



SRI BALAJI VIDYAPEETH (SBV)

(Deemed to be University)
U/S 3 of UGC Act 1956
Puducherry-607402

This document contains the details of the
Value added program in Protocol Writing,
conducted by the Medical Education Unit, Mahatma Gandhi Medical
College & Research Institute, Sri Balaji Vidyapeeth,
Deemed to be University.

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Criteria 1

Metrix 1.3 : Curriculum Enrichment

1.3.2

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Details of **Value-added Program in Protocol Writing**

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Value added course on Protocol Writing

Date: 20.08.2018 (DAY - 1)		
2.00 – 2.15PM	Introduction to workshop	Dr.M.Ravishankar
1 st session 2.15 – 3.00 pm	Writing Introduction, leading to aims & objectives Materials/subjects and method – How to modify from your protocol	Dr.K.Srikanth
2 nd Session 3.15 – 4.30 pm	Writing review of literature and References Part - I	Dr.Sivaprakash .B Dr.Sukanto Sarkar
Date: 21.08.2018 (DAY --2)		
1 st session 2-3 pm	Writing review of literature Part - II	Dr.Sivaprakash .B Dr.Sukanto Sarkar
2 nd Session 3.15 – 4.30 pm	Data Entry / cleaning the data	Dr.Ezhumalai
Date: 22.08.2018 (DAY - 3)		
1 st Session 2-3 pm	Interpretation of statistical analysis	Dr.Ezhumalai
2 nd Session 3.15 – 4.30	Write-up of Results	Dr.Sripriya
Date: 23.08.2018 (DAY - 4)		
2 -4.30 pm	Writing the Discussion: PPT Presentation (2.00-2.25pm) Group task on Discussion (2.25-3.10pm) Tea break (3.10-3.25pm) Plenary for Group task (3.25-4.00pm) Ethical issues (4-4.15pm) Feedback (4.15-4.30pm)	Dr. Gunasekaran Dr. Lokesh
Date: 24.08.2018 (DAY - 5)		
2 -3 pm	1) Writing, Summary 2) Formatting , Using template	Dr.Partha Nandhi Dr. Jagan
3.15 – 4.00 pm	Conversion of Dissertation into Journal article	Dr. Sukanto Sarkar
4.00 -4.30. pm	Final Check	Dr.M.Ravishankar

“A Study of menstrual hygiene and related personal hygiene practices among adolescent girls in rural Puducherry”

10 ABSTRACT

Background:

The word adolescent is derived from the Latin word “adolescere”, which means to grow into maturity. The World Health Organization (WHO)² defines adolescents as individual between 10 - 19 years of age group and this is the fastest growing segment of total world’s population.³ These adolescent girls are at risk for menstrual disorders leading to gynaecological problems due to lack of knowledge and poor hygiene practices. Reproductive tract infections have become a silent epidemic that affects women’s life and it is closely interrelated with poor menstrual hygiene. The interplay of socio- economic status, environmental factor such as housing and sanitation and reproductive tract infections are also noticeable. Keeping this above view an attempt has been made to study the menstrual hygiene practices among adolescent girls and also to find out the symptoms associated with poor menstrual hygiene practices in rural Puducherry.

Methodology:

A community based descriptive cross sectional study was conducted in rural field practicing area of MGMCRI, Puducherry, from 15th of March 2013 to 31st April 2014. By using universal sampling method 528 adolescent girls were included. Out of those 502 girls were enrolled for the study depending upon inclusion and exclusion criteria. Information regarding socio-demographic profile, menstrual cycle details, receipt of information on menarche and menstrual hygiene, restriction during menstruation, menstrual and related personal hygiene practices, and symptoms related to genito-urinary tract illness were recorded using semi-structured questionnaire by house to house visit.

Results:

Majority (89.2%) of the adolescent girls was using sanitary pads, fresh and reusable cloths were used by 6.6% and 4.2%, respectively. 65.3% girls changed their soaked absorbent 2-5 times in a day. Majority (60.8%) of the girls disposed their used absorbent by burying or burning. Nearly two third of the girls (67.9%) were washing genitalia during micturition.

