Abstract

Introduction: Peer learning is an important component of the postgraduate medical curriculum, and it is considered as an integral part of learning in some countries. The practice of peer learning among postgraduate trainees, especially the resident doctors, is an area that has not been explored in Nigeria and other third world countries. This study aims to examine the practice, perception, and drivers of peer-to-peer training in Nigeria.

Methodology: This study was a national multi-centre and multi-disciplinary cross-sectional survey, conducted among resident doctors in Nigeria. Semi-structured questionnaires were used to obtain respondents' biodata, perception and practice on peer learning. Data were analysed using SPSS version 23 software. Results were presented as frequency table and proportion, means, and standard deviation. Inferential statistics such as bivariate analysis was performed.

Results: Majority, 287 (73.2%), considered the peer education programme as an appropriate learning practice, 173 (45.9%) considered peer education programme integrated part of the training, while 350/383 (88.2%) engaged in a peer education programme. Statistically, a significant association was found between those who considered peer training as appropriate (p = 0.038) and those who considered peer education as an integral part of postgraduate medical training curriculum (p = 0.009).

Conclusion: Peer learning is popular among resident doctors in Nigeria. Concerted efforts are needed to re-structure the residency training curriculum in order to maximize the benefits of this learning approach for an effective training programme.

Keywords
Nigeria • medical • residents • doctors • peer • education • learning • medical • residents-as-teachers

Introduction

Peer learning, near-peer learning or peer-to-peer learning can be defined as an educational concept in which one trainee provides learning support to another trainee or a group of fellow trainees [1-3]. A similar term is peer-assisted learning [1]. This approach to learning is a real opportunity for trainees considering the dearth of didactic lectures in most residency training programmes. Although the residency training programme is a structured one, it essentially involves a great deal of self-driven learning and improvement. Furthermore, given the contemporary explosion of medical knowledge and skill required for specialist medical practice, resident doctors and interns have an enormous volume of information and competencies to acquire within a fixed training period. However, there is poor insight into how this feat is achieved. Peer learning may thus play some role in this regard [4].
Peer Learning is in fact considered to be an “under-recognised source of education in the medical education continuum” [5]. Besides, it is considered to be an innovative way to disseminate information rapidly, and an excellent way to entrench interprofessional collaboration. The latter may be necessary for the medical and dental practice, where team spirit is a necessary soft skill [6]. It may be an excellent way to inculcate teaching skills into resident doctors who are future faculties [5, 6]. Finally, there is evidence, albeit little, on its benefit in sharing theoretical and practical medical skills [7, 8]. A unique characteristic of the peer teachers or tutors is that it mostly takes place in semi-formal, non-classroom settings or arrangements.

Academic exchange between early career Doctors who are mainly residents doctors is poorly explored, especially in Nigeria [9, 10]. Furthermore, peer learning/teaching is a poorly explored part of the postgraduate medical curriculum; it is, therefore, imperative to characterise such and assess the perception of the participants themselves.

This study examined the practice and perception of resident doctors to peer-peer training experience in Nigeria.

Methods

Study design
This study was a national multi-centre, multi-disciplinary cross-sectional survey of resident doctors, who are early career doctors in Nigeria [11-13]. This study also forms a part of the CHARTING study; also, the study protocol had been published elsewhere, and preliminary data was also presented as a poster [12, 14].

Study tool
The study tool was an anonymous pre-tested, semi-structured paper questionnaire which obtained information about the basic demographics, practice, and perception of the study participants towards peer learning [12]. The basic characteristics of participants were extracted with 17 variables while those variable relevant to peer learning where gotten via seven stem questions.

Selection criteria
Only those doctors who were identified as resident doctors (i.e. a registrar/senior registrar) [9, 11] and who also gave verbal informed consent were included in this study.

Data collection and analysis
The survey was institution-based. Collected data was cleaned, coded, and computed into the IBM SPSS version 23 Software for analysis. Frequency distributions of all variables were determined. Continuous variables were summarised as mean and standard deviation, while the categorical variables were summarised as proportions and frequencies. Also, bivariate (Chi-square tests) analyses were done among the relevant variables. Results were presented using sentences and tables.

