Interobserver and Intraobserver Agreement of Antenatal Cardiotocography Assessments by Maternity Care Professionals: A Prospective Study.

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Abstract

Objective In the Netherlands, antenatal cardiotocography (aCTG) is performed in obstetrician-led care to assess fetal well-being. An innovation project was initiated to evaluate whether aCTG is feasible in non-obstetrician-led care settings. Healthy women received aCTG in midwife-led care if indicated for specific indications. Quality assessment is essential when shifting tasks and responsibilities. Therefore, we aimed to assess the interobserver and intraobserver agreement for aCTG assessments among four professional groups regarding the overall classification and the assessment of the various components of the CTG. Design Prospective study. Sample 47 Dutch primary care midwives, hospital-based midwives, residents, and obstetricians. Methods Ten aCTG traces were assessed twice at a one month interval on baseline heart frequency, accelerations, decelerations, variability and contractions, and overall classification. We used two sets of ten aCTG traces to ensure sufficient variation. Main Outcome Measure Proportion of agreement. Results The proportions of agreement for interobserver agreement on classification of aCTG among the professional groups varied from 0.82 to 0.94, indicating excellent agreement. The proportions of agreement for primary care midwives, hospital-based midwives and obstetricians were slightly higher for intraobserver (0.86 to 0.94) than for interobserver agreement. For various CTG components, the proportions of agreement for interobserver agreement varied from 0.64 (presence of contractions) to 0.98 (baseline heart frequency), indicating good to excellent agreement. Conclusion Excellent agreement for the overall classification and good to excellent agreement for the various components were found in the assessments of aCTG in healthy women, both between and within the different professional groups.

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Short Title Observer agreement in assessing antenatal CTGs.

Abstract

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Funding Source National Agency for Practice-Oriented Research (SIA), part of NWO.

Keywords Antenatal cardiotocography Low-risk pregnancy Interobserver agreement Intraobserver agreement Midwife-led care

Tweetable Abstract The proportion of agreement between professionals in midwife-led and obstetrician-led care in assessing antenatal cardiotocography is excellent for CTG classification and good to excellent for its various components.

Introduction Value-Based Health care (VBHC) has gained considerable momentum at international and national level. It aims to organize care based on the principle of the best possible quality of care for patients with optimal use of resources. This also holds for maternity care. Recently, three regions in the Netherlands (Nijmegen, Zwolle, and Amsterdam) initiated an innovation project according to VBHC principles. Healthy pregnant women receiving care in midwife-led practices were offered antenatal cardiotocography (aCTG) in midwife-led care, autonomously performed and assessed by a primary care midwife for specific indications (i.e. reduced fetal movements, external cephalic version, or postdates pregnancy (41+0 – 41+6 weeks gestation) to assess fetal well-being. Normally, CTGs are performed in obstetrician-led care. Within the VBHC initiative, pregnant women fulfilling the above criteria were offered aCTG by their midwife, either at home, in the midwifery practice, or at a community health care centre nearby. This task shift increases value for pregnant women, as it led to a reduction of referrals and an increase in the continuity of maternity care. There is growing evidence that task shifting to midwife-led care can be safe and effective, but this has not been established for antenatal CTG. Assessment of antenatal CTGs between
groups of health care professionals in obstetrician-led care varies.\textsuperscript{7-12} Although the interobserver agreement in the assessment of reassuring antenatal CTGs is fair to good,\textsuperscript{11} low interobserver agreement was found for non-reassuring antenatal CTGs.\textsuperscript{9, 11} There is also variation in the assessment of the various CTG components: baseline heart frequency, accelerations, and contractions showed good to excellent interobserver agreement in antenatal CTG assessment while other CTG components such as variability and the number of decelerations did not.\textsuperscript{7-9, 12} Baseline, variability, accelerations, and decelerations components all showed higher levels of intraobserver agreement than interobserver agreement.\textsuperscript{10} To date, little is known with regard to the interobserver and intraobserver agreement in antenatal CTG assessment by different groups of maternity care professionals (primary care midwives, hospital-based midwives, residents, and obstetricians). Regarding the overall classification and the various components of antenatal CTG, the aim of this study was therefore to assess: 1) the level of interobserver agreement between the four professional groups; 2) the level of interobserver agreement within these professional groups, and 3) the level of intraobserver agreement per professional group.