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54.4% used soap and water for cleaning hand after changing absorbent and washing their genitalia and 1.4% used other material like ash, mud etc. 35.9% reported abnormal vaginal discharge. Itching in the genitalia and foul smelling discharge were in 32.5% and 25.1% girls respectively. Burning micturition was stated by 22.7% girls. 2-4 symptoms and more than 4 symptoms were reported in 39% and 4.6% girls. The association between menstrual hygiene practices which includes type of absorbent, disposal, changing times, cleaning times and agent used for hand cleaning purpose with genito-urinary illness (symptomatic) were found to be statistically significant. Environmental variable like type of house and sanitary latrine facility as well as socio-economic status had statistically significant association with genito-urinary illness (p value < 0.001). In the present study, there were no statistically significant association found between educational status of the girls with their menstrual hygiene practices & genito-urinary tract illness, whereas these association were statistically significant in a study from south India.⁵² Highest prevalence (84.06%) of reproductive tract infection was observed among illiterate girls and the association was highly significant.⁶⁶

Conclusions:

Even though sanitary pad users were high, most of the girls reported symptoms that were suggestive of genito-urinary illness. Thus along with the provision of subsidized rate and increase availability of sanitary pads more emphasize is needed to be given on awareness of changing time, cleaning of genital for adequate number of time, sanitary material to be used, method of disposal of used absorbent among adolescent girls. The study also highlights the unavailability of sanitary latrine in majority of houses due to ignorance which also led the findings that the girls could not find privacy for their menstrual management which had resulted to poor practices. Awareness required to be created regarding this issue also in the study area.

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LITERATURE REVIEW & CITING / REFERENCING: Group Tasks

GROUP TASK 1

The dissertation topic of Dr. A, a postgraduate student, is - "A study of the clinical significance of depression in patients of myocardial infarction". Dr. A submits a draft of the review of literature of her dissertation to Prof. X, her dissertation guide. An extract from Dr. A's literature review is provided here.

PLEASE ANALYZE THE LITERATURE REVIEW STRATEGY FOLLOWED BY DR. A, AND GIVE YOUR COMMENTS.

Note: Your comments should focus on the review method (i.e. the way in which the review has been written/presented), & NOT on the subject matter & specific details of the content.

Frasure-Smith et al¹ conducted a study to assess gender differences in the impact of depression on 1-year cardiac mortality in patients hospitalized for an acute myocardial infarction (MI). Depression in hospital after MI is a significant predictor of 1-year cardiac mortality for women as well as for men, and its impact is largely independent of other post-MI risks.

Lauzon et al² prospectively evaluated patients admitted to 5 tertiary care and 5 community hospitals and followed them for 1 year to measure the prevalence and prognostic impact of depressive symptoms after acute myocardial infarction. Depressive symptoms are common after acute myocardial infarction and are associated with a slight increase in risk of in-hospital catheterization and angiography and readmission because of cardiac complications. Death was infrequent, with no statistically significant difference between the 2 groups.

In a study by Strik et al³, depression appeared to be a predictor of increased health care consumption, but not of major cardiac events such as cardiac death and recurrent infarction in first myocardial infarction (MI) patients up to 6 years post-MI. In contrast to depression, symptoms of anxiety do predict cardiac mortality and recurrent MI in patients following first MI independently of other risk factors of cardiac mortality. Recognition of risk factors for post-MI depression may help the cardiologist to identify patients at risk for depression. Examples of such risk factors are, according to our studies, complications during admission, such as arrhythmic disorders and recurrent angina pectoris, and prescription of benzodiazepines.

In a study by Spijkerman et al⁴, four hundred ninety-four MI patients were screened for depression. Patients with depression were compared with patients without on cardiovascular events (fatal or nonfatal) during an average follow-up of 2.5 years. Demographic characteristics and cardiac risk factors were controlled for. It was found that depression was associated with the occurrence of cardiovascular events in both univariate [hazard ratio (HR), 1.84; 95% confidence interval, 1.24-2.72] and multivariate analysis (HR, 1.56; 1.02-2.38). Depression still has an independent impact on cardiac prognosis after MI, but this influence is smaller than found in early studies. Improvements in general care for MI and better recognition and treatment of post-MI depression may have decreased the impact of depression on prognosis.