Definition of terms
1. Peer: a trainee who is the same level/cadre with another trainee, e.g. a house officer and another house officer or a senior registrar and another senior registrar.
2. Peer learning: Peer learning or near-peer learning are organised educational activities in which one trainee provide learning support to other trainees (resident doctors) or a group of fellow trainees (resident doctors)
3. Early career doctor: a medical or dental practitioner who has finished first-degree training and at least has a certification to practice clinically. Those in this category include interns, medical/dental officers below the rank of a principal medical/dental officer (PMO/PDO) and resident doctors [10, 12].
4. Registrar: A doctor in postgraduate medical training having passed the Primary exams of either or both of the National Post-graduate Medical College or the West African College following completion of internship and the mandatory one-year National Youth Service Corps [15, 16]. This usually takes between 2-3 years during which he/she learns from the Senior registrar and Consultant.
5. Senior Registrar: A doctor in residency training following success at the Part I exams of the College/s who directly supervises the registrar and interns under the overall guidance and tutelage of the Consultant [15, 16]. This programme usually lasts between 2-4 years depending on the specialty and culminates in success at the Part II examinations after which he/she is awarded a Fellowship and is appointable as a Consultant in a relevant health institution.
6. Specialty was considered as the department/field the trainee is currently under, while the grouping into surgical-related and non-surgical related was based on the Nigerian/West African Postgraduate Medical Colleges’ classifications.

Ethical Considerations
Ethical approval was obtained from the National Ethics Review Committee, Federal Ministry of Health, Nigeria, before data collection (Reference number: NHREC/01/01/2007-26/06/2019). Written and verbal consent were obtained from each participant before their participation. Also, the identity of each participant was treated with utmost confidentiality.
Results

A total of 411 participants were included in this report. The mean (±SD) age of the respondents was 35.3 (±4.5) years. The majority (72.0%) were males, 77.8% were married, 53.3% were registrars, 55.7% were in non-surgical specialities, 58.4% graduated from medical school more than seven years previously, and only 79 (19.3%) had acquired additional educational qualifications (like Masters or PhD) (Table 1). The respondents spent averagely 69.36 (±34.71) hours-per-week, 9.75 (±8.96) hours-per-week, and 3.98 (±5.79) hours-per-week on hospital works, private study, and research activities, respectively (Table 2). More than 90% spent over 40 hours per week at work, 61% being on-call duty for more than seven days in a month, and the majority having no free time after call duties.

The majority (73.2%) of the respondents considered peer education programmes/sessions as an appropriate educational practice; however, only 45.9% indicated that peer education programme was an integrated part of their training requirement. Among them, only 88.2% (350/383) engaged themselves in peer education programme(s) including social media discussion programmes (243/365, 66.6%), discussion group activities (327/365, 89.6%), and others (e.g. bedside teaching, among others) (13/365, 3.6%) (Table 3).

As shown in Table 4, a statistically significant association was found between participation in peer learning activities and consideration of peer education as an integral part of the curriculum as well as with consideration of peer training as appropriate. About nine out of every ten (91.6%) of those who considered peer education as an integral part of the curriculum participated in peer-education, as compared to only 84.9% of those who did not consider it as an integral part of the curriculum. Furthermore, 91.6% of those who considered peer training appropriate participation in peer education as compared to 84.2% of those who did not consider it appropriate. There was no significant association between age, gender, cadre and duration of practice of resident doctors and participation in peer education programmes.

Discussion

Worldwide, the theme of peer-to-peer education is an understudied subject and one with an enormous potential to improve knowledge dissemination and skill acquisition, especially among resident doctors. Peer-assisted learning has commonly been known to be implemented in medical education via programmes like ward-rounds, bedside teaching and other interactive sessions. However, it has more commonly been studied among medical students than doctors in postgraduate training [17-19]. Our study demonstrated that a high proportion of the respondents (88.2%) engage in peer learning activities. Among Nigerian resident doctors, discussion groups, social media interactions and bedside discussions were the most common modalities of peer education.