**Methods**

**Study Design**

We conducted a prospective study among four professional groups involved in Dutch maternity care: primary care midwives, hospital-based midwives, residents, and obstetricians who were purposively selected from different parts of the country. **Dutch Maternity Care System** In the Netherlands, pregnant women at low risk receive midwife-led care from independent primary care midwives in the community, while those at high risk receive obstetrician-led care from obstetricians, obstetrics and gynaecology residents, and hospital-based midwives.\textsuperscript{13} When a risk factor or a complication arises during pregnancy or childbirth, the midwife refers the woman to obstetrician-led care for consultation or transfer of care. **Participants** All care professionals received CTG assessment skills during their initial training and are legally authorized to perform CTGs. To acquire competence in performing an antenatal CTG, the primary care midwives who participated in this project followed an obligatory two-day course concluded with an examination. The course consisted of the theoretical background of the CTG, the assessment of a CTG according to the FIGO guidelines, skills needed to carry out a CTG, and training in clinical decision-making taking into account the woman’s overall well-being.\textsuperscript{5} To maintain competence, primary care midwives attended at least four multidisciplinary quality meetings annually organized with an obstetrician in each region about interpreting and evaluating antenatal CTGs. The hospital-based midwives, residents, and obstetricians taking part were already performing CTG monitoring daily in clinical settings and were therefore not obligated to follow a course and attend quality meetings.

**Study Procedure** The participants were recruited by email. After consenting to participate, they received an online set of ten antenatal CTGs with additional information about the indication for the antenatal CTG, the woman’s pregnancy details and relevant medical history, and a scoring form. Thirteen reassuring and seven non-reassuring CTG traces of healthy women with specific indications for antenatal CTG (reduced fetal movements, external cephalic version, or postdates pregnancy were obtained in digital form from Sense-forBaby. The CTG traces were at least 30 minutes, and the paper speed of the CTGs was 2 cm/min. We used two sets of ten CTG traces each to ensure sufficient variation. We had at least ten raters for each professional group, so each set was assessed by at least five raters. All participants were asked to assess the same ten CTGs twice at one-month intervals. **Outcome Measurements** Participants assessed the CTGs using an antenatal classification system based on the FIGO guideline (Figure S1), which was provided to them.\textsuperscript{14} The adapted classification for various CTG components and overall classification is as follows:

- **Baseline heart frequency**, classified into three categories:
  1) Normal baseline [110-150 beats per minute (bpm)]
  2) Tachycardia [>150 bpm lasting more than 10 minutes]
  3) Bradycardia [<110 bpm lasting more than 10 minutes]

- **Variability**, classified into three categories:
1) Normal variability [bandwidth amplitude of 5-25 bpm] 2) Reduced variability [bandwidth amplitude <5 bpm for more than 3 minutes during decelerations or more than 50 minutes in baseline segments. 3) Increased variability (salutatory pattern) [bandwidth value >25 bpm for at least 30 minutes]

**Accelerations** (lasting >15 seconds but <10 minutes, >15 bpm above baseline), dichotomized:
1) No, not present 2) Yes, present

**Decelerations** (lasting >15 seconds, >15 bpm below baseline), dichotomized:
1) No, not present 2) Yes, present

**Contractions** (uterine activity), dichotomized:
1) No, no uterine activity present 2) Yes, uterine activity present

**Overall CTG classification**, dichotomized:
Reassuring (normal)
Non-reassuring (suspicious (suboptimal) or pathological (abnormal).

**Statistical Analysis**

The analyses were performed using SPSS statistics 22.0 and RStudio 2021.09.1. The baseline characteristics of the study population were analyzed using descriptive statistics. Frequencies and percentages were presented for categorical variables and means with standard deviations (SD) or medians with ranges for continuous variables. We expressed the agreement among professional groups as a proportion of agreement because this is a better concept than Cohen’s kappa for answering our research questions. Cohen’s kappa is a widely-used measure of reliability, providing information about the distinctiveness of an instrument, while the level of agreement gives information about the extent to which professionals’ CTG assessments agree. The interobserver and intraobserver agreements for all outcomes were therefore expressed as the proportion of agreement with a 95% confidence interval (CI). To calculate the degree of agreement among professional groups, we used the agreement formula and calculations [R package from https://github.com/iriseekhout/Agree], including a 95% CI. We analyzed the interobserver agreement for the CTG classifications (reassuring, non-reassuring) and various CTG components (baseline heart frequency, variability, presence of accelerations, presence of decelerations, and presence of contractions) for each possible pairing of two participants (198 pairings). These analyses were performed for the two sets of CTGs separately and subsequently pooled as a proportion of agreement among the four professional groups. Intraobserver agreement was analyzed for each participant and pooled as a proportion of agreement for each professional group. Whether the four professional groups differed in the proportions of intraobserver and interobserver agreement was tested with the independent sample t-test for differences in proportions. In concordance with Cohen’s kappa, a score of 0.81–1.00 was classified as excellent agreement, a score of 0.61–0.80 as good, 0.21–0.60 as moderate, and less than 0.20 as poor agreement. With these numbers, differences in percentages of about 10% would become statistically significant.