References

1. Frasure-Smith N, Lesperance F, Juneau M, Talajic M, Bourassa MG. Gender, depression, and one-year prognosis after myocardial infarction. *Psychosom Med* 1999; 61(1):26-37.
2. Lauzon C, Beck CA, Huynh T, Dion D, Racine N, Carignan S et al. Depression and prognosis following hospital admission because of acute myocardial infarction. *CMAJ* 2003; 168(5):547-552.
3. Strik JJ, van Praag HM, Honig A. [Depression after first myocardial infarction. A prospective study on incidence, prognosis, risk factors and treatment]. *Tijdschr Gerontol Geriatr* 2003; 34(3):104-112.
4. Spijkerman TA, van den Brink RH, May JF, Winter JB, van Melle JP, de JP et al. Decreased impact of post-myocardial infarction depression on cardiac prognosis? *J Psychosom Res* 2006; 61(4):493-499.

LITERATURE REVIEW & CITING / REFERENCING: Group Tasks

GROUP TASK 2

The dissertation topic of Dr. B, a postgraduate student, is - "*A study of physical symptoms in depressive disorders*". Dr. B submits a draft of the review of literature of his dissertation to Prof. Y, his dissertation guide. The introductory paragraph of Dr. B's literature review thus reads as follows:

According to Henningsen et al¹, medically unexplained symptoms of pain and bodily dysfunction are the single most prevalent class of symptoms in primary care. They also have a high prevalence in specialist care and are responsible for a significant proportion of disability in the workforce. They are a defining feature of the different functional somatic syndromes within somatic medicine and of the somatoform disorders within psychiatry. Patients with medically unexplained physical symptoms have been shown to have increased rates of depression and anxiety. This correlation has not yet been reviewed systematically, and several possible explanations exist. The association might signify a reactive increase of depression and anxiety in patients suffering from chronic bodily symptoms.

Dr. B has provided the reference corresponding to this paragraph in his list of references, as follows:

1. Henningsen P, Zimmermann T, Sattel H. Medically unexplained physical symptoms, anxiety, and depression: A meta-analytic review. *Psychosomatic Medicine* 2003;65:528-33.

Prof. Y is impressed by this paragraph & acquires the article by Henningsen et al. He finds the following introductory paragraph in the article:

Medically unexplained symptoms of pain and bodily dysfunction are the single most prevalent class of symptoms in primary care. They also have a high prevalence in specialist care and are responsible for a significant proportion of disability in the workforce (1-3). They are a defining feature of the different functional somatic syndromes within somatic medicine and of the somatoform disorders within psychiatry. Patients with medically unexplained physical symptoms have been shown to have increased rates of depression and anxiety (3-5). This correlation has not yet been reviewed systematically, and several possible explanations exist. The association might signify a reactive increase of depression and anxiety in patients suffering from chronic bodily symptoms (6).

Prof. Y looks at the list of references provided at the end of the article, & finds that the references corresponding to this paragraph have been listed by Henningsen et al as follows:

1. Kroenke K, Spitzer RL, Williams JBW, Linzer M, Hahn SR, deGruy FV III, Brody D. Physical symptoms in primary care: predictors of psychiatric disorders and functional impairment. *Arch Fam Med* 1994;3:774 -9.
2. Reid S, Wessely S, Crayford T, Holopf M. Medically unexplained symptoms in frequent attenders of secondary health care: retrospective cohort study. *BMJ* 2001;322:767-70.
3. Bass C, Peveler R, House A. Somatoform disorders: severe psychiatric illnesses neglected by psychiatrists. *Br J Psychiatry* 2001;179:11-4.
4. Katon W, Sullivan M, Walker E. Medical symptoms without identified pathology: relationship to psychiatric disorders, childhood and adult trauma, and personality traits. *Ann Intern Med* 2001;134:917-25.
5. Von Korff M, Simon G. The relationship between pain and depression. *Br J Psychiatry Suppl* 1996;(30):101-8.
6. Nielson WR, Merskey H. Psychosocial aspects of fibromyalgia. *Curr Pain Headache Rep* 2001;5:330 -7.

PLEASE ANALYZE THE CITING/REFERENCING STRATEGY IMPLEMENTED BY DR. B IN HIS REVIEW, AND GIVE YOUR COMMENTS.

Note: Your comments should focus on the citing/referencing method (i.e. the way in which references have been handled), & NOT on the subject matter & specific details of the content.

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LITERATURE REVIEW & CITING / REFERENCING: Group Tasks

GROUP TASK 3

The dissertation topic of Dr. C, a postgraduate student, is - *"A study of the role of music therapy in perioperative scenarios"*. Dr. C submits a draft of the review of literature of her dissertation to Prof. Z, her dissertation guide. An extract from Dr. C's literature review is provided here, along with the corresponding list of references.

