.88 (0.15 to 5.35)	0 fewer per 1000 (from 1 fewer to 4 more)	⊕○○○ VERY LOW	CRITICAL

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy (normal progression at randomization)	No amniotomy	Relative (95% CI)	Absolute		
Seizures (neonate) – primiparous women												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	2/1318 (0.2%)	2/1227 (0.2%)	RR 0.88 (0.15 to 5.35)	0 fewer per 1000 (from 1 fewer to 7 more)	⊕○○○ VERY LOW	CRITICAL
Seizures (neonate) – multiparous women												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/565 (0%)	0/500 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Seizures (neonate) – primiparous and multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/235 (0%)	0/224 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Respiratory distress syndrome												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/575 (0%)	2/574 (0.3%)	RR 0.2 (0.01 to 4.16)	3 fewer per 1000 (from 3 fewer to 11 more)	⊕○○○ VERY LOW	CRITICAL
Respiratory distress syndrome – primiparous and multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/235 (0%)	0/224 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Respiratory distress syndrome – primiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/74 (0%)	0/83 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy (normal progression at randomization)	No amniotomy	Relative (95% CI)	Absolute		
Respiratory distress syndrome – multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/266 (0%)	2/267 (0.7%)	RR 0.2 (0.01 to 4.16)	6 fewer per 1000 (from 7 fewer to 24 more)	⊕○○○ VERY LOW	CRITICAL
Apgar score < 7 at 5 minutes												
6	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	14/1853 (0.8%)	25/1745 (1.4%)	RR 0.53 (0.28 to 1)	7 fewer per 1000 (from 10 fewer to 0 more)	⊕⊕○○ LOW	CRITICAL
Apgar score < 7 at 5 minutes – primiparous women												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	10/1318 (0.8%)	22/1224 (1.8%)	RR 0.42 (0.2 to 0.88)	10 fewer per 1000 (from 2 fewer to 14 fewer)	⊕⊕⊕○ MODERATE	CRITICAL
Apgar score < 7 at 5 minutes – primiparous and multiparous women												
2	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	3/269 (1.1%)	2/254 (0.8%)	RR 1.3 (0.26 to 6.43)	2 more per 1000 (from 6 fewer to 43 more)	⊕⊕○○ LOW	CRITICAL
Apgar score < 7 at 5 minutes – multiparous women												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	1/266 (0.4%)	1/267 (0.4%)	RR 1 (0.06 to 15.96)	0 fewer per 1000 (from 4 fewer to 56 more)	⊕⊕○○ LOW	CRITICAL
Acidosis as defined as a cord blood arterial pH of < 7.2												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	51/504 (10.1%)	44/510 (8.6%)	RR 1.18 (0.8 to 1.73)	16 more per 1000 (from 17 fewer to 63 more)	⊕⊕○○ LOW	CRITICAL

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy (normal progression at randomization)	No amniotomy	Relative (95% CI)	Absolute		
Admission to special care baby unit/neonatal intensive care unit												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	70/1388 (5%)	61/1298 (4.7%)	RR 1.08 (0.77 to 1.5)	4 more per 1000 (from 11 fewer to 23 more)	⊕⊕◯◯ LOW	IMPORTANT
Admission to special care baby unit/neonatal intensive care unit – primiparous women												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	67/1122 (6%)	57/1031 (5.5%)	RR 1.1 (0.78 to 1.54)	6 more per 1000 (from 12 fewer to 30 more)	⊕⊕◯◯ LOW	IMPORTANT
Admission to special care baby unit/neonatal intensive care unit – multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	3/266 (1.1%)	4/267 (1.5%)	RR 0.75 (0.17 to 3.33)	4 fewer per 1000 (from 12 fewer to 35 more)	⊕◯◯◯ VERY LOW	IMPORTANT
Cephalhaematoma												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	23/849 (2.7%)	15/863 (1.7%)	RR 1.52 (0.81 to 2.83)	9 more per 1000 (from 3 fewer to 32 more)	⊕⊕◯◯ LOW	CRITICAL
Cephalhaematoma – primiparous and multiparous women												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	23/509 (4.5%)	14/513 (2.7%)	RR 1.63 (0.86 to 3.1)	17 more per 1000 (from 4 fewer to 57 more)	⊕⊕◯◯ LOW	CRITICAL
Cephalhaematoma – primiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/74 (0%)	1/83 (1.2%)	RR 0.37 (0.02 to 9.03)	8 fewer per 1000 (from 12 fewer to 97 more)	⊕◯◯◯ VERY LOW	CRITICAL

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy (normal progression at randomization)	No amniotomy	Relative (95% CI)	Absolute		
Cephalhaematoma – multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/266 (0%)	0/267 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Meconium aspiration syndrome												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	8/802 (1%)	2/813 (0.2%)	RR 3.06 (0.83 to 11.27)	5 more per 1000 (from 0 fewer to 25 more)	⊕○○○ VERY LOW	IMPORTANT
Meconium aspiration syndrome – primiparous and multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	6/462 (1.3%)	2/463 (0.4%)	RR 3.01 (0.61 to 14.82)	9 more per 1000 (from 2 fewer to 60 more)	⊕○○○ VERY LOW	IMPORTANT
Meconium aspiration syndrome – primiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/74 (1.4%)	0/83 (0%)	RR 3.36 (0.14 to 81.24)	-	⊕○○○ VERY LOW	IMPORTANT
Meconium aspiration syndrome – multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/266 (0.4%)	0/267 (0%)	RR 3.01 (0.12 to 73.59)	-	⊕○○○ VERY LOW	IMPORTANT
Neonatal jaundice												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	168/1686 (10%)	187/1516 (12.3%)	RR 0.9 (0.76 to 1.06)	12 fewer per 1000 (from 30 fewer to 7 more)	⊕⊕⊕○ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy (normal progression at randomization)	No amniotomy	Relative (95% CI)	Absolute		
Neonatal jaundice – primiparous women												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	50/852 (5.9%)	45/762 (5.9%)	RR 1.16 (0.83 to 1.62)	9 more per 1000 (from 10 fewer to 37 more)	⊕⊕◯◯ LOW	IMPORTANT
Neonatal jaundice – multiparous women												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	100/565 (17.7%)	120/500 (24%)	RR 0.83 (0.67 to 1.02)	41 fewer per 1000 (from 79 fewer to 5 more)	⊕⊕◯◯ LOW	IMPORTANT
Neonatal jaundice – primiparous and multiparous women												
2	randomized trials	serious[1]	serious[7]	no serious indirectness	serious[5]	none	18/269 (6.7%)	22/254 (8.7%)	RR 0.76 (0.42 to 1.36)	21 fewer per 1000 (from 50 fewer to 31 more)	⊕◯◯◯ VERY LOW	IMPORTANT
Fracture												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	3/462 (0.6%)	1/463 (0.2%)	RR 3.01 (0.31 to 28.8)	4 more per 1000 (from 1 fewer to 60 more)	⊕◯◯◯ VERY LOW	IMPORTANT
Intracranial haemorrhage												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/235 (0%)	0/224 (0%)	not pooled	not pooled	⊕◯◯◯ VERY LOW	CRITICAL

[1] Most studies contributing data had design limitations.
[2] Wide confidence interval crossing the line of no effect and few events.
[3] No events, no estimable data.
[4] Wide confidence interval crossing line of no effect and failed to exclude appreciable benefit.
[5] Wide confidence interval crossing the line of no effect.
[6] Wide confidence interval crossing the line of no effect and failed to exclude appreciable harm.
[7] Statistical heterogeneity (I^2 = 70%).

Table 7a. Antispasmodics for prevention of delay in labour (maternal outcomes)

Source: Rohwer AC, Khondowe O, Young T. Antispasmodics for labour. Cochrane Database Syst Rev. 2013;(6):CD009243.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antispasmodics	Control	Relative (95% CI)	Absolute		
Total duration of labour of vaginal births (minutes) (better indicated by lower values)												
3	randomized trials	serious	serious[1]	no serious indirectness	no serious imprecision	none	245	147	-	MD 102.6 lower (164.12 to 41.08 lower)	⊕⊕◯◯ LOW	CRITICAL
Total duration of labour of vaginal births (minutes) – neurotropic agents (better indicated by lower values)												
3	randomized trials	serious[2]	serious[1]	no serious indirectness	serious[3]	none	146	98	-	MD 80.78 lower (153.81 to 7.75 lower)	⊕◯◯◯ VERY LOW	CRITICAL
Total duration of labour of vaginal births (minutes) – musculotropic agents (better indicated by lower values)												
2	randomized trials	serious[2]	serious[1]	no serious indirectness	very serious[4]	none	99	49	-	MD 138.21 lower (291.51 lower to 15.09 higher)	⊕◯◯◯ VERY LOW	CRITICAL
Postpartum haemorrhage												
2	randomized trials	no serious risk of bias	serious[5]	no serious indirectness	very serious[6]	none	11/90 (12.2%)	4/95 (4.2%)	RR 2.46 (0.2 to 30.17)	61 more per 1000 (from 34 fewer to 1000 more)	⊕◯◯◯ VERY LOW	CRITICAL
Postpartum haemorrhage – neurotropic agents												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[6]	none	2/40 (5%)	3/45 (6.7%)	RR 0.75 (0.13 to 4.26)	17 fewer per 1000 (from 58 fewer to 217 more)	⊕⊕◯◯ LOW	CRITICAL
Postpartum haemorrhage – musculotropic agents												
1	randomized trials	serious[7]	no serious inconsistency	no serious indirectness	very serious[8]	none	9/50 (18%)	1/50 (2%)	RR 9 (1.18 to 68.42)	160 more per 1000 (from 4 more to 1000 more)	⊕◯◯◯ VERY LOW	CRITICAL

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antispasmodics	Control	Relative (95% CI)	Absolute		
Duration of first stage of labour, vaginal births (minutes) (better indicated by lower values)												
7	randomized trials	serious[2]	serious[9]	no serious indirectness	no serious imprecision	none	635	416	-	MD 59.1 lower (95.81 to 22.38 lower)	⊕⊕◯◯ LOW	CRITICAL
Duration of first stage of labour, vaginal births (minutes) – neurotropic agents (better indicated by lower values)												
5	randomized trials	serious[2]	serious[1]	no serious indirectness	no serious imprecision	none	314	208	-	MD 60.5 lower (118.58 to 2.42 lower)	⊕⊕◯◯ LOW	CRITICAL
Duration of first stage of labour, vaginal births (minutes) – musculotropic agents (better indicated by lower values)												
5	randomized trials	serious[2]	serious[9]	no serious indirectness	no serious imprecision	none	321	208	-	MD 57.09 lower (108.58 to 5.6 lower)	⊕⊕◯◯ LOW	CRITICAL
Duration of second stage of labour of vaginal births (minutes) (better indicated by lower values)												
6	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision	none	435	318	-	MD 0.51 higher (3.04 lower to 4.06 higher)	⊕⊕⊕◯ MODERATE	IMPORTANT
Duration of second stage of labour of vaginal births (minutes) – neurotropic agents (better indicated by lower values)												
4	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision	none	214	161	-	MD 0.77 higher (2.58 lower to 4.12 higher)	⊕⊕⊕◯ MODERATE	IMPORTANT
Duration of second stage of labour of vaginal births (minutes) – musculotropic agents (better indicated by lower values)												
4	randomized trials	serious[2]	serious[10]	no serious indirectness	no serious imprecision	none	221	157	-	MD 0.55 higher (6.61 lower to 7.72 higher)	⊕⊕◯◯ LOW	IMPORTANT
Rate of normal vertex deliveries												
16	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision	none	1232/1322 (93.2%)	902/997 (90.5%)	RR 1.02 (1 to 1.05)	18 more per 1000 (from 0 more to 45 more)	⊕⊕⊕◯ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antispasmodics	Control	Relative (95% CI)	Absolute		
Rate of normal vertex deliveries – neurotropic agents												
13	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision	none	776/848 (91.5%)	625/688 (90.8%)	RR 1 (0.97 to 1.03)	0 fewer per 1000 (from 27 fewer to 27 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Rate of normal vertex deliveries – musculotropic agents												
8	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision	none	456/474 (96.2%)	277/309 (89.6%)	RR 1.06 (1.02 to 1.11)	54 more per 1000 (from 18 more to 99 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Rate of cervical dilatation of vaginal births (cm/hr) (better indicated by lower values)												
4	randomized trials	serious[2]	serious[11]	no serious indirectness	no serious imprecision	none	349	204	-	MD 0.67 higher (0.39 to 0.95 higher)	⊕⊕○○ LOW	IMPORTANT
Rate of cervical dilatation of vaginal births (cm/hr) – neurotropic agents (better indicated by lower values)												
3	randomized trials	serious[2]	serious[11]	no serious indirectness	very serious[6]	none	146	74	-	MD 0.48 higher (0 to 0.96 higher)	⊕○○○ VERY LOW	IMPORTANT
Rate of cervical dilatation of vaginal births (cm/hr) – musculotropic agents (better indicated by lower values)												
4	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision	none	203	130	-	MD 0.85 higher (0.5 to 1.19 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
Cervical laceration												
3	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	very serious[12]	none	3/170 (1.8%)	4/172 (2.3%)	RR 0.79 (0.2 to 3.12)	5 fewer per 1000 (from 19 fewer to 49 more)	⊕○○○ VERY LOW	IMPORTANT
Cervical laceration – neurotropic agents												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[6]	none	1/47 (2.1%)	0/49 (0%)	RR 3.12 (0.13 to 74.85)	-	⊕⊕○○ LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antispasmodics	Control	Relative (95% CI)	Absolute		
Cervical laceration – musculotropic agents												
2	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	very serious[6]	none	2/123 (1.6%)	4/123 (3.3%)	RR 0.5 (0.09 to 2.68)	16 fewer per 1000 (from 30 fewer to 55 more)	⊕○○○ VERY LOW	IMPORTANT
Tachycardia – neurotropic agents												
6	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision[12]	none	92/365 (25.2%)	6/209 (2.9%)	RR 7.6 (3.54 to 16.29)	189 more per 1000 (from 73 more to 439 more)	⊕⊕⊕○ MODERATE	IMPORTANT
								4%		264 more per 1000 (from 102 more to 612 more)		
Tachycardia – musculotropic agents												
3	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	very serious[6]	none	6/172 (3.5%)	5/86 (5.8%)	RR 0.6 (0.19 to 1.9)	23 fewer per 1000 (from 47 fewer to 52 more)	⊕○○○ VERY LOW	IMPORTANT
Headache												
3	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	very serious[12]	none	13/344 (3.8%)	3/171 (1.8%)	RR 1.51 (0.56 to 4.1)	9 more per 1000 (from 8 fewer to 54 more)	⊕○○○ VERY LOW	IMPORTANT
Headache – neurotropic agents												
3	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	very serious[12]	none	3/172 (1.7%)	2/85 (2.4%)	RR 0.67 (0.15 to 2.93)	8 fewer per 1000 (from 20 fewer to 45 more)	⊕○○○ VERY LOW	IMPORTANT
Headache – musculotropic agents												
3	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	very serious[12]	none	10/172 (5.8%)	1/86 (1.2%)	RR 2.78 (0.63 to 12.28)	21 more per 1000 (from 4 fewer to 131 more)	⊕○○○ VERY LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antispasmodics	Control	Relative (95% CI)	Absolute		
Vomiting												
2	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[12]	none	7/97 (7.2%)	3/99 (3%)	RR 2.21 (0.64 to 7.62)	37 more per 1000 (from 11 fewer to 201 more)	⊕⊕◯◯ LOW	IMPORTANT
Vomiting – neurotropic agents												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[12]	none	4/47 (8.5%)	3/49 (6.1%)	RR 1.39 (0.33 to 5.88)	24 more per 1000 (from 41 fewer to 299 more)	⊕⊕◯◯ LOW	IMPORTANT
Vomiting – musculotropic agents												
1	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	very serious[12]	none	3/50 (6%)	0/50 (0%)	RR 7 (0.37 to 132.1)	-	⊕◯◯◯ VERY LOW	IMPORTANT