**Results** Figure 1 shows the inclusion of the participants. Sixty-six health care professionals were asked to participate, of whom 47 (71.2%) took part in the study. In the first round, 23 participants (at least five per professional group) assessed the first set of ten CTGs, and 24 other participants (at least five per professional group) assessed the second set of CTGs. In the second round, all participants were asked to assess - after a one-month interval - the same CTGs they assessed in the first round. Five participants did not complete the second round and were excluded from the intraobserver analyses. Table 1 shows the baseline characteristics of the participants. The mean work experience with CTG assessment was 7.6 years (SD 6.3), varying from 3.7 (SD 1.4) (primary care midwives) to 16.7 years (SD 4.0) (obstetricians). The median training in CTG assessment yearly varied from 8.0 hours (primary care midwives (range 6.0 to 16.0) and residents (range 1.0 to 30.0)) to 11.5 hours (range 3.0 to 70.0) (obstetricians). Table 2 presents the results of the interobserver
agreement on the classification of antenatal CTG patterns (reassuring, non-reassuring) among the four professional groups. The proportions of agreement varied from 0.82 (95% CI: 0.67-0.91) to 0.94 (95% CI: 0.87-0.98), indicating excellent agreement. We found no differences in proportions of agreement within the professional groups among obstetricians and either primary care or hospital-based midwives. We did find a statistically significant difference in the proportion of agreement within the obstetricians versus residents (-0.12 (-0.03;-0.21), p-value 0.006). Table 3 describes the intraobserver agreement for the classification of CTG patterns for the professional groups. The proportions of agreement varied from 0.86 (95% CI: 0.55-0.97) to 0.94 (95% CI: 0.66-0.99), indicating excellent intraobserver agreement for antenatal CTG classification for the various professional groups. We found no differences in proportions of agreement between obstetricians and the other professional groups. For the professional groups, primary care midwives, hospital-based midwives and obstetricians, the proportions of agreement were slightly higher for intraobserver than for interobserver agreement. We also investigated the interobserver and intraobserver agreement on the different CTG components (baseline heart frequency, variability, accelerations, decelerations, and contractions) of antenatal CTG patterns among the four professional groups. These results are presented in Supporting information Tables S1 and S2. The interobserver agreement was good to excellent for all components. The proportions of agreement for the CTG components varied from 0.64 (presence of contractions) to 0.98 (baseline heart frequency). Overall, the proportions of agreement for the various CTG components among the professional groups were comparable. The proportions of agreement for each professional group were slightly higher for intraobserver than for interobserver agreement.

**Discussion Main Findings**

We studied the interobserver and intraobserver agreement between and within professionals in maternity care (primary care midwives, hospital-based midwives, residents, and obstetricians) in the assessment of antenatal CTG patterns among healthy women with an indication for an antenatal CTG. We found excellent interobserver and intraobserver agreement for antenatal CTG classification and good to excellent interobserver agreement for the CTG components among these four professional groups. For the professional groups, primary care midwives, hospital-based midwives and obstetricians, the proportions of agreement were slightly higher for intraobserver than for interobserver agreement.