There are many apparent advantages of peer education. According to Burgess et al., the peer teachers do not only develop teaching skills which are vital for all doctors but also improve their clinical knowledge and acumen [20]. Considering that this form of interaction occurs amongst resident doctors of similar cadre, there is a more relaxed and friendly atmosphere which allows for an adequate learning experience. Some researchers have demonstrated that more senior resident doctors in postgraduate training were able to impart knowledge on their junior colleagues by teaching during ward rounds and other clinical settings [21]. It was also found that there is no significant difference in the degree of knowledge impartation to residents between peer-led and faculty-led teachers [17]. Interestingly, in imparting certain skill sets there is evidence that peer learning may be better, possibly due to participants being of similar age brackets thereby enhancing those particular skill transfer [2]. These residents learn much more and prepare for the seminars and discussions much more intensively thus being beneficial to the peer trainers themselves. However, we did not test this in our study.

From this study, approximately 70% of respondents considered peer education appropriate for their learning and development. However, less than half agreed that peer education was integrated into the residency training programmes in their various institutions. This suggests that there is a need for increased integration of peer-to-peer education within the curriculum of the residency training programme in Nigeria. This study highlighted the increased workload among the participants - 91% of the participants worked more than 40 hours per week, and at least 60% of participants were on call for more than 7 days in a month. It can thus be extrapolated that, given the fact that residents who take regular calls have increased need for rest and recovery, there may be little, or no time left for peer education. Furthermore, above 60% of residents in this study had less than 7 hours of structured training by their trainers in a week, with less than 10 hours of private time for studies. This inadequate time for personal study/training by the resident might further make peer learning more challenging. On the flip side, the same dearth of time for other methods of learning and the compelling need for learning to succeed in the training may have served a strong driver of the practice of peer learning. Also interesting is the fact that those who engage in peer learning...
self-reported similar structured hours learning from trainers and self-reported hours of private study per week. It would be interesting to further explore how residents overcome the increase workload and thrive in peer learning practice. Of the 85% who engaged in peer-to-peer education, a vast majority (9 out of 10) participated in group discussions while a significant population engaged in social media interactive groups.

Habboush et al. identified four main themes which are essential in developing the teaching skills of residents, namely communication, professional engagement, practice-based learning, and systems-based learning [22]. They revealed a remarkably positive difference in the ability of the resident doctors he studied, to teach their peers and medical students following a structured-training [22]. To this effect, there may be a need for proper training on these methods to enhance better outcomes. Walker and her associates reported the use of the jigsaw technique in peer teaching and learning among American paediatric resident doctors, with the remarkable results of satisfactory knowledge transfer from resident to resident [23]. The jigsaw technique, among other techniques of peer-to-peer education, encourages a resident doctor to study and become an expert in a particular aspect of a topic, and then teach colleagues during group discussions while learning about other aspects from them. In other words, this approach allows much ground to be covered over a short period [24]. There are many more techniques that have been practised by Nigerian resident doctors but have not been documented due to inadequate knowledge of the theme of peer-to-peer education. This index study showed no obvious statistically significant difference in the perception, integration and engagement in peer education based on gender, age groups, marital status and type of specialty (surgical versus non-surgical). It thus suggests that it is useful across board, and should thus be further studied and understood in order to maximise its usefulness [25].

We did not explore how these activities affect skilled transfer, and capacity enhancement. This is a potential gap that further research would be needed to provide insight.

Conclusion

Peer learning/education is popular among Nigerian resident doctors. The residents who recognised peer learning as appropriate were more likely to participate further in peer training. It is therefore imperative for the stakeholders in the Nigerian Postgraduate Training Programme to encourage the integration of well-structured peer education into the residency training programme with the goal of making training/learning more efficient.

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Conflict of Interest Statement

All authors are members of NARD except KK, IA while OO, SO, SO and AS are officials of NARD; however, the study was independently conducted and reported. NARD played only a funder’s role.