[1] Statistical heterogeneity ($I^2 > 90\%$).
[2] Studies at high risk of bias.
[3] Small sample size.
[4] Wide confidence interval crossing the line of no effect and small sample size.
[5] Two trials with different effects.
[6] Wide confidence interval crossing the line of no effect, few events and small sample size.
[7] One study at high risk of bias.
[8] Few events and small sample size.
[9] Statistical heterogeneity ($I^2 > 80\%$).
[10] Statistical heterogeneity ($I^2 > 60\%$).
[11] Statistical heterogeneity ($I^2 > 70\%$).
[12] Wide confidence interval crossing the line of no effect and few events.

Table 7b. Antispasmodics for prevention of delay in labour (infant outcomes)

Source: Rohwer AC, Khondowe O, Young T. Antispasmodics for labour. Cochrane Database Syst Rev. 2013;(6):CD009243.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antispasmodics	Control	Relative (95% CI)	Absolute		
Admission to neonatal intensive care unit												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	11/497 (2.2%)	8/348 (2.3%)	RR 0.84 (0.34 to 2.05)	4 fewer per 1000 (from 15 fewer to 24 more)	⊕○○○ VERY LOW	IMPORTANT
Admission to neonatal intensive care unit – neurotropic agents												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	6/297 (2%)	4/223 (1.8%)	RR 0.94 (0.27 to 3.25)	1 fewer per 1000 (from 13 fewer to 40 more)	⊕○○○ VERY LOW	IMPORTANT
Admission to neonatal intensive care unit – musculotropic agents												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	5/200 (2.5%)	4/125 (3.2%)	RR 0.73 (0.2 to 2.66)	9 fewer per 1000 (from 26 fewer to 53 more)	⊕○○○ VERY LOW	IMPORTANT
Fetal distress												
1	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[2]	none	2/50 (4%)	4/50 (8%)	RR 0.5 (0.1 to 2.61)	40 fewer per 1000 (from 72 fewer to 129 more)	⊕○○○ VERY LOW	IMPORTANT
Fetal bradycardia												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	2/65 (3.1%)	3/65 (4.6%)	RR 0.67 (0.12 to 3.86)	15 fewer per 1000 (from 41 fewer to 132 more)	⊕⊕○○ LOW	IMPORTANT
Fetal tachycardia – neurotropic agents only												
2	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	8/115 (7%)	2/115 (1.7%)	RR 3.4 (0.85 to 13.67)	42 more per 1000 (from 3 fewer to 220 more)	⊕⊕○○ LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Antispasmodics	Control	Relative (95% CI)	Absolute		
Meconium-stained liquor												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	6/53 (11.3%)	3/54 (5.6%)	RR 2.04 (0.54 to 7.73)	58 more per 1000 (from 26 fewer to 374 more)	⊕⊕◯◯ LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] Wide confidence interval crossing the line of no effect and few events.
[3] One study with design limitations.

Table 8a. Effect of pain relief on duration of labour and oxytocin augmentation

Source: Anim-Somuah M, Smyth RMD, Jones L. Epidural versus non-epidural or no analgesia in labour. Cochrane Database Syst Rev. 2011;(12):CD000331.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Epidural	Non-epidural	Relative (95% CI)	Absolute		
Duration of first stage of labour (minutes) (better indicated by lower values)												
11	randomized trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	1422	1559	-	MD 18.51 higher (12.91 lower to 49.92 higher)	⊕○○○ VERY LOW	CRITICAL
Duration of second stage of labour (minutes) (better indicated by lower values)												
13	randomized trials	serious[1]	serious[2]	no serious indirectness	no serious imprecision	none	2053	2180	-	MD 13.66 higher (6.67 to 20.66 higher)	⊕⊕○○ LOW	IMPORTANT
Oxytocin augmentation												
13	randomized trials	serious[1]	serious[2]	no serious indirectness	no serious imprecision	none	1347/2898 (46.5%)	1162/2917 (39.8%)	RR 1.19 (1.03 to 1.39)	76 more per 1000 (from 12 more to 155 more)	⊕⊕○○ LOW	IMPORTANT
								35.3%		67 more per 1000 (from 11 more to 138 more)		

[1] All of the studies contributing data had design limitations.

[2] Statistical heterogeneity (I^2 > 80%).

[3] Wide confidence interval crossing the line of no effect.

Table 8b. Effect of pain relief on duration of labour and oxytocin augmentation

Source: Novikova N, Cluver C. Local anaesthetic nerve block for pain management in labour. Cochrane Database Syst Rev. 2012;(4):CD009200.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Local anaesthetic nerve block	Opioids	Relative (95% CI)	Absolute		
Mean time from performing local anaesthesia to birth (paracervical block versus intramuscular pethidine) (better indicated by lower values)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	55	62	-	MD 37 higher (31.72 to 42.28 higher)	⊕⊕◯◯ LOW	CRITICAL

[1] One study with design limitations.
[2] Estimate based on small sample size.

Table 8c. Effect of pain relief on duration of labour and oxytocin augmentation

Source: Simmons SW, Taghizadeh N, Dennis AT, Hughes D, Cyna AM. Combined spinal-epidural versus epidural analgesia in labour. Cochrane Database Syst Rev. 2012;(10):CD003401.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Combined spinal-epidural	Traditional epidural	Relative (95% CI)	Absolute		
Labour augmentation required												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	192/440 (43.6%)	203/443 (45.8%)	RR 0.95 (0.84 to 1.09)	23 fewer per 1000 (from 73 fewer to 41 more)	⊕⊕⊕◯ MODERATE	IMPORTANT
								86%		43 fewer per 1000 (from 138 fewer to 77 more)		
Labour augmentation required – combined spinal-epidural versus traditional epidural												
2	randomized trials	no serious risk of bias	serious[1]	no serious indirectness	no serious imprecision	none	153/401 (38.2%)	163/403 (40.4%)	RR 0.94 (0.8 to 1.11)	24 fewer per 1000 (from 81 fewer to 44 more)	⊕⊕⊕◯ MODERATE	IMPORTANT
								60%		36 fewer per 1000 (from 120 fewer to 66 more)		
Labour augmentation required – opioid combined spinal-epidural versus traditional epidural												
1	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	39/39 (100%)	40/40 (100%)	RR 1 (0.95 to 1.05)	0 fewer per 1000 (from 50 fewer to 50 more)	⊕⊕◯◯ LOW	IMPORTANT
Augmentation after analgesia												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[4]	none	8/50 (16%)	16/50 (32%)	RR 0.5 (0.24 to 1.06)	160 fewer per 1000 (from 243 fewer to 19 more)	⊕⊕◯◯ LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] One study with design limitations.
[3] Estimate based on small sample size.
[4] Wide confidence interval crossing the line of no effect, few events and small sample size.

Table 8d. Effect of pain relief on duration of labour and oxytocin augmentation

Source: Simmons SW, Taghizadeh N, Dennis AT, Hughes D, Cyna AM. Combined spinal-epidural versus epidural analgesia in labour. Cochrane Database Syst Rev. 2012;(10):CD003401.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Combined spinal-epidural	Low-dose epidural	Relative (95% CI)	Absolute		
Labour augmentation required												
6	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	245/632 (38.8%)	258/653 (39.5%)	RR 1 (0.88 to 1.13)	0 fewer per 1000 (from 47 fewer to 51 more)	⊕⊕⊕○ MODERATE	IMPORTANT
								24.5%		0 fewer per 1000 (from 29 fewer to 32 more)		
Labour augmentation required – combined spinal-epidural versus low-dose epidural												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	153/470 (32.6%)	162/474 (34.2%)	RR 0.95 (0.8 to 1.13)	17 fewer per 1000 (from 68 fewer to 44 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Labour augmentation required – opioid combined spinal-epidural versus test local anaesthetic/opioid epidural												
1	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	8/35 (22.9%)	5/34 (14.7%)	RR 1.55 (0.56 to 4.28)	81 more per 1000 (from 65 fewer to 482 more)	⊕○○○ VERY LOW	IMPORTANT
Labour augmentation required – opioid combined spinal-epidural versus low-dose epidural												
1	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/20 (5%)	2/22 (9.1%)	RR 0.55 (0.05 to 5.61)	41 fewer per 1000 (from 86 fewer to 419 more)	⊕○○○ VERY LOW	IMPORTANT
Labour augmentation required – null combined spinal-epidural versus low-dose epidural												
1	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	serious[4]	none	83/107 (77.6%)	89/123 (72.4%)	RR 1.07 (0.92 to 1.24)	51 more per 1000 (from 58 fewer to 174 more)	⊕⊕○○ LOW	IMPORTANT

[1] All of the studies contributing data had design limitations.

[2] One study with design limitations.

[3] Wide confidence interval crossing the line of no effect, few events and small sample size.

[4] Estimate based on small sample size.

Table 8e. Effect of pain relief on duration of labour and oxytocin augmentation

Source: Dowswell T, Bedwell C, Lavender T, Neilson JP. Transcutaneous electrical nerve stimulation (TENS) for pain management in labour. Cochrane Database Syst Rev. 2009;(2):CD007214.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	TENS	Placebo TENS or routine care	Relative (95% CI)	Absolute		
Augmentation of labour – TENs to back												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	23/46 (50%)	28/48 (58.3%)	RR 0.86 (0.59 to 1.25)	82 fewer per 1000 (from 239 fewer to 146 more)	⊕○○○ VERY LOW	IMPORTANT
Augmentation of labour – TENS to acu-points												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	40/50 (80%)	43/50 (86%)	RR 0.93 (0.78 to 1.11)	60 fewer per 1000 (from 189 fewer to 95 more)	⊕⊕○○ LOW	IMPORTANT
Augmentation of labour – Limoge current to cranium												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	5/10 (50%)	9/10 (90%)	RR 0.56 (0.29 to 1.07)	396 fewer per 1000 (from 639 fewer to 63 more)	⊕○○○ VERY LOW	IMPORTANT
Duration of first stage of labour (minutes) (various starting points) – TENS to back (better indicated by lower values)												
3	randomized trials	serious[4]	no serious inconsistency	no serious indirectness	serious[5]	none	161	157	-	MD 14.1 lower (36.73 lower to 8.53 higher)	⊕⊕○○ LOW	CRITICAL
Duration of first stage of labour (minutes) (various starting points) – TENS to acu-points (better indicated by lower values)												
2	randomized trials	serious[4]	serious[6]	no serious indirectness	very serious[2]	none	110	80	-	MD 55.77 lower (170.3 lower to 58.76 higher)	⊕○○○ VERY LOW	CRITICAL

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	TENS	Placebo TENS or routine care	Relative (95% CI)	Absolute		
Duration of second stage of labour (minutes) – TENS to back (better indicated by lower values)												
3	randomized trials	serious[4]	serious[6]	no serious indirectness	serious[5]	none	161	157	-	MD 0.59 higher (12.21 lower to 13.39 higher)	⊕○○○ VERY LOW	IMPORTANT
Duration of second stage of labour (minutes) – TENS to acu-points (better indicated by lower values)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	47	48	-	MD 3 lower (14.87 lower to 8.87 higher)	⊕○○○ VERY LOW	IMPORTANT

[1] One study with design limitations.
[2] Wide confidence interval crossing the line of no effect and small sample size.
[3] Estimate based on small sample size.
[4] All of the studies contributing data had design limitations.
[5] Wide confidence interval crossing the line of no effect.
[6] Statistical heterogeneity (I^2 > 70%).

Table 8f. Effect of pain relief on duration of labour and oxytocin augmentation

Source: Dowswell T, Bedwell C, Lavender T, Neilson JP. Transcutaneous electrical nerve stimulation (TENS) for pain management in labour. Cochrane Database Syst Rev. 2009;(2):CD007214.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Cranial TENS with epidural	Epidural alone	Relative (95% CI)	Absolute		
Duration of first stage of labour (minutes) (better indicated by lower values)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	60	60	-	MD 22.79 higher (27.81 lower to 73.39 higher)	⊕○○○ VERY LOW	CRITICAL

[1] One study with design limitations.

[2] Wide confidence interval crossing the line of no effect and small sample size.

Table 8g. Effect of pain relief on duration of labour and oxytocin augmentation

Source: Smith CA, Levett KM, Collins CT, Crowther CA. Relaxation techniques for pain management in labour. Cochrane Database Syst Rev. 2011;(12):CD009514.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Relaxation	Usual care	Relative (95% CI)	Absolute		
Duration of labour (minutes) (better indicated by lower values)												
1	randomized trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	19	17	-	MD 105.56 higher (1.5 lower to 212.62 higher)	⊕○○○ VERY LOW	CRITICAL
Augmentation with oxytocin												
1	randomized trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12/14 (85.7%)	15/20 (75%)	RR 1.14 (0.82 to 1.59)	105 more per 1000 (from 135 fewer to 443 more)	⊕○○○○ VERY LOW	IMPORTANT

[1] One study with serious design limitations.