PLEASE ANALYZE THE CITING/REFERENCING STRATEGY IMPLEMENTED BY DR. C IN HER REVIEW, AND GIVE YOUR COMMENTS.

Note: Your comments should focus on the citing/referencing method (i.e. the way in which in-text citations & the list of references have been presented), & NOT on the subject matter & specific details of the content.

Several researchers have studied the role of music in the control of patients' anxiety in perioperative scenarios. Music can reduce the anxiety and stress of patients in the surgical holding area.¹ Augustin and Hains² demonstrated that music can be more beneficial than preoperative instruction alone in reducing ambulatory surgery patients' preoperative anxiety. Patients who listened to their choice of music before surgery in addition to receiving preoperative instruction had significantly lower heart rates than patients in the control group who received only preoperative instruction.

In a controlled study (Haun et al. 2001), it was observed that music produced a significant reduction in anxiety and respiratory rates of women awaiting breast biopsy. A recent study (Wang et al. 2002) evaluated the role of music in the management of preoperative anxiety through a randomized, controlled study. Patients who listened to music before surgery reported lower levels of state anxiety. A recent randomized controlled trial (Cooke et al. 2005) demonstrated that exposure to music resulted in a statistically significant reduction of preoperative anxiety in patients undergoing day surgery.

Patients who listened to their choice of music during surgery with local anesthesia experience significantly lower anxiety levels, heart rates, and blood pressure than patients who did not listen to music.

Allred et al⁷ studied the effect of music on postoperative pain and anxiety following total knee arthroplasty. The music group's decrease in pain and anxiety was not significantly different from the comparison rest group's decrease in pain or anxiety. However, statistical findings within groups indicated that the sample had a statistically significant decrease in pain and anxiety over time. In a systematic review of 42 randomized controlled trials of the effects of music interventions in perioperative settings⁸, it was observed that music intervention had positive effects on reducing patients' anxiety and pain in approximately half of the reviewed studies.

References

1. Winter MJ, Paskin S, Baker T. Music reduces stress and anxiety of patients in the surgical holding area. *Journal of Post Anesth Nurs* 1994;9:340-343.
2. Augustin, P. & Hains, A.A. 1996. Effect of music on ambulatory surgery patients' preoperative anxiety. *AORN J* 1996;63:750,753-758.
3. Haun, Mainous, Looney. Effect of music on anxiety of women awaiting breast biopsy. *Behav Med* 2001;27:127-132.
4. Wang, S.M., Kulkarni, L., Dolev, J., & Kain, Z.N. 2002. Music and preoperative anxiety: a randomized, controlled study. *Anesth Analg*;94:1489-94.
5. Cooke M, Chaboyer, Schluter, Hiratos M. The effect of music on preoperative anxiety in day surgery. *J Adv Nurs* 2005;52:47-55.
6. Mok E, Wong KY. Effects of music on patient anxiety. *AORN J*;77:396-6, 409.
7. Allred, K.D., Byers, J.F., & Sole, M.L. 2010. The effect of music on postoperative pain and anxiety. *Pain Manag Nurs*.
8. Nilsson U. The anxiety- and pain-reducing effects of music interventions: a systematic review. *AORN J* 2008;87:780-807.

LITERATURE REVIEW & CITING / REFERENCING: Group Tasks

GROUP TASK 4

The dissertation topic of Dr. X, a postgraduate student, is - "*A study of physical symptoms in depressive disorders*". Dr. X is in the process of writing the Review of Literature for his dissertation. Dr. X is behind schedule & needs to submit a draft of his dissertation to his guide within two days. While conducting a literature search, he had retrieved the following reference:

Henningsen P, Zimmermann T, Sattel H. Medically Unexplained Physical Symptoms, Anxiety, and Depression: A Meta-Analytic Review. *Psychosomatic Medicine* 2003;65:528-33.