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### Table 1. Basic Profile of Participants

| Variables (n)                  | (mean SD) | n (%)   |
|--------------------------------|-----------|---------|
| Age (368)                      | 35.3± 4.5 |         |
| <40 years n (%)                | 307(83.4) |         |
| more than or equal to 40 years | 61(16.6)  |         |
| Gender (411)                   |           |         |
| Male n (%)                     | 296(72.0) |         |
| Female n (%)                   | 115(28.0) |         |
| Cadres (411)                   |           |         |
| Registrar n (%)                | 219(53.3) |         |
| Senior Registrar n (%)         | 192(46.7) |         |
| Married status (409)           |           |         |
| Yes                            | 318(77.8) |         |
| No                             | 91(22.2)  |         |
| Categories of specialty (402)  |           |         |
| Surgical related n (%)         | 178(44.3) |         |
| Non-surgical related n (%)     | 224(55.7) |         |
| Undergraduate training (397)   |           |         |
| Foreign n (%)                  | 5(1.3)    |         |
| Foreign-trained n (%)          | 392(98.7) |         |
| Years of graduation from medical school (397) | | |
| less or equal to 7 years n (%) | 157(38.2) |         |
| more than 7 years n (%)        | 240(58.4) |         |
| Additional qualification (Master, PhD, PGD)(410) | | |
| Yes n (%)                      | 79(19.3)  |         |
| No n (%)                       | 331(80.7) |         |
| Number of children             |           |         |
| less than or equal to 2 children | 224(78.3)|         |
| more than 2 children           | 62(21.7)  |         |
| Average hour of sleeps per day (396) | | |
| less or equal to 7 hours       | 374(92.8) |         |
| more than 7                    | 29(7.2)   |         |
| Variables (n)                                      |          |
|--------------------------------------------------|----------|
| Years of practice (396)                         |          |
| less or equal to 7 years                        | 202(51.0) |
| more than 7 years                               | 194(49.0) |
| Years on current job (396)                      |          |
| less or equal to 5 years                        | 271(70.6) |
| more than 5 years                               | 113(27.5) |
| Average work hours per week (391)               |          |
| less than 40 hours                              | 34(8.7)  |
| more or equal to 40 hours                       | 357(91.3) |
| Number of call days in a month (393)            |          |
| less or equal to 7                              | 157(39.9) |
| greater than 7 days                             | 236(60.1) |
| Mode of calls duty (401)                        |          |
| Staggered                                       | 339(84.5) |
| Not staggered                                   | 62(15.5)  |
| Usual Free hours after each call (376)          |          |
| equal or less than 7 hours                      | 150(87.2) |
| more than 7 hours                               | 22(12.8)  |
| Hours of formal educational activities in a week (376) |          |
| less or equal to 5 hours                        | 173(46.0) |
| more 5 hours                                    | 203(54.0) |
| Dedicated Private or research hours per week (339) |          |
| less or equal to 5 hours                        | 123(36.4) |
| more 5 hours                                    | 215(63.6) |
| Variables (n)                                                                 | Yes    | No     | Undecided |
|------------------------------------------------------------------------------|--------|--------|-----------|
| Do you consider peer educational program/sessions such as discussion group appropriate (397) | 287(73.2) | 95(24.2) | 10(2.6)   |
| Do you engage in peer educational program such as discussion group seminars (383) | 350(88.2) | 47(11.8) |            |
| Peer education engage in Discussion group (383)                              | 332(86.7) | 51(13.3) |            |
| Peer education engage in Others (240)                                       | 14(5.8) | 226(94.2) |            |
| Is the peer education programme integrated as part of your training requirement (377) | 173(45.9) | 172(45.6) | 32(8.5)   |
| Reported structured hour of training in residency by trainers (269)          |        |        |           |
| 0-7 hours                                                                    | 179(66.5) |        |           |
| 8 hours or more                                                              | 90(33.5) |        |           |
| Reported hours of private study per week (338)                              |        |        |           |
| 10 hours equal or less                                                       | 237(70.1) |        |           |
| More than 10 hours                                                           | 101(29.9) |        |           |
### Table 4. Factors associated with participation in peer learning activities