[2] Wide confidence interval crossing the line of no effect and small sample size.

Table 8h. Effect of pain relief on duration of labour and oxytocin augmentation

Source: Smith CA, Levett KM, Collins CT, Crowther CA. Relaxation techniques for pain management in labour. Cochrane Database Syst Rev. 2011;(12):CD009514.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga	Control	Relative (95% CI)	Absolute		
Duration of labour (minutes) (better indicated by lower values)												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	73	76	-	MD 182.19 lower (229.68 to 134.7 lower)	⊕⊕◯◯ LOW	CRITICAL
Augmentation with oxytocin												
1	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[4]	none	13/33 (39.4%)	17/33 (51.5%)	RR 0.76 (0.45 to 1.31)	124 fewer per 1000 (from 283 fewer to 160 more)	⊕◯◯◯ VERY LOW	IMPORTANT

[1] All of the studies contributing data had design limitations.
[2] Estimate based on small sample size.
[3] One study with design limitations.
[4] Wide confidence interval crossing the line of no effect, few events and small sample size.

Table 8i. Effect of pain relief on duration of labour and oxytocin augmentation

Source: Smith CA, Levett KM, Collins CT, Crowther CA. Relaxation techniques for pain management in labour. Cochrane Database Syst Rev. 2011;(12):CD009514.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Music	Control	Relative (95% CI)	Absolute		
Duration of labour (minutes) (better indicated by lower values)												
1	randomized trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	30	30	-	MD 2.6 lower (11.58 lower to 6.38 higher)	⊕○○○ VERY LOW	CRITICAL

[1] One study with serious design limitations.

[2] Wide confidence interval crossing the line of no effect and small sample size.

Table 8j. Effect of pain relief on duration of labour and oxytocin augmentation

Source: Smith CA, Collins CT, Crowther CA, Levett KM. Acupuncture or acupressure for pain management in labour. Cochrane Database Syst Rev. 2011;(7):CD009232.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupressure	Control	Relative (95% CI)	Absolute		
Augmentation with oxytocin												
2	randomized trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	63/131 (48.1%)	113/201 (56.2%)	RR 0.86 (0.69 to 1.06)	79 fewer per 1000 (from 174 fewer to 34 more)	⊕○○○ VERY LOW	IMPORTANT
Duration of labour (minutes) (better indicated by lower values)												
2	randomized trials	serious[1]	serious[2]	no serious indirectness	serious[4]	none	96	99	-	MD 119.65 lower (253.31 lower to 14.01 higher)	⊕○○○ VERY LOW	

[1] All of the studies contributing data had design limitations.
[2] Statistical heterogeneity (I^2 > 70%).
[3] Wide confidence interval crossing the line of no effect.
[4] Estimate based on small sample size.

Table 8k. Effect of pain relief on duration of labour and oxytocin augmentation

Source: Madden K, Middleton P, Cyna AM, Matthewson M, Jones L. Hypnosis for pain management during labour and childbirth. Cochrane Database Syst Rev. 2012;(11):CD009356.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnosis	Control	Relative (95% CI)	Absolute		
Augmentation with oxytocin												
3	randomized trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	21/312 (6.7%)	71/310 (22.9%)	RR 0.29 (0.19 to 0.45)	163 fewer per 1000 (from 126 fewer to 186 fewer)	⊕⊕○○ LOW	IMPORTANT
								30%		213 fewer per 1000 (from 165 fewer to 243 fewer)		

[1] All of the studies contributing data had design limitations, with more than 40% of weight from studies with serious design limitations.

Table 8l. Effect of pain relief on duration of labour and oxytocin augmentation

Source: Madden K, Middleton P, Cyna AM, Matthewson M, Jones L. Hypnosis for pain management during labour and childbirth. Cochrane Database Syst Rev. 2012;(11):CD009356.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnosis	Control	Relative (95% CI)	Absolute		
Augmentation with oxytocin												
3	randomized trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	21/312 (6.7%)	71/310 (22.9%)	RR 0.29 (0.19 to 0.45)	163 fewer per 1000 (from 126 fewer to 186 fewer)	⊕⊕○○ LOW	IMPORTANT
								30%		213 fewer per 1000 (from 165 fewer to 243 fewer)		

[1] All of the studies contributing data had design limitations, with more than 40% of weight from studies with serious design limitations.

Table 8m. Effect of pain relief on duration of labour and oxytocin augmentation

Source: Smith CA, Collins CT, Crowther CA. Aromatherapy for pain management in labour. Cochrane Database Syst Rev. 2011;(7):CD009215.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Aromatherapy	Standard care	Relative (95% CI)	Absolute		
Augmentation												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	92/251 (36.7%)	84/262 (32.1%)	RR 1.14 (0.9 to 1.45)	45 more per 1000 (from 32 fewer to 144 more)	⊕⊕○○ LOW	IMPORTANT

[1] One study with design limitations.

[2] Wide confidence interval crossing the line of no effect.

Table 8n. Effect of pain relief on duration of labour and oxytocin augmentation

Source: Barragán Loayza IM, Solà I, Juandó Prats C. Biofeedback for pain management during labour. Cochrane Database Syst Rev. 2011;(6):CD006168.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Biofeedback	No treatment	Relative (95% CI)	Absolute		
Augmentation of labour with oxytocin												
1	randomized trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	12/23 (52.2%)	14/32 (43.8%)	RR 1.19 (0.68 to 2.08)	83 more per 1000 (from 140 fewer to 472 more)	⊕○○○ VERY LOW	IMPORTANT

[1] One study with serious design limitations.

[2] Wide confidence interval crossing the line of no effect, few events and small sample size.

Table 9a. Intravenous fluids for shortening the duration of labour (maternal outcomes)

Source: Dawood F, Dowswell T, Quenby S. Intravenous fluids for reducing the duration of labour in low-risk nulliparous women. Cochrane Database Syst Rev. 2013;(6):CD007715.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intravenous fluids + oral intake	Oral intake alone	Relative (95% CI)	Absolute		
Mean duration of labour (minutes) (better indicated by lower values)												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	150	91	-	MD 28.86 lower (47.41 to 10.3 lower)	⊕⊕◯◯ LOW	CRITICAL
Caesarean section												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	36/186 (19.4%)	38/129 (29.5%)	RR 0.73 (0.49 to 1.08)	80 fewer per 1000 (from 150 fewer to 24 more)	⊕⊕◯◯ LOW	IMPORTANT
Fluid overload												
1	randomized trials	serious[4]	no serious inconsistency	no serious indirectness	very serious[5]	none	0/96 (0%)	0/99 (0%)	not pooled	not pooled	⊕◯◯◯ VERY LOW	IMPORTANT

[1] Studies contributing data had design limitations.
[2] Small sample size.
[3] Wide confidence interval crossing the line of no effect.
[4] One study with design limitations.
[5] No events.

Table 9b. Intravenous fluids for shortening the duration of labour (infant outcomes)

Source: Dawood F, Dowswell T, Quenby S. Intravenous fluids for reducing the duration of labour in low-risk nulliparous women. Cochrane Database Syst Rev. 2013;(6):CD007715.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intravenous fluids + oral intake	Oral intake alone	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/90 (0%)	0/30 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
								0%		not pooled		
Admission to neonatal intensive care unit												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/96 (1%)	2/99 (2%)	RR 0.52 (0.05 to 5.59)	10 fewer per 1000 (from 19 fewer to 93 more)	⊕○○○ VERY LOW	IMPORTANT
								2%		10 fewer per 1000 (from 19 fewer to 92 more)		

[1] One study with design limitations.
[2] No events.
[3] Wide confidence interval crossing the line of no effect and few events.

Table 9c. Intravenous fluids for shortening the duration of labour (maternal outcomes)

Source: Dawood F, Dowswell T, Quenby S. Intravenous fluids for reducing the duration of labour in low-risk nulliparous women. Cochrane Database Syst Rev. 2013;(6):CD007715.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	125 ml/hour intravenous fluids + oral intake	250 ml/hour intravenous fluids + oral intake	Relative (95% CI)	Absolute		
Mean duration of labour (minutes) (better indicated by lower values)												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	130	126	-	MD 23.87 higher (3.72 to 44.02 higher)	⊕⊕◯◯ LOW	CRITICAL
Caesarean section												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	41/171 (24%)	37/163 (22.7%)	RR 1 (0.54 to 1.87)	0 fewer per 1000 (from 104 fewer to 197 more)	⊕⊕◯◯ LOW	IMPORTANT
Assisted delivery												
1	randomized trials	serious[4]	no serious inconsistency	no serious indirectness	serious[2]	none	12/43 (27.9%)	22/37 (59.5%)	RR 0.47 (0.27 to 0.81)	315 fewer per 1000 (from 113 fewer to 434 fewer)	⊕⊕◯◯ LOW	IMPORTANT
Fluid overload												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	0/141 (0%)	0/133 (0%)	not pooled	not pooled	⊕◯◯◯ VERY LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] Small sample size.
[3] Wide confidence interval crossing the line of no effect.
[4] One study with design limitations.
[5] No events.

Table 9d. Intravenous fluids for shortening the duration of labour (infant outcomes)

Source: Dawood F, Dowswell T, Quenby S. Intravenous fluids for reducing the duration of labour in low-risk nulliparous women. Cochrane Database Syst Rev. 2013;(6):CD007715.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	125 ml/hour intravenous fluids + oral intake	250 ml/hour intravenous fluids + oral intake	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/73 (0%)	0/67 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Admission to neonatal intensive care unit												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	3/141 (2.1%)	5/133 (3.8%)	RR 0.56 (0.15 to 2.06)	17 fewer per 1000 (from 32 fewer to 40 more)	⊕○○○ VERY LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] No events.
[3] Wide confidence interval crossing the line of no effect and few events.

Table 9e. Intravenous fluids for shortening the duration of labour (maternal outcomes)

Source: Dawood F, Dowswell T, Quenby S. Intravenous fluids for reducing the duration of labour in low-risk nulliparous women. Cochrane Database Syst Rev. 2013;(6):CD007715.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	125 ml/hour fluids (restricted oral intake)	250 ml/hour fluids (restricted oral intake)	Relative (95% CI)	Absolute		
Mean duration of labour (minutes) (better indicated by lower values)												
4	randomized trials	serious[1]	serious[2]	no serious indirectness	no serious imprecision	none	316	316	-	MD 105.61 higher (53.19 to 158.02 higher)	⊕⊕◯◯ LOW	CRITICAL
Caesarean section												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	72/388 (18.6%)	44/360 (12.2%)	RR 1.56 (1.1 to 2.21)	68 more per 1000 (from 12 more to 148 more)	⊕⊕⊕◯ MODERATE	IMPORTANT
Assisted delivery												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	16/247 (6.5%)	22/248 (8.9%)	RR 0.78 (0.44 to 1.4)	20 fewer per 1000 (from 50 fewer to 35 more)	⊕⊕◯◯ LOW	IMPORTANT
Fluid overload												
1	randomized trials	serious[4]	no serious inconsistency	no serious indirectness	serious[3]	none	1/94 (1.1%)	0/101 (0%)	RR 3.22 (0.13 to 78.11)	-	⊕⊕◯◯ LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] Statistical heterogeneity (I^2=53%). Variation is size and direction of effect.
[3] Wide confidence interval crossing the line of no effect.
[4] One study with design limitations.

Table 9f. Intravenous fluids for shortening the duration of labour (infant outcomes)

Source: Dawood F, Dowswell T, Quenby S. Intravenous fluids for reducing the duration of labour in low-risk nulliparous women. Cochrane Database Syst Rev. 2013;(6):CD007715.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	125 ml/hour fluids (restricted oral intake)	250 ml/hour fluids (restricted oral intake)	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	9/359 (2.5%)	1/330 (0.3%)	RR 4.35 (0.97 to 19.51)	10 more per 1000 (from 0 fewer to 56 more)	⊕○○○ VERY LOW	CRITICAL
Admission to neonatal intensive care unit												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	8/359 (2.2%)	13/330 (3.9%)	RR 0.48 (0.07 to 3.17)	20 fewer per 1000 (from 37 fewer to 85 more)	⊕○○○ VERY LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] Wide confidence interval crossing the line of no effect and few events.

Table 9g. Intravenous fluids for shortening the duration of labour (maternal outcomes)

Source: Dawood F, Dowswell T, Quenby S. Intravenous fluids for reducing the duration of labour in low-risk nulliparous women. Cochrane Database Syst Rev. 2013;(6):CD007715.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Normal saline	5% dextrose solutions	Relative (95% CI)	Absolute		
Mean duration of labour (minutes) (better indicated by lower values)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	44	47	-	MD 12 lower (30.09 lower to 6.09 higher)	⊕○○○ VERY LOW	CRITICAL
Caesarean section												
2	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	15/142 (10.6%)	19/142 (13.4%)	RR 0.77 (0.41 to 1.43)	31 fewer per 1000 (from 79 fewer to 58 more)	⊕⊕○○ LOW	IMPORTANT
Assisted delivery												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	5/45 (11.1%)	9/48 (18.8%)	RR 0.59 (0.21 to 1.63)	77 fewer per 1000 (from 148 fewer to 118 more)	⊕○○○ VERY LOW	IMPORTANT
Fluid overload												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/45 (0%)	0/48 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	IMPORTANT
Maternal hyponatraemia (sodium level < 135 mmol/L)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	0/44 (0%)	9/47 (19.1%)	RR 0.06 (0 to 0.94)	180 fewer per 1000 (from 11 fewer to 191 fewer)	⊕⊕○○ LOW	IMPORTANT

[1] One study with design limitations.
[2] Wide confidence interval crossing the line of no effect and small sample size.
[3] No events.
[4] Small sample size and few events.