Dr. X finds that the introductory paragraph of this reference article is highly relevant to his dissertation topic. He extracts the entire introductory paragraph verbatim, along with six citations, & inserts it into his literature review. He hasn't made an attempt to search for and retrieve the six references that the paragraph is based on, but lists all six in his own list of references at the end of the dissertation. The introductory paragraph of Dr. X's literature review thus reads as follows:

Medically unexplained symptoms of pain and bodily dysfunction are the single most prevalent class of symptoms in primary care. They also have a high prevalence in specialist care and are responsible for a significant proportion of disability in the workforce (1-3). They are a defining feature of the different functional somatic syndromes within somatic medicine and of the somatoform disorders within psychiatry. Patients with medically unexplained physical symptoms have been shown to have increased rates of depression and anxiety (3-5). This correlation has not yet been reviewed systematically, and several possible explanations exist. The association might signify a reactive increase of depression and anxiety in patients suffering from chronic bodily symptoms (6).

References

- 1) Kroenke K, Spitzer RL, Williams JBW, Linzer M, Hahn SR, deGruy FV III, Brody D. Physical symptoms in primary care: predictors of psychiatric disorders and functional impairment. *Arch Fam Med* 1994;3:774-9.
- 2) Reid S, Wessely S, Crayford T, Hotopf M. Medically unexplained symptoms in frequent attenders of secondary health care: retrospective cohort study. *BMJ* 2001;322:767-70.
- 3) Bass C, Peveler R, House A. Somatoform disorders: severe psychiatric illnesses neglected by psychiatrists. *Br J Psychiatry* 2001;179:11-4.
- 4) Katon W, Sullivan M, Walker E. Medical symptoms without identified pathology: relationship to psychiatric disorders, childhood and adult trauma, and personality traits. *Ann Intern Med* 2001;134:917-25.
- 5) Von Korff M, Simon G. The relationship between pain and depression. *Br J Psychiatry Suppl* 1996;(30):101-8.
- 6) Nielson WR, Merskey H. Psychosocial aspects of fibromyalgia. *Curr Pain Headache Rep* 2001;5:330-7.

PLEASE ANALYZE THE STRATEGY FOLLOWED BY DR. X, AND GIVE YOUR COMMENTS.

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GROUP TASK 1: FOR GROUPS A & B

GIVEN TIME: 30 MINUTES

TASK TO BE DONE: READ THE FOLLOWING STUDY, AND WRITE THE DISCUSSION

Iron Deficiency as a Risk Factor for Simple Febrile Seizures- A Case Control Study

Introduction:

Febrile seizures are the commonest cause of seizures in children, occurring in 2-5% of children [1]. Iron deficiency is the commonest micronutrient deficiency worldwide, and is a preventable and treatable condition [7]. Iron is needed for brain energy metabolism, for metabolism of neurotransmitters and for myelination. Thus, iron deficiency may alter the seizure threshold of a child [8,9]. Iron deficiency is postulated as a risk factor for febrile seizures in children [10,11]. We, therefore, studied the association between iron deficiency and simple febrile seizures.

Methods

This case control study was done in the Department of Pediatrics, in a tertiary care Hospital during January 2011 to December 2011. Cases were children of age group 6 months to 3 years presenting with simple febrile seizures to the Pediatrics Emergency Department and wards of the hospital during the study period. Diagnostic criteria for simple febrile seizures was based on AAP Clinical Practice Guidelines(2); those who did not satisfy AAP criteria and those who were on iron supplements were excluded. Consecutive cases were selected for the study and concurrent controls were selected from the same setting and included febrile children of age group 6 months to 3 years who presented with short duration fever (<3 days) but without seizures. Cases and controls were selected in 1:1 ratio.

After informed consent, detailed history was elicited and physical examination was done. Iron deficiency was diagnosed by hemoglobin, serum ferritin, serum iron and red cell width distribution ratio (RDW), based on WHO recommended standard values [7]. Other variables

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studied are sex, socioeconomic status and protein energy malnutrition (IAP classification).

Sample size was calculated using standard procedure and analysis was done using SPSS version 11.

Results:

Criteria	Cases (n=154)	Controls (n=154)	P value
Female	71(46.15%)	81(52.6%)	0.254
Social Class 4	115(74.7%)	109(70.8%)	0.443
Iron deficiency	98 (63.6%)	38 (24.7%)	0.001
Malnutrition	62 (40.3%)	52(33.8%)	0.238
Rural / urban	69 (44.8%)	83 (55.2%)	0.234

154 cases and 154 controls were included in the study. The average age of cases and controls was 17.5 ± 8.81 and 17.6 ± 8.54 months, respectively. Iron deficiency is found to be significantly associated with simple febrile seizures (see *Table*). Variables malnutrition (p value 0.238), socio-economic status (p value 0.443) and sex of the child (p value 0.254) were found to be insignificant. No difference between rural and urban children (p value 0.234). All children who had reduced Hb also had reduced iron and ferritin levels in their blood.

