INTRODUCTION

Induction of labor is indicated in a number of clinical settings. Most modalities for the induction of labor are minimally effective when the cervix is unfavorable ***(Mackenzie, 1988).*** The use of agents to ripen the cervix prior to conventional methods of induction is now standard practice ***(Morgulies et al., 1992).***

Prostaglandins have been used extensively for the induction of labor ***(Bernstein et al., 1987; Shaala et al., 1989 ;Norchi et al., 1993 and Trofatter, 1993).*** They could be administered intravaginally, and intracervically with no increase in hyperstimulation or maternal side effects ***(Ekman et al.,1983).***

Recently, Misoprostol has been studied for the induction of labor. Misoprostol, an orally active prostaglandins E_1 (Methyl – 11 α - dihydroxy – 16 – methyl – 9 - oxoprost – 13E – en – 1- oate) used in peptic ulcer, and recently used vaginally to ripen the cervix and induce labor without any adverse outcome ***(Morgulies et al., 1992).***

Misoprostol is inexpensive and is stable at room temperature, and so does not require refrigerator, a factor which may be of considerable importance in conditions where no such facilities exists ***(Fletcher et al., 1993).***

Fletcher et al. (1994) found that Misoprostol was more effective for inducing labor and the need for oxytocin was significantly less with its use.

Sanchez – Ramos et al. (1993) used Misoprostol intravaginally. They found that interval from induction to vaginal delivery to be much shorter in the Misoprostol group.