Table 9h. Intravenous fluids for shortening the duration of labour (infant outcomes)

Source: Dawood F, Dowswell T, Quenby S. Intravenous fluids for reducing the duration of labour in low-risk nulliparous women. Cochrane Database Syst Rev. 2013;(6):CD007715.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Normal saline	5% dextrose solutions	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
2	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[1]	none	1/142 (0.7%)	2/142 (1.4%)	RR 0.48 (0.04 to 5.25)	7 fewer per 1000 (from 14 fewer to 60 more)	⊕⊕○○ LOW	CRITICAL
Admission to neonatal intensive care unit												
2	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[1]	none	8/142 (5.6%)	7/142 (4.9%)	RR 1.11 (0.42 to 2.93)	5 more per 1000 (from 29 fewer to 95 more)	⊕⊕○○ LOW	IMPORTANT
Neonatal hyperbilirubinaemia												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[1]	none	2/97 (2.1%)	5/94 (5.3%)	RR 0.39 (0.08 to 1.95)	32 fewer per 1000 (from 49 fewer to 51 more)	⊕⊕○○ LOW	IMPORTANT
Neonatal hyponatraemia (cord sodium level < 135 mmol/L)												
1	randomized trials	serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	6/45 (13.3%)	16/48 (33.3%)	RR 0.4 (0.17 to 0.93)	200 fewer per 1000 (from 23 fewer to 277 fewer)	⊕⊕○○ LOW	IMPORTANT
Neonatal hypoglycaemia (< 40 mg/dL)												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[1]	none	3/97 (3.1%)	3/94 (3.2%)	RR 0.97 (0.2 to 4.68)	1 fewer per 1000 (from 26 fewer to 117 more)	⊕⊕○○ LOW	IMPORTANT

[1] Wide confidence interval crossing the line of no effect and few events.
[2] One study with design limitations.
[3] Small sample size.

Table 10a. Oral fluid and food intake during labour (maternal outcomes)

Source: Singata M, Tranmer J, Gyte GML. Restricting oral fluid and food intake during labour. Cochrane Database Syst Rev. 2013;(8):CD003930.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any restriction of oral fluid and food	Some fluid and food	Relative (95% CI)	Absolute		
Duration of labour (hours) (better indicated by lower values)												
3	randomized trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	238	238	-	MD 0.29 lower (1.55 lower to 0.97 higher)	⊕○○○ VERY LOW	CRITICAL
Caesarean section												
5	randomized trials	serious[1]	serious[4]	no serious indirectness	serious[3]	none	422/1544 (27.3%)	439/1559 (28.2%)	RR 0.89 (0.63 to 1.25)	31 fewer per 1000 (from 104 fewer to 70 more)	⊕○○○ VERY LOW	IMPORTANT
								20.6%		23 fewer per 1000 (from 76 fewer to 52 more)		
Epidural analgesia												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	1014/1544 (65.7%)	1027/1559 (65.9%)	RR 0.98 (0.91 to 1.05)	13 fewer per 1000 (from 59 fewer to 33 more)	⊕⊕⊕○ MODERATE	IMPORTANT
								79.1%		16 fewer per 1000 (from 71 fewer to 40 more)		
Augmentation of labour												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	837/1544 (54.2%)	817/1559 (52.4%)	RR 1.02 (0.95 to 1.09)	10 more per 1000 (from 26 fewer to 47 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Operative vaginal birth												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	416/1544 (26.9%)	428/1559 (27.5%)	RR 0.98 (0.88 to 1.1)	5 fewer per 1000 (from 33 fewer to 27 more)	⊕⊕⊕○ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any restriction of oral fluid and food	Some fluid and food	Relative (95% CI)	Absolute		
Narcotic pain relief												
3	randomized trials	serious[1]	serious[5]	no serious indirectness	serious[3]	none	100/172 (58.1%)	115/177 (65%)	RR 0.94 (0.74 to 1.21)	39 fewer per 1000 (from 169 fewer to 136 more)	⊕○○○ VERY LOW	IMPORTANT
								93.3%		56 fewer per 1000 (from 243 fewer to 196 more)		
Mendelson's syndrome												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	0/1372 (0%)	0/1382 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	IMPORTANT
Maternal ketoacidosis												
1	randomized trials	serious[7]	no serious inconsistency	no serious indirectness	serious[3]	none	36/165 (21.8%)	36/163 (22.1%)	RR 0.99 (0.66 to 1.49)	2 fewer per 1000 (from 75 fewer to 108 more)	⊕⊕○○ LOW	IMPORTANT
Regurgitation during general anaesthesia												
1	randomized trials	serious[7]	no serious inconsistency	no serious indirectness	very serious[6]	none	0/1207 (0%)	0/1219 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	IMPORTANT
Maternal vomiting												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	428/1280 (33.4%)	458/1294 (35.4%)	RR 0.9 (0.62 to 1.31)	35 fewer per 1000 (from 134 fewer to 110 more)	⊕⊕○○ LOW	IMPORTANT
Maternal nausea												
1	randomized trials	serious[7]	no serious inconsistency	no serious indirectness	very serious[8]	none	34/133 (25.6%)	39/122 (32%)	RR 0.8 (0.54 to 1.18)	64 fewer per 1000 (from 147 fewer to 58 more)	⊕○○○ VERY LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] Statistical heterogeneity (I^2=58%). Variation in direction of effect.
[3] Wide confidence interval crossing the line of no effect.
[4] Statistical heterogeneity (I^2=57%). Variation in size and direction of effect.
[5] Statistical heterogeneity (I^2=88%). Variation in size and direction of effect.
[6] No events.
[7] Single study with design limitations.
[8] Wide confidence interval crossing the line of no effect and small sample size.

Table 10b. Oral fluid and food intake during labour (infant outcomes)

Source: Singata M, Tranmer J, Gyte GML. Restricting oral fluid and food intake during labour. Cochrane Database Syst Rev. 2013;(8):CD003930.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Any restriction of oral fluid and food	Some fluid and food	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23/1445 (1.6%)	16/1457 (1.1%)	RR 1.43 (0.77 to 2.68)	5 more per 1000 (from 3 fewer to 18 more)	⊕⊕○○ LOW	CRITICAL
Admission to neonatal intensive care unit												
1	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	serious[2]	none	62/1207 (5.1%)	61/1219 (5%)	RR 1.03 (0.73 to 1.45)	2 more per 1000 (from 14 fewer to 23 more)	⊕⊕○○ LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] Wide confidence interval crossing the line of no effect.
[3] One study with design limitations.

Table 10c. Oral fluid and food intake during labour (maternal outcomes)

Source: Singata M, Tranmer J, Gyte GML. Restricting oral fluid and food intake during labour. Cochrane Database Syst Rev. 2013;(8):CD003930.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Complete restriction of oral fluid and food (other than ice chips)	Freedom to eat and drink	Relative (95% CI)	Absolute		
Duration of labour (hours) (better indicated by lower values)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	165	163	-	MD 0.8 lower (2.13 lower to 0.53 higher)	⊕⊕○○ LOW	CRITICAL
Caesarean section												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	32/165 (19.4%)	41/163 (25.2%)	RR 0.77 (0.51 to 1.16)	58 fewer per 1000 (from 123 fewer to 40 more)	⊕⊕○○ LOW	IMPORTANT
Epidural analgesia												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	120/165 (72.7%)	129/163 (79.1%)	RR 0.92 (0.81 to 1.04)	63 fewer per 1000 (from 150 fewer to 32 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Augmentation of labour												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	91/165 (55.2%)	92/163 (56.4%)	RR 0.98 (0.81 to 1.18)	11 fewer per 1000 (from 107 fewer to 102 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Operative vaginal birth												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	53/165 (32.1%)	53/163 (32.5%)	RR 0.99 (0.72 to 1.35)	3 fewer per 1000 (from 91 fewer to 114 more)	⊕⊕○○ LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Complete restriction of oral fluid and food (other than ice chips)	Freedom to eat and drink	Relative (95% CI)	Absolute		
Mendelson's syndrome												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/165 (0%)	0/163 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	IMPORTANT
Maternal ketoacidosis												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	36/165 (21.8%)	36/163 (22.1%)	RR 0.99 (0.66 to 1.49)	2 fewer per 1000 (from 75 fewer to 108 more)	⊕⊕○○ LOW	IMPORTANT
Maternal nausea												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	34/133 (25.6%)	39/122 (32%)	RR 0.8 (0.54 to 1.18)	64 fewer per 1000 (from 147 fewer to 58 more)	⊕○○○ VERY LOW	IMPORTANT

[1] Single study with design limitations.
[2] Wide confidence interval crossing the line of no effect.
[3] No events.
[4] Wide confidence interval crossing the line of no effect and small sample size.

Table 10d. Oral fluid and food intake during labour (infant outcomes)

Source: Singata M, Tranmer J, Gyte GML. Restricting oral fluid and food intake during labour. Cochrane Database Syst Rev. 2013;(8):CD003930.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Complete restriction of oral fluid and food (other than ice chips)	Freedom to eat and drink	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/165 (0%)	0/163 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL

[1] Single study with design limitations.
[2] No events.

Table 10e. Oral fluid and food intake during labour (maternal outcomes)

Source: Singata M, Tranmer J, Gyte GML. Restricting oral fluid and food intake during labour. Cochrane Database Syst Rev. 2013;(8):CD003930.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Water only	Specific oral fluid and food	Relative (95% CI)	Absolute		
Duration of labour (hours) (better indicated by lower values)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	43	45	-	MD 1.1 lower (2.66 lower to 0.46 higher)	⊕○○○ VERY LOW	CRITICAL
Caesarean section												
2	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	375/1250 (30%)	371/1264 (29.4%)	RR 1.02 (0.91 to 1.15)	6 more per 1000 (from 26 fewer to 44 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Epidural analgesia												
2	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	852/1250 (68.2%)	844/1264 (66.8%)	RR 1.02 (0.97 to 1.08)	13 more per 1000 (from 20 fewer to 53 more)	⊕⊕⊕○ MODERATE	IMPORTANT
								77.4%		15 more per 1000 (from 23 fewer to 62 more)		
Augmentation of labour												
2	randomized trials	serious[3]	serious[4]	no serious indirectness	no serious imprecision	none	704/1250 (56.3%)	685/1264 (54.2%)	RR 0.97 (0.8 to 1.19)	16 fewer per 1000 (from 108 fewer to 103 more)	⊕⊕○○ LOW	IMPORTANT
								68.8%		21 fewer per 1000 (from 138 fewer to 131 more)		
Operative vaginal birth												
2	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	323/1250 (25.8%)	340/1264 (26.9%)	RR 0.96 (0.84 to 1.1)	11 fewer per 1000 (from 43 fewer to 27 more)	⊕⊕⊕○ MODERATE	IMPORTANT
								31.1%		12 fewer per 1000 (from 50 fewer to 31 more)		

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Water only	Specific oral fluid and food	Relative (95% CI)	Absolute		
Narcotic pain relief												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	41/43 (95.3%)	43/45 (95.6%)	RR 1 (0.91 to 1.09)	0 fewer per 1000 (from 86 fewer to 86 more)	⊕⊕○○ LOW	IMPORTANT
Mendelson's syndrome												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	0/1207 (0%)	0/1219 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	IMPORTANT
Regurgitation during general anaesthesia												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	0/1207 (0%)	0/1219 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	IMPORTANT
Maternal vomiting												
2	randomized trials	serious[3]	serious[7]	no serious indirectness	serious[8]	none	414/1250 (33.1%)	447/1264 (35.4%)	RR 0.76 (0.41 to 1.41)	85 fewer per 1000 (from 209 fewer to 145 more)		IMPORTANT

[1] Single study with design limitations.
[2] Wide confidence interval crossing the line of no effect and small sample size.
[3] Most studies contributing data had design limitations.
[4] Statistical heterogeneity (I^2=67%). Variation in direction of effect.
[5] Small sample size.
[6] No events.
[7] Statistical heterogeneity (I^2=68%). Variation in size of effect.
[8] Wide confidence interval crossing the line of no effect.

Table 10f. Oral fluid and food intake during labour (infant outcomes)

Source: Singata M, Tranmer J, Gyte GML. Restricting oral fluid and food intake during labour. Cochrane Database Syst Rev. 2013;(8):CD003930.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Water only	Specific oral fluid and food	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	22/1250 (1.8%)	16/1264 (1.3%)	RR 1.39 (0.73 to 2.63)	5 more per 1000 (from 3 fewer to 21 more)	⊕⊕○○ LOW	CRITICAL
								0.7%		3 more per 1000 (from 2 fewer to 11 more)		
Admission to neonatal intensive care unit												
1	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	serious[2]	none	62/1207 (5.1%)	61/1219 (5%)	RR 1.03 (0.73 to 1.45)	2 more per 1000 (from 14 fewer to 23 more)	⊕⊕○○ LOW	IMPORTANT
								5%		1 more per 1000 (from 13 fewer to 23 more)		

[1] Studies contributing data had design limitations.
[2] Wide confidence interval crossing the line of no effect.
[3] One study with design limitations.

Table 10g. Oral fluid and food intake during labour (maternal outcomes)

Source: Singata M, Tranmer J, Gyte GML. Restricting oral fluid and food intake during labour. Cochrane Database Syst Rev. 2013;(8):CD003930.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Water only	Oral carbohydrate-based fluids	Relative (95% CI)	Absolute		
Duration of labour (hours) (better indicated by lower values)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	30	30	-	MD 0.95 higher (0.42 lower to 2.32 higher)	⊕○○○ VERY LOW	CRITICAL
Caesarean section												
2	randomized trials	no serious risk of bias	serious[3]	no serious indirectness	very serious[2]	none	15/129 (11.6%)	27/132 (20.5%)	RR 0.66 (0.17 to 2.53)	70 fewer per 1000 (from 170 fewer to 313 more)	⊕○○○ VERY LOW	IMPORTANT
Epidural analgesia												
2	randomized trials	serious[4]	serious[3]	no serious indirectness	very serious[2]	none	42/129 (32.6%)	54/132 (40.9%)	RR 0.8 (0.44 to 1.43)	82 fewer per 1000 (from 229 fewer to 176 more)	⊕○○○ VERY LOW	IMPORTANT
								59.4%		119 fewer per 1000 (from 333 fewer to 255 more)		
Augmentation of labour												
2	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	42/129 (32.6%)	40/132 (30.3%)	RR 1.07 (0.75 to 1.52)	21 more per 1000 (from 76 fewer to 158 more)	⊕⊕○○ LOW	IMPORTANT
								38.4%		27 more per 1000 (from 96 fewer to 200 more)		
Operative vaginal birth												
2	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	40/129 (31%)	35/132 (26.5%)	RR 1.17 (0.8 to 1.71)	45 more per 1000 (from 53 fewer to 188 more)	⊕⊕○○ LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Water only	Oral carbohydrate-based fluids	Relative (95% CI)	Absolute		
Narcotic pain relief												
2	randomized trials	serious[4]	serious[3]	no serious indirectness	very serious[2]	none	59/129 (45.7%)	72/132 (54.5%)	RR 0.86 (0.36 to 2.06)	76 fewer per 1000 (from 349 fewer to 578 more)	⊕○○○ VERY LOW	IMPORTANT
								68.2%		95 fewer per 1000 (from 436 fewer to 723 more)		
Maternal vomiting												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	14/30 (46.7%)	11/30 (36.7%)	RR 1.27 (0.69 to 2.33)	99 more per 1000 (from 114 fewer to 488 more)	⊕○○○ VERY LOW	IMPORTANT

[1] Single study with design limitations.
[2] Wide confidence interval crossing the line of no effect and small sample size.
[3] Statistical heterogeneity ($I^2 > 75\%$).
[4] Most of the pooled effect was provided by studies with design limitations.