References

12. Pisacane A, Roland P, Sansone R, Impagliazzo N, Coppola A, D' Appuzo A. Iron Deficiency anaemia and febrile convulsions: A case control study. *BMJ*. 1996;313:343{age group studied: 6 months to 3 years; Hb, serum iron and serum ferritin levels were less in cases. Iron deficiency anemia in controls was 10 % and in cases 50%}
13. Dawn SH, Jonatan T, Jerome Y, Don S. The association between iron deficiency and febrile seizures in childhood. *ClinPediatr*. 2009;48:420-6. {Hb, serum iron and serum ferritin were less in children with febrile seizures. Febrile seizures was 1.83 times more likely in iron deficient children aged 3 months to 5 years}

14. Daud AS, Batieha A, Ekteish A, Gharaibeh N, Ajlouni S, Hijazi S. Iron status: a possible risk factor for first febrile seizures. *Epilepsia*. 2002;43:740-3. {The mean serum ferritin level in the cases was 29.5 mcg/L, and in the controls 53.5 mcg/L. But, Hb and serum iron levels were similar in both cases and controls. This study was conducted in Jordan}
15. Rajwanti KV, Praveen GD, Swati K, Ghosh K. Iron deficiency as a risk factor for first febrile seizure. *Indian Pediatr*. 2010;47:437-9. {The mean serum ferritin level in children with first febrile seizures (31.9 ± 31.0 mcg/L) and in controls (53.9 ± 56.5 mcg/L) ($P=0.003$). Mean hemoglobin value of cases (9.4 ± 1.2 g/dL) and controls (9.5 ± 1.0 g/dL) ($P=0.7$)}. The serum iron values were also similar in both the groups. This study was done in Mumbai}
16. Rao S. Assessment of iron status; ICMR. {Serum ferritin is the early indicator of iron deficiency in the body; serum ferritin gets lowered in the early stages in iron deficiency and lowering of serum iron and Hb occurs later}
17. Jonghankim et al. Iron and mechanisms of emotional behavior – a review article. *J NutrBiochem* 2014 Nov;25(11): 1101-07.
{Less iron status probably interferes with myelination of brain, metabolism of monoamine oxidases, and homeostasis in Glutamate and GABA levels in the brain}
18. Kanth et al. Nutritional status in upper socioeconomic status:
{50% of children <5 years belonging to India's upper most economic group have less Hb values}.
19. Nutritional status of Indian children. NFHS survey III. {iron deficiency in rural community of India is 74% and urban community of India 66 % in children < 3 years; the difference is not significant}

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GROUP TASK 2: FOR GROUPS C & D

GIVEN TIME: 30 MINUTES

TASK TO BE DONE: READ THE FOLLOWING STUDY AND WRITE THE DISCUSSION

Determinants of Vitamin A Deficiency amongst Children in Aligarh District, Uttar Pradesh

Introduction:

Vitamin A deficiency (VAD) is an important cause of preventable blindness among children and a major public health problem in developing countries like India. It has also been established that VAD increases the risk of childhood morbidity and mortality [1,2]. Identification of focal pockets of xerophthalmia is necessary so that interventions can be prioritized. We estimated the prevalence of xerophthalmia among rural and urban preschool children, and analyzed the risk factors in 6 villages and 4 peri-urban areas in Western Uttar Pradesh, as the same has not been studied so far.

Methods

The present cross-sectional descriptive study was undertaken between January and July 2009. The study population comprised all the under-five children (0-60 months) residing in the specified locality in Aligarh district ($n=3679$). Ethical clearance was obtained from the Institutional ethics committee.

A house-to-house survey was carried out and information was obtained about socio-economic status, dietary details and the presence of symptom of vitamin A deficiency (night blindness) in the child. Then the child was examined for signs of vitamin A deficiency.