**Strengths and Limitations**

As far as we are aware, this is the first study that includes primary care midwives as well as professionals in obstetrician-led care (hospital-based midwives, residents, and obstetricians) to give a picture of the level of agreement in CTG interpretation between these professional groups. For the data collection, we used an efficient approach to maximize the number of CTGs without extra work for the professionals. With at least five raters per professional group for each set of ten CTGs, we guaranteed a reasonable sample of the four professional groups (n=47), and the sample size was large enough to gain sufficient power (20 CTGs). However, some limitations need to be addressed. Standard criteria for agreement measures are not available. We, therefore, used the same criteria for qualification of agreement as for the reliability (Cohen’s kappa). However, reliability and agreement are different parameters. Although these criteria are arbitrary, they have been widely adopted for reporting results. Another limitation is that the participants in our sample who work in obstetrician-led care work more frequently in the same centre and region than the participating primary care midwives. The literature shows that professionals working in the same centre share similar clinical cultures, which could have influenced the results (observer bias). Although this might have impacted the proportion of agreement of participants working in obstetrician-led care, we do not expect this would alter our conclusion as the interobserver and intraobserver agreement were good to excellent for all professional groups. Finally, participants who agreed to participate might have been those most knowledgeable about CTG monitoring or most motivated to prove their proficiency. The effect estimates of the main analysis might therefore be overestimated (selection bias), but we do not expect this has biased the comparison between the professional groups as participants in the different professional groups were selected similarly.

**Interpretation**

Studies on the reliability of the overall classification of CTG patterns among health care professionals in obstetrician-led care showed a lower rate of observer agreement. Ayres-de-Campos et al. (2005) found for antepartum and intrapartum CTGs together, a proportion of agreement of 0.62 (95% CI: 0.51-0.73) for normal traces, 0.42 (95% CI: 0.34-0.50) for suspicious traces and 0.25 (95% CI: 0.14-0.36) for pathological traces. This difference in agreement levels with our findings may partly be related to the fact that they expressed the proportion of agreement for antepartum and intrapartum CTGs together and
not specifically for antepartum CTG traces as in our study. In our study, we studied a low-risk antepartum population, which would be expected to include a larger number of reassuring traces and thus yield a higher level of agreement.\textsuperscript{19} In a Dutch study (1982), the interobserver and intraobserver variation was investigated among five experienced observers who assessed antenatal CTGs using three different scoring systems. For all three systems, they found a low level of agreement between observers (the weighted kappa varied from 0.41 to 0.37).\textsuperscript{10} However, in our study we measured a different concept: we examined the level of agreement between professional groups in maternity care (measured as the proportion of agreement), while Lotgering’s study investigated the level of agreement between different scoring systems (measured using Cohen’s kappa).\textsuperscript{15} Furthermore, they used different scoring systems than the FIGO guideline we used. Differences in scoring systems have a profound effect on interobserver agreement and reliability.\textsuperscript{20} Finally, in recent years, more attention has been paid to quality assurance in the assessment of antenatal CTGs in training programs, which may have improved professionals’ assessments of CTGs. Previous studies showed variation in the assessment of the various components of the CTG: good to excellent interobserver agreement in antenatal CTG assessment was found for baseline heart frequency, accelerations, and contractions,\textsuperscript{7, 9} in contrast to other CTG components such as variability and decelerations.\textsuperscript{7} In our study we found good to excellent agreement for all CTG components. We suggest two main reasons for these differences in results. Firstly, in our study the CTG component deceleration was dichotomized into present or absent instead of classifying deceleration as early, variable, or late, as defined in FIGO guideline. Secondly, exposure to antenatal CTGs has increased in clinical practice in the past decade, potentially improving professionals’ assessment of antenatal CTGs. In line with the literature,\textsuperscript{10} we detected a slightly higher level of agreement in intraobserver agreement than in interobserver agreement for classification of antenatal CTGs. This observation shows consistency in the assessment of antenatal CTGs by all maternity care professionals.

**Conclusions**

Our study showed excellent interobserver and intraobserver agreement for the overall classification and good to excellent agreement for the various CTG components among primary care midwives, hospital-based midwives, residents, and obstetricians, in the assessment of antenatal CTGs of healthy women. This means that the professional groups are equally well able to assess antenatal CTGs.

**Acknowledgements**

We want to thank Iris Eekhout for her consultation role during the analysis. We would also like to thank the participants for contributing to this study.

**Disclosure of Interests**

The authors declare no conflicts of interest.