Table 10h. Oral fluid and food intake during labour (infant outcomes)

Source: Singata M, Tranmer J, Gyte GML. Restricting oral fluid and food intake during labour. Cochrane Database Syst Rev. 2013;(8):CD003930.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Water only	Oral carbohydrate-based fluids	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/30 (3.3%)	0/30 (0%)	RR 3 (0.13 to 70.83)	-	⊕◯◯◯ VERY LOW	CRITICAL

[1] Single study with design limitations.
[2] Wide confidence interval crossing the line of no effect, few events and small sample size.

Table 11a. Maternal position and mobility during the first stage of labour for improving outcomes (maternal outcomes)

Source: Maternal positions and mobility during first stage labour. Cochrane Database Syst Rev. 2013;(8):CD003934.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Upright and ambulant positions	Recumbent positions and bed care	Relative (95% CI)	Absolute		
Estimated blood loss > 500 ml												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	2/120 (1.7%)	3/120 (2.5%)	RR 0.71 (0.14 to 3.55)	7 fewer per 1000 (from 22 fewer to 64 more)	⊕○○○ VERY LOW	CRITICAL
Duration of first stage labour (hours) (better indicated by lower values)												
15	randomized trials	very serious[3]	very serious[4]	no serious indirectness	no serious imprecision	none	1243	1260	-	MD 1.36 lower (2.22 to 0.51 lower)	⊕○○○ VERY LOW	CRITICAL
Duration of first stage labour (hours): subgroup analysis: parity – nulliparous women (better indicated by lower values)												
12	randomized trials	very serious[3]	very serious[4]	no serious indirectness	no serious imprecision	none	737	749	-	MD 1.21 lower (2.35 to 0.07 lower)	⊕○○○ VERY LOW	CRITICAL
Duration of first stage labour (hours): subgroup analysis: parity – multiparous women (better indicated by lower values)												
4	randomized trials	very serious[3]	no serious inconsistency	no serious indirectness	serious[5]	none	324	338	-	MD 0.56 lower (1.19 lower to 0.06 higher)	⊕○○○ VERY LOW	CRITICAL
Mode of birth: caesarean birth												
14	randomized trials	very serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	72/1329 (5.4%)	106/1353 (7.8%)	RR 0.71 (0.54 to 0.94)	23 fewer per 1000 (from 5 fewer to 36 fewer)	⊕⊕○○ LOW	IMPORTANT

Quality assessment								No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency		Indirectness	Imprecision	Other considerations	Upright and ambulant positions	Recumbent positions and bed care	Relative (95% CI)	Absolute		
Mode of birth: caesarean birth: subgroup analysis: parity – nulliparous women													
8	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	37/610 (6.1%)	51/627 (8.1%)	RR 0.79 (0.52 to 1.18)	17 fewer per 1000 (from 39 fewer to 15 more)		⊕⊕◯◯ LOW	IMPORTANT
Mode of birth: caesarean birth: subgroup analysis: parity – multiparous women													
	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]		none	6/325 (1.8%)	13/350 (3.7%)	RR 0.55 (0.22 to 1.38)	17 fewer per 1000 (from 29 fewer to 14 more)	⊕◯◯◯ VERY LOW	IMPORTANT
Mode of birth: spontaneous vaginal													
14	randomized trials	very serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision		none	1105/1306 (84.6%)	1084/1320 (82.1%)	RR 1.05 (0.99 to 1.11)	41 more per 1000 (from 8 fewer to 90 more)	⊕⊕◯◯ LOW	IMPORTANT
Mode of birth: spontaneous vaginal: subgroup analysis: parity – nulliparous women													
8	randomized trials	very serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision		none	507/633 (80.1%)	505/649 (77.8%)	RR 1.06 (0.96 to 1.17)	47 more per 1000 (from 31 fewer to 132 more)	⊕⊕◯◯ LOW	IMPORTANT
Mode of birth: spontaneous vaginal: subgroup analysis: parity – multiparous women													
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision		none	316/325 (97.2%)	333/350 (95.1%)	RR 1.02 (0.99 to 1.05)	19 more per 1000 (from 10 fewer to 48 more)	⊕⊕⊕◯ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Upright and ambulant positions	Recumbent positions and bed care	Relative (95% CI)	Absolute		
Duration of second stage of labour (minutes) (better indicated by lower values)												
9	randomized trials	very serious[3]	serious[6]	no serious indirectness	no serious imprecision	none	1035	1042	-	MD 2.29 lower (6.49 lower to 1.91 higher)	⊕○○○ VERY LOW	IMPORTANT
Duration of second stage of labour (minutes) – nulliparous women (better indicated by lower values)												
7	randomized trials	very serious[3]	serious[7]	no serious indirectness	serious[5]	none	604	604	-	MD 6.31 lower (14.99 lower to 2.38 higher)	⊕○○○ VERY LOW	IMPORTANT
Duration of second stage of labour (minutes) – multiparous women (better indicated by lower values)												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	306	321	-	MD 0.53 higher (2.06 lower to 3.12 higher)	⊕⊕○○ LOW	IMPORTANT
Duration of second stage of labour (minutes) – mixed or unclear parity (better indicated by lower values)												
2	randomized trials	very serious[3]	serious[8]	no serious indirectness	very serious[9]	none	125	117	-	MD 1.69 higher (6.04 lower to 9.41 higher)	⊕○○○ VERY LOW	IMPORTANT
Epidural												
9	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	reporting bias[10]	117/1020 (11.5%)	155/1087 (14.3%)	RR 0.81 (0.66 to 0.99)	27 fewer per 1000 (from 1 fewer to 48 fewer)	⊕⊕○○ LOW	IMPORTANT
Augmentation of labour using oxytocin												
8	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	200/880 (22.7%)	228/946 (24.1%)	RR 0.89 (0.76 to 1.05)	27 fewer per 1000 (from 58 fewer to 12 more)	⊕⊕⊕○ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Upright and ambulant positions	Recumbent positions and bed care	Relative (95% CI)	Absolute		
Mode of birth: operative vaginal: all women												
13	randomized trials	very serious[3]	no serious inconsistency	no serious indirectness	serious[5]	none	125/1252 (10%)	135/1267 (10.7%)	RR 0.91 (0.73 to 1.14)	10 fewer per 1000 (from 29 fewer to 15 more)	⊕○○○ VERY LOW	IMPORTANT
								15%		13 fewer per 1000 (from 41 fewer to 21 more)		
Mode of birth: operative vaginal: subgroup analysis: parity – nulliparous women												
7	randomized trials	very serious[3]	no serious inconsistency	no serious indirectness	serious[5]	none	67/579 (11.6%)	76/596 (12.8%)	RR 0.87 (0.65 to 1.18)	17 fewer per 1000 (from 45 fewer to 23 more)	⊕OOO VERY LOW	IMPORTANT
								21.9%		28 fewer per 1000 (from 77 fewer to 39 more)		
Mode of birth: operative vaginal: subgroup analysis: parity – multiparous women												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	3/325 (0.9%)	4/350 (1.1%)	RR 0.91 (0.24 to 3.51)	1 fewer per 1000 (from 9 fewer to 29 more)	⊕OOO VERY LOW	IMPORTANT

[1] Most of the pooled effect was provided by studies with design limitations.
[2] Wide confidence interval crossing the line of no effect and few events.
[3] Most of the pooled effect was provided by studies with serious design limitations.
[4] Statistical heterogeneity (I^2 > 90%). Considerable variation in size and direction of effect.
[5] Wide confidence interval crossing the line of no effect
[6] Statistical heterogeneity (I^2 > 68%).
[7] Statistical heterogeneity (I^2 > 77%).
[8] Two studies with inconsistent results.
[9] Wide confidence interval crossing the line of no effect and small sample size.
[10] Forest plot suggests increased effect in studies with small sample size.

Table 11b. Maternal position and mobility during the first stage of labour for improving outcomes (infant outcomes)

Source: Maternal positions and mobility during first stage labour. Cochrane Database Syst Rev. 2013;(8):CD003934.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Upright and ambulant positions	Recumbent positions and bed care	Relative (95% CI)	Absolute		
Perinatal mortality												
5	randomized trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/784 (0.1%)	2/780 (0.3%)	RR 0.5 (0.05 to 5.37)	1 fewer per 1000 (from 2 fewer to 11 more)	⊕○○○ VERY LOW	CRITICAL
Fetal distress (requiring immediate delivery)												
6	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	serious[4]	none	12/848 (1.4%)	20/909 (2.2%)	RR 0.69 (0.35 to 1.33)	7 fewer per 1000 (from 14 fewer to 7 more)	⊕⊕○○ LOW	CRITICAL
Apgar score < 7 at 5 minutes												
4	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[2]	none	2/229 (0.9%)	0/237 (0%)	RR 3.27 (0.34 to 31.05)	-	⊕○○○ VERY LOW	CRITICAL
Admission to neonatal intensive care unit												
2	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[2]	none	8/196 (4.1%)	14/200 (7%)	RR 0.58 (0.25 to 1.36)	29 fewer per 1000 (from 53 fewer to 25 more)	⊕○○○ VERY LOW	IMPORTANT
Intubation in delivery room												
2	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[2]	none	3/556 (0.5%)	4/551 (0.7%)	RR 0.77 (0.19 to 3.1)	2 fewer per 1000 (from 6 fewer to 15 more)	⊕○○○ VERY LOW	IMPORTANT

[1] Most of the pooled effect was provided by studies with serious design limitations.
[2] Wide confidence interval crossing the line of no effect and few events.
[3] Most of the pooled effect was provided by studies with design limitations.
[4] Wide confidence interval crossing the line of no effect.

Table 11c. Maternal position and mobility during the first stage of labour for improving outcomes (maternal outcomes)

Source: Maternal positions and mobility during first stage labour. Cochrane Database Syst Rev. 2013;(8):CD003934.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Upright and ambulant positions (with epidural: all women)	Recumbent positions and bed care (with epidural: all women)	Relative (95% CI)	Absolute		
Mode of birth: caesarean birth												
6	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	127/808 (15.7%)	116/758 (15.3%)	RR 1.05 (0.83 to 1.32)	8 more per 1000 (from 26 fewer to 49 more)	⊕⊕○○ LOW	IMPORTANT
Mode of birth: caesarean birth: subgroup analysis: parity – nulliparous women												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	105/584 (18%)	78/500 (15.6%)	RR 1.14 (0.75 to 1.73)	22 more per 1000 (from 39 fewer to 114 more)	⊕⊕○○ LOW	IMPORTANT
Mode of birth: caesarean birth: subgroup analysis: parity – multiparous women												
1	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[4]	none	20/148 (13.5%)	6/58 (10.3%)	RR 1.31 (0.55 to 3.09)	32 more per 1000 (from 47 fewer to 216 more)	⊕○○○ VERY LOW	IMPORTANT
Mode of birth: spontaneous vaginal												
6	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	475/808 (58.8%)	447/758 (59%)	RR 0.96 (0.89 to 1.05)	24 fewer per 1000 (from 65 fewer to 29 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Mode of birth: spontaneous vaginal: subgroup analysis: parity – nulliparous women												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	300/584 (51.4%)	326/595 (54.8%)	RR 0.94 (0.84 to 1.04)	33 fewer per 1000 (from 88 fewer to 22 more)	⊕⊕⊕○ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Upright and ambulant positions (with epidural: all women)	Recumbent positions and bed care (with epidural: all women)	Relative (95% CI)	Absolute		
Mode of birth: spontaneous vaginal: subgroup analysis: parity – multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	39/53 (73.6%)	42/58 (72.4%)	RR 1.02 (0.81 to 1.27)	14 more per 1000 (from 138 fewer to 196 more)	⊕○○○ VERY LOW	IMPORTANT
Duration of second stage of labour (minutes) (better indicated by lower values)												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	100	104	-	MD 2.35 higher (15.22 lower to 19.91 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
Augmentation of labour using oxytocin												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	364/609 (59.8%)	347/552 (62.9%)	RR 0.98 (0.9 to 1.07)	13 fewer per 1000 (from 63 fewer to 44 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Mode of birth: operative vaginal												
6	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	206/808 (25.5%)	195/758 (25.7%)	RR 1.06 (0.9 to 1.25)	15 more per 1000 (from 26 fewer to 64 more)	⊕⊕⊕○ MODERATE	IMPORTANT
								18.2%		11 more per 1000 (from 18 fewer to 46 more)		
Mode of birth: operative vaginal: subgroup analysis: parity – nulliparous women												
4	randomized trials	serious[1]	serious[5]	no serious indirectness	serious[2]	none	179/584 (30.7%)	113/500 (22.6%)	RR 1.36 (0.95 to 1.94)	81 more per 1000 (from 11 fewer to 212 more)	⊕○○○ VERY LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Upright and ambulant positions (with epidural: all women)	Recumbent positions and bed care (with epidural: all women)	Relative (95% CI)	Absolute		
Mode of birth: operative vaginal: subgroup analysis: parity – multiparous women												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	10/53 (18.9%)	10/58 (17.2%)	RR 1.09 (0.49 to 2.42)	16 more per 1000 (from 88 fewer to 245 more)	⊕○○○ VERY LOW	IMPORTANT

[1] Most of the pooled effect was provided by studies with design limitations.
[2] Wide confidence interval crossing the line of no effect.
[3] One study with design limitations.
[4] Wide confidence interval crossing the line of no effect and small sample size.
[5] Statistical heterogeneity (I^2 = 54%).

Table 11d. Maternal position and mobility during the first stage of labour for improving outcomes (infant outcomes)

Source: Maternal positions and mobility during first stage labour. Cochrane Database Syst Rev. 2013;(8):CD003934.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Upright and ambulant positions (with epidural: all women)	Recumbent positions and bed care (with epidural: all women)	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	3/413 (0.7%)	3/422 (0.7%)	RR 1.04 (0.21 to 5.05)	0 more per 1000 (from 6 fewer to 29 more)	⊕○○○ VERY LOW	CRITICAL

[1] Most of the pooled effect was provided by studies with design limitations.