|                              | Yes       | No       | X²  | p-value |
|------------------------------|-----------|----------|-----|---------|
| **Age**                      | 0.41      | 0.518    |     |         |
| less than 40 years           | 266(88.1) | 36(11.9) |     |         |
| more than or equal to 40 years| 317(88.5) | 41(11.5) |     |         |
| **Gender(397)**              | 3.04      | 0.081    |     |         |
| Male                         | 248(86.4) | 39(13.6) |     |         |
| Female                       | 102(92.7) | 8(7.3%)  |     |         |
| **Marital Status(395)**      | 2.61      | 0.101    |     |         |
| Married                      | 274(89.5) | 32(10.5) |     |         |
| Not married                  | 74(83.1)  | 15(16.9) |     |         |
| **Cadre (397)**              | 0.43      | 0.513    |     |         |
| Registrar                    | 189(89.2) | 23(10.8) |     |         |
| Senior Registrar             | 161(87.0) | 24(13.0) |     |         |
| **Type of specialty (390)**  |           |          |     |         |
| Surgical related             | 151(88.8) | 19(11.2) | 0.22| 0.641   |
| non-surgical related         | 192(87.3) | 28(12.7) |     |         |
| **Location of undergraduate medical training (384)** |     |         |     |         |
| Foreign                      | 4(100.0)  | 0        |     |         |
| not foreign-trained          | 333(87.6) | 47(12.4) |     |         |
| **Years of graduation from medical school (383)** |     |         |     |         |
| less or equal to 7 years     | 132(87.4) | 19(12.6) |     |         |
| more than 7 years            | 205(88.4) | 27(11.6) |     |         |
| **Years of practice (383)**  | 0.00      | 0.955    |     |         |
| less or equal to 7 years     | 170(88.1) | 23(11.9) |     |         |
| more than 7 years            | 167(87.9) | 23(12.1) |     |         |
| **Years on current job (371)** | 3.65      | 0.056    |     |         |
| less or equal to 7 years     | 237(90.5) | 25(9.5)  |     |         |
| more than 7 years            | 91(83.5)  | 18(16.5) |     |         |
### Average work hours per week (378)

| Category                      | Count (Percentage) | Count (Percentage) |
|-------------------------------|--------------------|--------------------|
| less than 40                  | 26 (86.7)          | 4 (13.3)           |
| more or equal to 40           | 305 (87.6)         | 43 (12.4)          |

### Number of days on-call duty in a month (380)

| Category                     | Count (Percentage) | Count (Percentage) |
|------------------------------|--------------------|--------------------|
| less or equal to 7 days      | 132 (88.0)         | 18 (12.0)          |
| Greater than 7 days          | 202 (87.8)         | 28 (12.2)          |

### Usual Mode of call duty (388)

| Mode             | Count (Percentage) | Count (Percentage) |
|------------------|--------------------|--------------------|
| Staggered        | 289 (88.1)         | 39 (11.9)          |
| Not staggered    | 52 (86.7)          | 8 (13.3)           |

### Free hours after each call (164)

| Category                  | Count (Percentage) | Count (Percentage) |
|---------------------------|--------------------|--------------------|
| equal to or less than 7   | 128 (89.5)         | 15 (10.5)          |
| more than 7 years         | 18 (85.7)          | 3 (14.3)           |

### Considered peer education as an integral part of the curriculum (345)

| Category                  | Count (Percentage) | Count (Percentage) |
|----------------------------|--------------------|--------------------|
| Yes                        | 162 (93.6)         | 11 (6.4)           |
| No                         | 146 (84.9)         | 26 (15.1)          |

### Consider peer training appropriate (382)

| Category                  | Count (Percentage) | Count (Percentage) |
|----------------------------|--------------------|--------------------|
| Yes                        | 263 (91.6)         | 24 (8.4)           |
| No                         | 80 (84.2)          | 15 (15.8)          |

### Reported structured hours learning from trainers

| Category                          | Count (Percentage) | Count (Percentage) |
|-----------------------------------|--------------------|--------------------|
| Less or equal to 10 hours         | 216 (91.1)         | 21 (8.9)           |
| More than 10 hours                | 27 (84.4)          | 5 (15.6)           |

### Reported hours of private study per week

| Category                          | Count (Percentage) | Count (Percentage) |
|-----------------------------------|--------------------|--------------------|
| 10 hours equal or less            | 129 (89.0)         | 16 (11.0)          |
| More than 10 hours                | 163 (90.1)         | 18 (9.9)           |