**Practical and Research Recommendations**

The most relevant question for clinical practice is whether maternity care professionals will provide the same assessment when classifying antenatal CTGs. Westerhuis et al. showed higher rates of agreement in more experienced and recently educated professionals.\textsuperscript{21} Other studies showed that both clinical midwives and residents had better agreement than obstetricians.\textsuperscript{19, 22} This is consistent with our study, as we found the level of interobserver agreement in the classification of antenatal CTGs within the professional group of residents was higher than the group of obstetricians. Di Lieto et al. assessed the agreement in antenatal CTG interpretation between experienced (EO) and inexperienced (IEO) observers. They found a similar agreement between the group EO versus IEO and EO versus EO.\textsuperscript{12} This is in line with our results, showing excellent interobserver agreement levels between professionals for the classification of antenatal CTGs, despite differences in years of experience. Until now, it was unclear how interobserver and intraobserver agreement among primary care midwives compares to other professional groups in maternity care. The proportions of agreement for interobserver agreement were excellent between primary care midwives and other professional groups, meaning that these professional groups are equally able to assess the antenatal CTG. In addition to antenatal CTG assessment, the subsequent clinical management may also vary between professionals. In future research, it is important to evaluate variations in antenatal care management after CTG assessment among professionals in maternity care and their effects on perinatal outcomes.
Details of Ethics Approval The participants were provided with written information about the aim and procedure of the study and gave their written informed consent. The identity of the participants was anonymized and processed confidentially in an SPSS file. The CTG traces used in the study were not traceable to patients. Ethical approval was requested from the Medical Ethics Committee of VU University Medical Centre. They deemed the Medical Research Involving Human Subjects Act not to be applicable to our study (VUmc MEC, #2016.484). Funding Source National Agency for Practice-Oriented Research (SIA), part of NWO.

References


**TABLE 1** Baseline characteristics of the participating maternity care professionals

<table>
<thead>
<tr>
<th>All professionals</th>
<th>n=47 (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary care midwives</strong></td>
<td>n=12 (25.5%)</td>
</tr>
<tr>
<td><strong>Hospital-based midwives</strong></td>
<td>n=12 (25.5%)</td>
</tr>
<tr>
<td><strong>Residents</strong></td>
<td>n=13 (27.7%)</td>
</tr>
<tr>
<td><strong>Obstetricians</strong></td>
<td>n=10 (21.3%)</td>
</tr>
</tbody>
</table>

**Age (years),**
- mean (SD)
  - 36.5 (9.4)
  - 35.0 (6.7)
  - 39.2 (13.8)
  - 30.1 (2.6)
  - 43.2 (6.0)
Work experience in maternity care (years),
mean (SD)
11.2 (8.8)
11.2 (7.3)
14.1 (12.5)
4.1 (2.2)
16.7 (4.0)

Work experience in current profession (years),
mean (SD)
8.4 (7.8)
11.2 (7.3)
9.9 (11.2)
3.7 (2.2)
9.2 (6.0)

Work experience in CTG assessment (years),
mean (SD)
7.6 (6.3)
3.7 (1.4)
8.0 (6.5)
4.0 (1.8)
16.7 (4.0)

Hours of training in CTG assessment (yearly), median (range)
8.0 (0 to 70.0)
8.0 (6.0 to 16.0)
9.0 (0 to 50.0)
8.0 (1.0 to 30.0)
11.5 (3.0 to 70.0)

**TABLE 2** Interobserver agreement in classification (reassuring and non-reassuring) of antenatal CTGs between (values off the diagonal) and within (values on the diagonal) professional groups using proportions of agreement.

<table>
<thead>
<tr>
<th></th>
<th>Primary care midwives</th>
<th>Hospital-based midwives</th>
<th>Obstetricians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportions of agreement (95% CI)</td>
<td>0.84 (0.72-0.91)</td>
<td>0.84 (0.73-0.90)</td>
<td>0.83 (0.70-0.90)</td>
</tr>
<tr>
<td>Proportions of agreement (95% CI)</td>
<td>0.86 (0.75-0.92)</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Proportions of agreement (95% CI)</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
**TABLE 3** Intraobserver agreement in classification (reassuring and non-reassuring) of antenatal CTGs for professional groups in maternity care using proportions of agreement.

**Proportions of agreement (95% CI)**

<table>
<thead>
<tr>
<th></th>
<th>Primary care midwives</th>
<th>Hospital-based midwives</th>
<th>Residents</th>
<th>Obstetricians</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.92 (0.62 -0.99)</td>
<td>0.94 (0.66 -0.99)</td>
<td>0.91 (0.63-0.98)</td>
<td>0.86 (0.55 -0.97)</td>
</tr>
</tbody>
</table>

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