[2] Wide confidence interval crossing the line of no effect and few events.

Table 12a. Continuous companionship during labour for improving labour outcomes (maternal outcomes)

Source: Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. Cochrane Database Syst Rev. 2013;(7):CD003766.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Continuous support	Usual care	Relative (95% CI)	Absolute		
Duration of labour (hours) (better indicated by lower values)												
12	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	2699	2667	-	MD 0.58 lower (0.85 to 0.31 lower)	⊕⊕⊕○ MODERATE	CRITICAL
Caesarean birth												
22	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	942/7577 (12.4%)	1094/7598 (14.4%)	RR 0.78 (0.67 to 0.91)	32 fewer per 1000 (from 13 fewer to 48 fewer)	⊕⊕⊕○ MODERATE	IMPORTANT
Spontaneous vaginal birth												
19	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	4972/7028 (70.7%)	4794/7091 (67.6%)	RR 1.08 (1.04 to 1.12)	54 more per 1000 (from 27 more to 81 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Regional analgesia/anaesthesia												
9	randomized trials	serious[1]	serious[2]	no serious indirectness	no serious imprecision	none	3760/5727 (65.7%)	3959/5717 (69.2%)	RR 0.93 (0.88 to 0.99)	48 fewer per 1000 (from 7 fewer to 83 fewer)	⊕⊕○○ LOW	IMPORTANT
Synthetic oxytocin during labour												
15	randomized trials	serious[1]	serious[3]	no serious indirectness	no serious imprecision	none	2334/6275 (37.2%)	2299/6345 (36.2%)	RR 0.97 (0.91 to 1.04)	11 fewer per 1000 (from 33 fewer to 14 more)	⊕⊕○○ LOW	IMPORTANT
Instrumental vaginal birth												
19	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	1283/7028 (18.3%)	1420/7090 (20%)	RR 0.9 (0.85 to 0.96)	20 fewer per 1000 (from 8 fewer to 30 fewer)	⊕⊕⊕○ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Continuous support	Usual care	Relative (95% CI)	Absolute		
Postpartum depression												
2	randomized trials	no serious risk of bias	serious[4]	no serious indirectness	no serious imprecision	none	253/2890 (8.8%)	321/2826 (11.4%)	not pooled	not pooled	⊕⊕⊕○ MODERATE	IMPORTANT
Perineal trauma												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	2339/4057 (57.7%)	2396/4063 (59%)	RR 0.97 (0.92 to 1.01)	18 fewer per 1000 (from 47 fewer to 6 more)	⊕⊕⊕○ MODERATE	IMPORTANT
								85.9%		26 fewer per 1000 (from 69 fewer to 9 more)		
Negative rating of/negative feelings about birth experience												
11	randomized trials	serious[1]	serious[5]	no serious indirectness	no serious imprecision	none	653/5583 (11.7%)	982/5550 (17.7%)	RR 0.69 (0.59 to 0.79)	55 fewer per 1000 (from 37 fewer to 73 fewer)	⊕⊕○○ LOW	IMPORTANT
								24.8%		77 fewer per 1000 (from 52 fewer to 102 fewer)		
Any analgesia/anaesthesia												
14	randomized trials	serious[1]	serious[5]	no serious indirectness	no serious imprecision	none	4438/6098 (72.8%)	4680/6185 (75.7%)	RR 0.9 (0.84 to 0.96)	76 fewer per 1000 (from 30 fewer to 121 fewer)	⊕⊕○○ LOW	IMPORTANT
								62.8%		63 fewer per 1000 (from 25 fewer to 100 fewer)		

[1] Most studies contributing data had design limitations.
[2] Statistical heterogeneity (I^2 = 81%). Variation in size of effect.
[3] Statistical heterogeneity (I^2 = 65%). Variation is size and direction of effect.
[4] Statistical heterogeneity (I^2 = 95%). Results of studies inconsistent.
[5] Statistical heterogeneity (I^2 > 60%). Direction of effect consistent but size of effect variable.

Table 12b. Continuous companionship during labour for improving labour outcomes (infant outcomes)

Source: Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. Cochrane Database Syst Rev. 2013;(7):CD003766.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Continuous support	Usual care	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
13	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	61/6277 (1%)	88/6238 (1.4%)	RR 0.69 (0.5 to 0.95)	4 fewer per 1000 (from 1 fewer to 7 fewer)	⊕⊕⊕○ MODERATE	CRITICAL
Admission to special care nursery												
7	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	350/4413 (7.9%)	364/4484 (8.1%)	RR 0.97 (0.76 to 1.25)	2 fewer per 1000 (from 19 fewer to 20 more)	⊕⊕⊕○ MODERATE	IMPORTANT
								5.6%		2 fewer per 1000 (from 13 fewer to 14 more)		
Prolonged neonatal hospital stay												
3	randomized trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	39/553 (7.1%)	48/545 (8.8%)	RR 0.83 (0.42 to 1.65)	15 fewer per 1000 (from 51 fewer to 57 more)	⊕○○○ VERY LOW	IMPORTANT
								4.8%		8 fewer per 1000 (from 28 fewer to 31 more)		
Breastfeeding at 1–2 months postpartum												
3	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	1636/2747 (59.6%)	1581/2616 (60.4%)	RR 1.01 (0.94 to 1.09)	6 more per 1000 (from 36 fewer to 54 more)	⊕⊕⊕⊕ HIGH	IMPORTANT
								68%		7 more per 1000 (from 41 fewer to 61 more)		

[1] Most studies contributing data had design limitations.

[2] Statistical heterogeneity (I^2 = 62%). Two studies with different results.

[3] Wide confidence interval crossing the line of no effect.

Table 13a. Routine enema for improving labour outcomes (maternal outcomes)

Source: Reveiz L, Gaitán HG, Cuervo LG. Enemas during labour. Cochrane Database Syst Rev. 2013;(5):CD000330.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Enema	No enema	Relative (95% CI)	Absolute		
Duration of labour (minutes) (better indicated by lower values)												
2	randomized trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	575	604	-	MD 28.04 higher (131.01 lower to 187.1 higher)	⊕○○○ VERY LOW	CRITICAL
Duration of the second stage of labour (minutes) (better indicated by lower values)												
1	randomized trials	serious[4]	no serious inconsistency	no serious indirectness	serious[3]	none	176	171	-	MD 5.2 higher (2.56 lower to 12.96 higher)	⊕⊕○○ LOW	IMPORTANT
Perineal tear: second and third degree tears												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	18/713 (2.5%)	26/735 (3.5%)	RR 0.68 (0.39 to 1.21)	11 fewer per 1000 (from 22 fewer to 7 more)	⊕⊕○○ LOW	IMPORTANT
								6%		19 fewer per 1000 (from 37 fewer to 13 more)		
Women's levels of satisfaction (Likert scale) (better indicated by lower values)												
1	randomized trials	serious[4]	no serious inconsistency	no serious indirectness	no serious imprecision	none	500	527	-	MD 0 higher (0.1 lower to 0.1 higher)	⊕⊕⊕○ MODERATE	IMPORTANT
Need for systemic antibiotics (postpartum)												
1	randomized trials	serious[4]	no serious inconsistency	no serious indirectness	serious[3]	none	33/216 (15.3%)	28/212 (13.2%)	RR 1.16 (0.73 to 1.84)	21 more per 1000 (from 36 fewer to 111 more)	⊕⊕○○ LOW	IMPORTANT

[1] Studies contributing data had design limitations.
[2] Statistical heterogeneity (I^2 = 95%).
[3] Wide confidence interval crossing the line of no effect.
[4] One study with design limitations.

Table 13b. Routine enema for improving labour outcomes (infant outcomes)

Source: Reveiz L, Gaitán HG, Cuervo LG. Enemas during labour. Cochrane Database Syst Rev. 2013;(5):CD000330.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Enema	No enema	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12/217 (5.5%)	9/214 (4.2%)	RR 1.31 (0.57 to 3.06)	13 more per 1000 (from 18 fewer to 87 more)	⊕○○○ VERY LOW	CRITICAL
Neonatal infection (all infections, including umbilical)												
3	randomized trials	very serious[3]	no serious inconsistency	no serious indirectness	very serious[2]	none	7/787 (0.9%)	12/829 (1.4%)	RR 0.61 (0.24 to 1.52)	6 fewer per 1000 (from 11 fewer to 8 more)	⊕○○○ VERY LOW	CRITICAL
								2.7%		11 fewer per 1000 (from 21 fewer to 14 more)		

[1] One study with design limitations.

[2] Wide confidence interval crossing the line of no effect.

[3] All studies contributing data had design limitations; > 40% of weight from a study with serious design limitations.

Table 14a. Oxytocin (alone) for treatment of slow progress in the first stage of labour (maternal outcomes)

Source: Bugg GJ, Siddiqui F, Thornton JG. Oxytocin versus no treatment or delayed treatment for slow progress in the first stage of spontaneous labour. Cochrane Database Syst Rev. 2013;(6):CD007123.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intravenous oxytocin	No treatment	Relative (95% CI)	Absolute		
Caesarean section												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	8/65 (12.3%)	10/73 (13.7%)	RR 0.84 (0.36 to 1.96)	22 fewer per 1000 (from 88 fewer to 132 more)	⊕○○○ VERY LOW	IMPORTANT
Normal vaginal birth												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	48/65 (73.8%)	53/73 (72.6%)	RR 1.02 (0.84 to 1.25)	15 more per 1000 (from 116 fewer to 182 more)	⊕⊕○○ LOW	IMPORTANT
Instrumental vaginal delivery												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	9/65 (13.8%)	10/73 (13.7%)	RR 1.04 (0.45 to 2.41)	5 more per 1000 (from 75 fewer to 193 more)	⊕○○○ VERY LOW	IMPORTANT

[1] Studies contributing data had design limitations.

[2] Wide confidence interval crossing the line of no effect and few events.

[3] Wide confidence interval crossing the line of no effect and small sample.

Table 14b. Oxytocin (alone) for treatment of slow progress in the first stage of labour (infant outcomes)

Source: Bugg GJ, Siddiqui F, Thornton JG. Oxytocin versus no treatment or delayed treatment for slow progress in the first stage of spontaneous labour. Cochrane Database Syst Rev. 2013;(6):CD007123.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intravenous oxytocin	No treatment	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/45 (0%)	0/42 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL

[1] One study with design limitations.
[2] No events.

Table 15a. Early versus delayed use of oxytocin for treatment of slow progress in the first stage of labour (maternal outcomes)

Source: Bugg GJ, Siddiqui F, Thornton JG. Oxytocin versus no treatment or delayed treatment for slow progress in the first stage of spontaneous labour. Cochrane Database Syst Rev. 2013;(6):CD007123.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early use of intravenous oxytocin	Delayed use of intravenous oxytocin	Relative (95% CI)	Absolute		
Uterine hyperstimulation with fetal heart rate changes necessitating intervention												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	17/248 (6.9%)	6/224 (2.7%)	RR 2.51 (1.04 to 6.05)	40 more per 1000 (from 1 more to 135 more)	⊕⊕○○ LOW	CRITICAL
Postpartum haemorrhage												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	54/549 (9.8%)	65/550 (11.8%)	RR 0.83 (0.59 to 1.15)	20 fewer per 1000 (from 48 fewer to 18 more)	⊕⊕○○ LOW	CRITICAL
Emergency caesarean section for fetal distress												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	20/437 (4.6%)	19/472 (4%)	RR 1.08 (0.59 to 2)	3 more per 1000 (from 17 fewer to 40 more)	⊕⊕○○ LOW	CRITICAL
Caesarean section												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	74/610 (12.1%)	76/590 (12.9%)	RR 0.88 (0.66 to 1.19)	15 fewer per 1000 (from 44 fewer to 24 more)	⊕⊕○○ LOW	IMPORTANT
Normal vaginal birth												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	388/583 (66.6%)	375/560 (67%)	RR 1.02 (0.88 to 1.19)	13 more per 1000 (from 80 fewer to 127 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Epidural analgesia												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	343/543 (63.2%)	373/540 (69.1%)	RR 0.9 (0.76 to 1.06)	69 fewer per 1000 (from 166 fewer to 41 more)	⊕⊕⊕○ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early use of intravenous oxytocin	Delayed use of intravenous oxytocin	Relative (95% CI)	Absolute		
Instrumental vaginal delivery												
5	randomized trials	serious[1]	serious[4]	no serious indirectness	serious[3]	none	132/610 (21.6%)	115/590 (19.5%)	RR 1.17 (0.72 to 1.88)	33 more per 1000 (from 55 fewer to 172 more)	⊕○○○ VERY LOW	IMPORTANT
Uterine hyperstimulation without fetal heart rate changes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	6/40 (15%)	0/20 (0%)	RR 6.66 (0.39 to 112.6)	-	⊕○○○ VERY LOW	IMPORTANT
Woman not satisfied (better indicated by lower values)												
1	randomized trials	serious[6]	no serious inconsistency	no serious indirectness	serious[3]	none	145	136	-	MD 3 higher (3.33 lower to 9.33 higher)	⊕⊕○○ LOW	IMPORTANT
Woman not satisfied (number of women with negative memories of childbirth)												
1	randomized trials	serious[6]	no serious inconsistency	no serious indirectness	serious[3]	none	100/233 (42.9%)	86/209 (41.1%)	RR 1.04 (0.84 to 1.3)	16 more per 1000 (from 66 fewer to 123 more)	⊕⊕○○ LOW	IMPORTANT
Woman not satisfied (number of women saying depressed by childbirth experience)												
1	randomized trials	serious[6]	no serious inconsistency	no serious indirectness	serious[3]	none	72/233 (30.9%)	69/209 (33%)	RR 0.94 (0.71 to 1.23)	20 fewer per 1000 (from 96 fewer to 76 more)	⊕⊕○○ LOW	IMPORTANT
Time from randomization to delivery (hours) (better indicated by lower values)												
3	randomized trials	serious[1]	serious[7]	no serious indirectness	no serious imprecision	none	543	540	-	MD 2.2 lower (3.29 to 1.1 lower)	⊕⊕○○ LOW	CRITICAL

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early use of intravenous oxytocin	Delayed use of intravenous oxytocin	Relative (95% CI)	Absolute		
Women undelivered after 12 hours from randomization												
2	randomized trials	serious[1]	serious[8]	no serious indirectness	serious[3]	none	100/522 (19.2%)	207/520 (39.8%)	RR 0.32 (0.07 to 1.43)	271 fewer per 1000 (from 370 fewer to 171 more)	⊕◯◯◯ VERY LOW	CRITICAL

[1] Most studies contributing data had design limitations.
[2] Few events.
[3] Wide confidence interval crossing the line of no effect.
[4] Statistical heterogeneity (I^2 = 68%).
[5] Wide confidence interval crossing the line of no effect and few events.
[6] One study with design limitations.
[7] Statistical heterogeneity (I^2 = 80%). Considerable variation in size of effect.
[8] Statistical heterogeneity (I^2 = 95%). Considerable variation in size of effect.

Table 15b. Early versus delayed use of oxytocin for treatment of slow progress in the first stage of labour (infant outcomes)

Source: Bugg GJ, Siddiqui F, Thornton JG. Oxytocin versus no treatment or delayed treatment for slow progress in the first stage of spontaneous labour. Cochrane Database Syst Rev. 2013;(6):CD007123.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early use of intravenous oxytocin	Delayed use of intravenous oxytocin	Relative (95% CI)	Absolute		
Serious neonatal morbidity or perinatal death												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/235 (0.4%)	1/234 (0.4%)	RR 0.98 (0.06 to 15.57)	0 fewer per 1000 (from 4 fewer to 62 more)	⊕○○○ VERY LOW	CRITICAL
Apgar score < 7 at 5 minutes												
5	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12/610 (2%)	11/590 (1.9%)	RR 1.02 (0.46 to 2.28)	0 more per 1000 (from 10 fewer to 24 more)	⊕○○○ VERY LOW	CRITICAL
Admission to neonatal intensive care unit												
4	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	33/570 (5.8%)	35/570 (6.1%)	RR 0.95 (0.6 to 1.5)	3 fewer per 1000 (from 25 fewer to 31 more)	⊕⊕○○ LOW	IMPORTANT

[1] Most studies contributing data had design limitations.

[2] Wide confidence interval crossing the line of no effect and few events.

[3] Wide confidence interval crossing the line of no effect.

Table 16a. High versus low oxytocin dosage regimen for labour augmentation (maternal outcomes)

Source: Kenyon S, Tokumasu H, Dowswell T, Pledge D, Mori R. High-dose versus low-dose oxytocin for augmentation of delayed labour. Cochrane Database Syst Rev. 2013;(7):CD007201.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	High dose of oxytocin	Low dose of oxytocin	Relative (95% CI)	Absolute		
Duration of labour (hours from administration of oxytocin to delivery) (better indicated by lower values)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	19	21	-	MD 3.5 lower (6.38 to 0.62 lower)	⊕⊕○○ LOW	CRITICAL
Duration of labour (minutes from onset of first stage to delivery) (better indicated by lower values)												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[3]	none	46	46	-	MD 26 lower (128.06 lower to 76.06 higher)	⊕⊕⊕○ MODERATE	CRITICAL
Postpartum haemorrhage												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	21/47 (44.7%)	22/47 (46.8%)	RR 0.95 (0.61 to 1.48)	23 fewer per 1000 (from 183 fewer to 225 more)	⊕⊕○○ LOW	CRITICAL
Caesarean section – all women												
4	randomized trials	very serious[4]	serious[5]	no serious indirectness	no serious imprecision	none	43/320 (13.4%)	71/324 (21.9%)	RR 0.62 (0.44 to 0.86)	83 fewer per 1000 (from 31 fewer to 123 fewer)	⊕○○○ VERY LOW	IMPORTANT
								28.8%		109 fewer per 1000 (from 40 fewer to 161 fewer)		
Caesarean section – nulliparous women												
3	randomized trials	very serious[4]	serious[6]	no serious indirectness	serious[7]	none	30/138 (21.7%)	48/162 (29.6%)	RR 0.71 (0.47 to 1.06)	86 fewer per 1000 (from 157 fewer to 18 more)	⊕○○○ VERY LOW	IMPORTANT
Caesarean section – multiparous women												
1	randomized trials	very serious[8]	no serious inconsistency	no serious indirectness	no serious imprecision	none	8/82 (9.8%)	14/62 (22.6%)	RR 0.43 (0.19 to 0.97)	129 fewer per 1000 (from 7 fewer to 183 fewer)	⊕⊕○○ LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	High dose of oxytocin	Low dose of oxytocin	Relative (95% CI)	Absolute		
Hyperstimulation												
4	randomized trials	serious[9]	no serious inconsistency	no serious indirectness	serious[10]	none	34/320 (10.6%)	21/324 (6.5%)	RR 1.63 (0.97 to 2.72)	41 more per 1000 (from 2 fewer to 111 more)	⊕⊕○○ LOW	IMPORTANT
Spontaneous vaginal birth												
3	randomized trials	very serious[4]	no serious inconsistency	no serious indirectness	no serious imprecision	none	128/220 (58.2%)	96/224 (42.9%)	RR 1.35 (1.13 to 1.62)	150 more per 1000 (from 56 more to 266 more)	⊕⊕○○ LOW	IMPORTANT
								23.8%		83 more per 1000 (from 31 more to 148 more)		
Diagnosis of chorioamnionitis												
2	randomized trials	very serious[4]	no serious inconsistency	no serious indirectness	serious[10]	none	25/201 (12.4%)	36/203 (17.7%)	RR 0.7 (0.44 to 1.12)	53 fewer per 1000 (from 99 fewer to 21 more)	⊕○○○ VERY LOW	IMPORTANT
								12.3%		37 fewer per 1000 (from 69 fewer to 15 more)		
Epidural analgesia												
2	randomized trials	very serious[4]	no serious inconsistency	no serious indirectness	no serious imprecision	none	138/201 (68.7%)	142/203 (70%)	RR 0.98 (0.86 to 1.12)	14 fewer per 1000 (from 98 fewer to 84 more)	⊕⊕○○ LOW	IMPORTANT
Instrumental vaginal birth												
3	randomized trials	very serious[4]	no serious inconsistency	no serious indirectness	serious[10]	none	53/220 (24.1%)	65/224 (29%)	RR 0.83 (0.61 to 1.13)	49 fewer per 1000 (from 113 fewer to 38 more)	⊕○○○ VERY LOW	IMPORTANT
								42.9%		73 fewer per 1000 (from 167 fewer to 56 more)		
Pathological cardiotocography leading to immediate birth without fetal blood sampling												
1	randomized trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	9/47 (19.1%)	15/47 (31.9%)	RR 0.6 (0.29 to 1.23)	128 fewer per 1000 (from 227 fewer to 73 more)	⊕⊕○○ LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	High dose of oxytocin	Low dose of oxytocin	Relative (95% CI)	Absolute		
Caesarean section – all women (sensitivity analysis: study at high risk of bias excluded)												
3	randomized trials	serious[9]	no serious inconsistency	no serious indirectness	serious[10]	none	27/166 (16.3%)	31/168 (18.5%)	RR 0.89 (0.57 to 1.38)	20 fewer per 1000 (from 79 fewer to 70 more)	⊕⊕◯◯ LOW	IMPORTANT
								31.9%		35 fewer per 1000 (from 137 fewer to 121 more)		

[1] One study with design limitations.
[2] Small sample size.
[3] Wide confidence interval crossing the line of no effect and small sample size.
[4] Most of the pooled effect was provided by studies with serious design limitations.
[5] Statistical heterogeneity (I^2 = 58%). Considerable variation in size of effect.
[6] Statistical heterogeneity (I^2 = 60%). Considerable variation in size of effect.
[7] Wide confidence interval crossing the line of no effect and fails to exclude appreciable benefit.
[8] One study with serious design limitations.
[9] Most studies contributing data had design limitations.
[10] Wide confidence interval crossing the line of no effect.

Table 16b. High versus low oxytocin dosage regimen for labour augmentation (infant outcomes)

Source: Kenyon S, Tokumasu H, Dowswell T, Pledge D, Mori R. High-dose versus low-dose oxytocin for augmentation of delayed labour. Cochrane Database Syst Rev. 2013;(7):CD007201.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	High dose of oxytocin	Low dose of oxytocin	Relative (95% CI)	Absolute		
Neonatal mortality												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/301 (0%)	0/303 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Apgar score < 7 at 5 minutes												
3	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/220 (0%)	1/224 (0.4%)	RR 0.37 (0.02 to 8.5)	3 fewer per 1000 (from 4 fewer to 33 more)	⊕○○○ VERY LOW	CRITICAL
Umbilical cord (artery) pH (better indicated by lower values)												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	66	68	-	MD 0 higher (0.03 lower to 0.03 higher)	⊕⊕○○ LOW	CRITICAL
Neonatal admission to special care baby units												
2	randomized trials	very serious[5]	serious[6]	no serious indirectness	very serious[3]	none	8/201 (4%)	16/203 (7.9%)	RR 0.5 (0.22 to 1.15)	39 fewer per 1000 (from 61 fewer to 12 more)	⊕○○○ VERY LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] No events.
[3] Wide confidence interval crossing the line of no effect and few events.
[4] Small sample size.
[5] Most of the pooled effect was provided by studies with serious design limitations.
[6] Statistical heterogeneity (I^2 = 56%). Size of effect very different in the two studies contributing data.

Table 17a. Oral misoprostol for augmenting labour (maternal outcomes)

Source: Vogel JP, West HM, Dowswell T. Titrated oral misoprostol for augmenting labour to improve maternal and neonatal outcomes. Cochrane Database Syst Rev. 2013;(9):CD010648.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Titrated misoprostol (20mcg dose)	Intravenous oxytocin	Relative (95% CI)	Absolute		
Vaginal birth within 24 hours of commencement of augmentation												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	106/118 (89.8%)	100/113 (88.5%)	RR 1.02 (0.93 to 1.11)	18 more per 1000 (from 62 fewer to 97 more)	⊕⊕○○ LOW	CRITICAL
Caesarean section												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	12/118 (10.2%)	13/113 (11.5%)	RR 0.88 (0.42 to 1.85)	14 fewer per 1000 (from 67 fewer to 98 more)	⊕○○○ VERY LOW	IMPORTANT
Uterine hyperstimulation with fetal heart rate changes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	2/118 (1.7%)	2/113 (1.8%)	RR 0.96 (0.14 to 6.68)	1 fewer per 1000 (from 15 fewer to 101 more)	⊕○○○ VERY LOW	IMPORTANT
Hypertonus												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	0/118 (0%)	0/113 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	IMPORTANT
Tachysystole												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	7/118 (5.9%)	17/113 (15%)	RR 0.39 (0.17 to 0.91)	92 fewer per 1000 (from 14 fewer to 125 fewer)	⊕⊕○○ LOW	IMPORTANT
Vaginal birth within 12 hours of commencement of augmentation												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	92/118 (78%)	97/113 (85.8%)	RR 0.91 (0.8 to 1.03)	77 fewer per 1000 (from 172 fewer to 26 more)	⊕⊕○○ LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Titrated misoprostol (20mcg dose)	Intravenous oxytocin	Relative (95% CI)	Absolute		
Rate of failure to progress												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	10/118 (8.5%)	12/113 (10.6%)	RR 0.8 (0.36 to 1.77)	21 fewer per 1000 (from 68 fewer to 82 more)	⊕○○○ VERY LOW	IMPORTANT

[1] One study with design limitations.
[2] Estimate based on small sample.
[3] Wide confidence interval crossing the line of no effect, few events and small sample size.
[4] No events.

Table 17b. Oral misoprostol for augmenting labour (infant outcomes)

Source: Vogel JP, West HM, Dowswell T. Titrated oral misoprostol for augmenting labour to improve maternal and neonatal outcomes. Cochrane Database Syst Rev. 2013;(9):CD010648.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Titrated misoprostol (20mcg dose)	Intravenous oxytocin	Relative (95% CI)	Absolute		
Apgar score < 7 at 5 minutes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/118 (0%)	0/113 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Admission to neonatal intensive care unit												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	5/118 (4.2%)	2/113 (1.8%)	RR 2.39 (0.47 to 12.09)	25 more per 1000 (from 9 fewer to 196 more)	⊕○○○ VERY LOW	IMPORTANT

[1] One study with design limitations.
[2] No events.
[3] Wide confidence interval crossing the line of no effect, few events and small sample size.

Table 17c. Oral misoprostol for augmenting labour (maternal outcomes)

Source: Vogel JP, West HM, Dowswell T. Titrated oral misoprostol for augmenting labour to improve maternal and neonatal outcomes. Cochrane Database Syst Rev. 2013;(9):CD010648..

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Titrated misoprostol (75mcg dose)	Intravenous oxytocin	Relative (95% CI)	Absolute		
Caesarean for non-reassuring fetal heart rate (i.e. fetal distress)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	8/176 (4.5%)	5/174 (2.9%)	RR 1.58 (0.53 to 4.74)	17 more per 1000 (from 14 fewer to 107 more)	⊕○○○ VERY LOW	CRITICAL
Caesarean section												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	19/176 (10.8%)	18/174 (10.3%)	RR 1.04 (0.57 to 1.92)	4 more per 1000 (from 44 fewer to 95 more)	⊕⊕○○ LOW	IMPORTANT
Uterine hyperstimulation (tachysystole, hypertonus or both) associated with fetal heart changes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	51/176 (29%)	40/174 (23%)	RR 1.26 (0.88 to 1.8)	60 more per 1000 (from 28 fewer to 184 more)	⊕⊕○○ LOW	IMPORTANT
Caesarean section for dystocia (i.e. prolonged labour)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	11/176 (6.3%)	13/174 (7.5%)	RR 0.84 (0.39 to 1.82)	12 fewer per 1000 (from 46 fewer to 61 more)	⊕○○○ VERY LOW	IMPORTANT
Chorioamnionitis												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	28/176 (15.9%)	32/174 (18.4%)	RR 0.87 (0.55 to 1.37)	24 fewer per 1000 (from 83 fewer to 68 more)	⊕⊕○○ LOW	IMPORTANT
Spontaneous vaginal birth												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	153/176 (86.9%)	154/174 (88.5%)	RR 0.98 (0.91 to 1.06)	18 fewer per 1000 (from 80 fewer to 53 more)	⊕⊕⊕○ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Titrated misoprostol (75mcg dose)	Intravenous oxytocin	Relative (95% CI)	Absolute		
Epidural analgesia												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	141/176 (80.1%)	152/174 (87.4%)	RR 0.92 (0.84 to 1.01)	70 fewer per 1000 (from 140 fewer to 9 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Forceps delivery												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	4/176 (2.3%)	2/174 (1.1%)	RR 1.98 (0.37 to 10.66)	11 more per 1000 (from 7 fewer to 111 more)	⊕○○○ VERY LOW	IMPORTANT
Maternal blood transfusion for hypovolemia												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	6/176 (3.4%)	2/174 (1.1%)	RR 2.97 (0.61 to 14.49)	23 more per 1000 (from 4 fewer to 155 more)	⊕○○○ VERY LOW	IMPORTANT
Uterine tachysystole, hypertonus, or both in a 10-minute period (hyperstimulation of labour)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	133/176 (75.6%)	112/174 (64.4%)	RR 1.17 (1.02 to 1.35)	109 more per 1000 (from 13 more to 225 more)	⊕⊕⊕○ MODERATE	IMPORTANT
Uterine tachysystole in a 20-minute interval												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	50/176 (28.4%)	41/174 (23.6%)	RR 1.21 (0.84 to 1.72)	49 more per 1000 (from 38 fewer to 170 more)	⊕⊕○○ LOW	IMPORTANT

[1] One study with design limitations.
[2] Wide confidence interval crossing the line of no effect and few events.
[3] Wide confidence interval crossing the line of no effect.

Table 17d. Oral misoprostol for augmenting labour (infant outcomes)

Source: Vogel JP, West HM, Dowswell T. Titrated oral misoprostol for augmenting labour to improve maternal and neonatal outcomes. Cochrane Database Syst Rev. 2013;(9):CD010648.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Titrated misoprostol (75mcg dose)	Intravenous oxytocin	Relative (95% CI)	Absolute		
Apgar score < 4 at 5 minutes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/176 (0%)	0/174 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Umbilical cord artery pH < 7.1												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	3/176 (1.7%)	4/174 (2.3%)	RR 0.74 (0.17 to 3.26)	6 fewer per 1000 (from 19 fewer to 52 more)	⊕○○○ VERY LOW	CRITICAL
Admission to neonatal intensive care unit												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/176 (0.6%)	0/174 (0%)	RR 2.97 (0.12 to 72.31)	-	⊕○○○ VERY LOW	IMPORTANT

[1] One study with design limitations.
[2] No events.
[3] Wide confidence interval crossing the line of no effect and few events.

Table 18a. The use of routine amniotomy alone for treatment of delay in the first stage of labour (maternal outcomes)

Source: Smyth RMD, Markham C, Dowswell T. Amniotomy for shortening spontaneous labour. Cochrane Database Syst. Rev. 2013;(6):CD006167.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy	No amniotomy	Relative (95% CI)	Absolute		
Maternal mortality												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/20 (0%)	0/19 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Caesarean section												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	2/20 (10%)	2/19 (10.5%)	RR 0.95 (0.15 to 6.08)	5 fewer per 1000 (from 89 fewer to 535 more)	⊕○○○ VERY LOW	IMPORTANT
Instrumental vaginal birth												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	4/20 (20%)	3/19 (15.8%)	RR 1.27 (0.33 to 4.93)	43 more per 1000 (from 106 fewer to 621 more)	⊕○○○ VERY LOW	IMPORTANT
Caesarean section for fetal distress												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/20 (5%)	0/19 (0%)	RR 2.86 (0.12 to 66.11)	-	⊕○○○ VERY LOW	CRITICAL
Caesarean section for prolonged labour												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/20 (5%)	2/19 (10.5%)	RR 0.47 (0.05 to 4.82)	56 fewer per 1000 (from 100 fewer to 402 more)	⊕○○○ VERY LOW	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Amniotomy	No amniotomy	Relative (95% CI)	Absolute		
Use of pain relief – epidural/narcotic												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	14/20 (70%)	9/19 (47.4%)	RR 1.48 (0.85 to 2.57)	227 more per 1000 (from 71 fewer to 744 more)	⊕○○○ VERY LOW	IMPORTANT
Oxytocin augmentation												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	11/20 (55%)	12/19 (63.2%)	RR 0.87 (0.52 to 1.47)	82 fewer per 1000 (from 303 fewer to 297 more)	⊕○○○ VERY LOW	IMPORTANT

[1] One study with design limitations.
[2] No events.
[3] Wide confidence interval crossing the line of no effect, few events and small sample size.

Table 18b. The use of routine amniotomy alone for treatment of delay in the first stage of labour (infant outcomes)

Source: Smyth RMD, Markham C, Dowswell T. Amniotomy for shortening spontaneous labour. Cochrane Database Syst Rev. 2013;(6):CD006167.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Amniotomy**	**No amniotomy**	**Relative (95% CI)**	**Absolute**		
Apgar score < 7 at 5 minutes												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	1/20 (5%)	0/19 (0%)	RR 2.86 (0.12 to 66.11)	-	⊕○○○ VERY LOW	CRITICAL
Admission to special care baby unit/neonatal intensive care unit												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/20 (0%)	0/19 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	IMPORTANT

[1] One study with design limitations.

[2] Wide confidence interval crossing the line of no effect, few events and small sample size.

[3] No events.

Table 19a. Amniotomy and oxytocin for treatment of delay in the first stage of labour (maternal outcomes)

Source: Wei S, Wo BL, Qi HP, Xu H, Luo ZC, Roy C, Fraser WD. Early amniotomy and early oxytocin for prevention of, or therapy for, delay in first stage spontaneous labour compared with routine care. Cochrane Database Syst Rev. 2013(8):CD006794.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early amniotomy and early oxytocin	Routine care	Relative (95% CI)	Absolute		
Postpartum haemorrhage (blood loss > 500 ml)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	3/71 (4.2%)	0/70 (0%)	RR 6.9 (0.36 to 131.23)	-	⊕○○○ VERY LOW	CRITICAL
Duration of first stage of labour (hours) (better indicated by lower values)												
2	randomized trials	serious[3]	serious[4]	no serious indirectness	very serious[5]	none	121	119	-	MD 1.58 lower (4.27 lower to 1.1 higher)	⊕○○○ VERY LOW	CRITICAL
Caesarean section rate												
3	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[2]	none	17/142 (12%)	11/138 (8%)	RR 1.47 (0.73 to 2.96)	37 more per 1000 (from 22 fewer to 156 more)	⊕○○○ VERY LOW	IMPORTANT
Spontaneous vaginal birth												
3	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	serious[6]	none	104/142 (73.2%)	107/140 (76.4%)	RR 0.96 (0.85 to 1.08)	31 fewer per 1000 (from 115 fewer to 61 more)	⊕⊕○○ LOW	IMPORTANT
Duration of labour (hours from admission in labour) (better indicated by lower values)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	none	71	70	-	MD 3.1 lower (4.63 to 1.57 lower)	⊕⊕○○ LOW	CRITICAL

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early amniotomy and early oxytocin	Routine care	Relative (95% CI)	Absolute		
Postpartum fever or infection												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	5/50 (10%)	3/49 (6.1%)	RR 1.63 (0.41 to 6.47)	39 more per 1000 (from 36 fewer to 335 more)	⊕○○○ VERY LOW	IMPORTANT
Satisfied with labour experience												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	42/88 (47.7%)	44/94 (46.8%)	RR 1.02 (0.75 to 1.39)	9 more per 1000 (from 117 fewer to 183 more)	⊕⊕○○ LOW	IMPORTANT

[1] One study with design limitations.
[2] Wide confidence interval crossing the line of no effect and few events.
[3] Most of the pooled effect was provided by studies with design limitations.
[4] Statistical heterogeneity (I^2 > 60%). Direction of effect consistent but size of effect variable.
[5] Wide confidence interval crossing the line of no effect.
[6] Small sample size.
[7] Single study contributing data, with wide confidence interval.

Table 19b. Amniotomy and oxytocin for treatment of delay in the first stage of labour (infant outcomes)

Source: Wei S, Wo BL, Qi HP, Xu H, Luo ZC, Roy C, Fraser WD. Early amniotomy and early oxytocin for prevention of, or therapy for, delay in first stage spontaneous labour compared with routine care. Cochrane Database Syst Rev. 2013;(8):CD006794.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early amniotomy and early oxytocin	Routine care	Relative (95% CI)	Absolute		
Admission to special care nursery												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/50 (0%)	6/49 (12.2%)	RR 0.08 (0 to 1.3)	113 fewer per 1000 (from 122 fewer to 37 more)	⊕○○○ VERY LOW	IMPORTANT
Apgar score < 7 at 5 minutes												
1	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[4]	none	1/21 (4.8%)	0/19 (0%)	RR 2.73 (0.12 to 63.19)	-	⊕○○○ VERY LOW	CRITICAL

[1] Most studies contributing data had design limitations.
[2] Wide confidence interval crossing the line of no effect, small sample size and failed to exclude appreciable benefit.
[3] One study with design limitations.
[4] Wide confidence interval crossing the line of no effect, few events and failed to exclude appreciable harm or benefit.

Table 20a. Internal versus external tocodynamometry in augmented labour (maternal outcomes)

Source: Bakker JJH, Janssen PF, van Halem K, van der Goes BY, Papatsonis DNM, van der Post JAM, Mol BWJ. Internal versus external tocodynamometry during induced or augmented labour. Cochrane Database Syst Rev. 2013;(8):CD006947.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Internal tocodynamometry	External tocodynamometry	Relative (95% CI)	Absolute		
Mean time to delivery (vaginal deliveries) (better indicated by lower values)												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	252	248	-	MD 3.47 lower (42.84 lower to 35.9 higher)	⊕⊕◯◯ LOW	CRITICAL
Serious maternal outcomes (defined as death, coma, cardiac arrest, respiratory arrest, use of a mechanical ventilator, admission to intensive care unit)												
2	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[4]	none	0/377 (0%)	0/373 (0%)	not pooled	not pooled	⊕◯◯◯ VERY LOW	CRITICAL
Uterine rupture												
2	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	very serious[4]	none	0/377 (0%)	0/373 (0%)	not pooled	not pooled	⊕◯◯◯ VERY LOW	CRITICAL
Caesarean section												
2	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	serious[2]	none	72/377 (19.1%)	57/373 (15.3%)	RR 1.25 (0.91 to 1.71)	38 more per 1000 (from 14 fewer to 108 more)	⊕⊕◯◯ LOW	IMPORTANT
Hyperstimulation												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	25/125 (20%)	24/125 (19.2%)	RR 1.04 (0.63 to 1.72)	8 more per 1000 (from 71 fewer to 138 more)	⊕◯◯◯ VERY LOW	IMPORTANT
Instrumental delivery (caesarean section + vaginal instrumental delivery)												
2	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	143/377 (37.9%)	113/373 (30.3%)	RR 1.25 (1.02 to 1.53)	76 more per 1000 (from 6 more to 161 more)	⊕⊕⊕◯ MODERATE	IMPORTANT

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Internal tocodynamometry	External tocodynamometry	Relative (95% CI)	Absolute		
Instrumental vaginal delivery												
2	randomized trials	serious[3]	no serious inconsistency	no serious indirectness	serious[2]	none	71/377 (18.8%)	56/373 (15%)	RR 1.25 (0.91 to 1.73)	38 more per 1000 (from 14 fewer to 110 more)	⊕⊕◯◯ LOW	IMPORTANT
Signs intrauterine infection during labour requiring antibiotic therapy												
1	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	10/252 (4%)	18/248 (7.3%)	RR 0.55 (0.26 to 1.16)	33 fewer per 1000 (from 54 fewer to 12 more)	⊕◯◯◯ VERY LOW	IMPORTANT

[1] One study with design limitations.
[2] Wide confidence interval crossing the line of no effect.
[3] Most studies contributing data had design limitations.
[4] No events.
[5] Wide confidence interval crossing the line of no effect and small sample size.
[6] Wide confidence interval crossing the line of no effect and few events.

Table 20b. Internal versus external tocodynamometry in augmented labour (infant outcomes)

Source: Bakker JJH, Janssen PF, van Halem K, van der Goes BY, Papatsonis DNM, van der Post JAM, Mol BWJ. Internal versus external tocodynamometry during induced or augmented labour. Cochrane Database Syst Rev. 2013;(8):CD006947.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Internal tocodynamometry	External tocodynamometry	Relative (95% CI)	Absolute		
Perinatal mortality												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/377 (0%)	0/373 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Apgar score < 7 at 5 minutes												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	8/377 (2.1%)	7/372 (1.9%)	RR 1.12 (0.41 to 3.06)	2 more per 1000 (from 11 fewer to 39 more)	⊕○○○ VERY LOW	CRITICAL
Placental or fetal vessel damage												
2	randomized trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	0/377 (0%)	0/373 (0%)	not pooled	not pooled	⊕○○○ VERY LOW	CRITICAL
Umbilical artery pH < 7.05												
1	randomized trials	serious[4]	no serious inconsistency	no serious indirectness	very serious[3]	none	7/174 (4%)	6/169 (3.6%)	RR 1.13 (0.39 to 3.3)	5 more per 1000 (from 22 fewer to 82 more)	⊕○○○ VERY LOW	CRITICAL
Umbilical artery pH < 7.15												
1	randomized trials	serious[4]	no serious inconsistency	no serious indirectness	serious[5]	none	38/174 (21.8%)	27/170 (15.9%)	RR 1.38 (0.88 to 2.15)	60 more per 1000 (from 19 fewer to 183 more)	⊕⊕○○ LOW	CRITICAL

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Internal tocodynamometry	External tocodynamometry	Relative (95% CI)	Absolute		
Neonatal admission > 48 hours												
1	randomized trials	serious[4]	no serious inconsistency	no serious indirectness	very serious[3]	none	26/252 (10.3%)	31/248 (12.5%)	RR 0.83 (0.51 to 1.35)	21 fewer per 1000 (from 61 fewer to 44 more)	⊕○○○ VERY LOW	IMPORTANT
Admission to neonatal intensive care unit												
1	randomized trials	serious[4]	no serious inconsistency	no serious indirectness	serious[5]	none	1/125 (0.8%)	1/125 (0.8%)	RR 1 (0.06 to 15.81)	0 fewer per 1000 (from 8 fewer to 118 more)	⊕⊕○○ LOW	IMPORTANT

[1] Most studies contributing data had design limitations.
[2] No events.
[3] Wide confidence interval crossing the line of no effect and few events.
[4] One study with design limitations.
[5] Wide confidence interval crossing the line of no effect.