Results

Mean age of the participants was 36 ± 21 months. Prevalence of xerophthalmia in the present study was 9.1%; most of them had only early signs of vitamin A deficiency. There was a rising trend in the prevalence and severity of xerophthalmia with increasing age (**Table I**). The difference in xerophthalmia prevalence among under two and over two years age groups was statistically significant ($P < 0.001$). **Table II** depicts the socio demographic status in relation to xerophthalmia. Other risk factors associated with xerophthalmia are depicted in **Table III**. Inadequate intake of vitamin A rich foods and predominant intake of white maize as the staple diet (which lacks carotenoid pigments, the provitamin A) are the significant dietary factors. Vitamin A deficiency was less among children who were given prolonged breast feeding.

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TABLE I Prevalence of Xerophthalmia (Vitamin A deficiency) in Different Age Groups

Age-group (months)	Number	Only night Blindness (XN only)	Only Bitot's spots (XIB only)	Corneal xerosis X2	Corneal ulceration X3A	Kerato-Malacia X3B	Corneal scarring XS	Total number with Xerophthalmia
0-12	789	-	6 (0.7)	0 (0)	0 (0)	0(0)	2 (0.3)	8(1.1)
13-24	742	-	44 (5.9)	1 (0.1)	1 (0.2)	0(0)	1 (0.2)	47(6.3)
25-36	666	23 (3.5)	47 (6.9)	3 (0.4)	1 (0.2)	0(0)	3 (0.4)	77(11.6)
37-48	762	43 (5.6)	42 (5.5)	3 (0.4)	2 (0.2)	0(0)	6 (0.8)	96(12.6)
49-60	612	35 (5.7)	54 (8.8)	2 (0.3)	1 (0.2)	0(0)	5 (0.8)	97(15.8)
Total	3571	101 (2.8)	193 (5.4)	9 (0.3)	5 (0.2)	0(0)	17 (0.5)	325(9.1)

Figures in parentheses indicate percentages.

TABLE II Socio Demographic factors in relation to Xerophthalmia

Variable	Number in the group	Children with Xerophthalmia No & Percentage	P value
Social class			
Upper	286	9 (3.1%)	<0.01
Lower	3285	316 (9.6%)	
Place of residence			
Rural	2160	247 (11.4%)	<0.01
Urban	1411	78 (5.5%)	
Maternal literacy			
Literate	367	13 (3.5%)	<0.01
Illiterate	3204	322 (10%)	

Table III. Nutritional and other co-morbid factors in relation to Xerophthalmia:

Variable	Total number	No. of children with Xerophthalmia	P value
Vitamin A rich foods (By 24 hour recall method)			
Adequate	964	48 (4.9%)	<0.01
In adequate	2607	277 (10.6%)	
Breast feeding up to 2 years			
Yes	2144	134 (6.2%)	<0.01
No	1427	191 (13.3%)	
White maize as the main food			
Yes	2765	295 (10.6%)	<0.01
No	810	30 (3.7%)	

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References

10. WHO/UNICEF. "Indicators for Assessing Vitamin A Deficiency and their Application in Monitoring and Evaluating Intervention Programmes. Report of a Joint WHO/UNICEF Consultation. Geneva, Switzerland, 9-11 November 1992; Review Version. May 1994. {if the prevalence of xerophthalmia is >5% and corneal involvement is >0.1% then possibly it is a major public health problem in that community}
11. Khandait DW, Vasudeo ND, Zodpey SP, Ambadekar NN, Koram MR. Vitamin A intake and xerophthalmia among Indian children. *Public Health*. 1999;113:69-72. {prevalence of xerophthalmia in Nagpur urban preschool slum children was 8.7%}
14. NNMB National Nutrition Monitoring Bureau. National Institute of Nutrition, Hyderabad: NNMB Micronutrient Survey; 2002. {a) prevalence of vitamin A deficiency was 0.7%. (b) 68% of individuals consume less than 1/3rd of RDA of vitamin A. (c) Vitamin A intake was assessed by 24 hour recall method}
15. Curtale F, Tammam H, Hammoud ES, Aloi A. Prevalence of xerophthalmia among children in Beheira governorate, Egypt. *East Med Health J*. 1999;5:984-91. {number of children with vitamin A deficiency progressively increased from 1 to 7 years}
16. WHO fact sheet. Vitamin A content of the human breast milk is high
17. Swami HM, Thakur JS, Bhatia SP, Ahuja R. Rapid assessment and delivery of Vitamin A to slum children by using National Immunization Day in Chandigarh. *Indian J Pediatr*. 2001;68:719-23. {of children with vitamin A deficiency, only 5% had corneal ulceration and 1% had keratomalacia}
18. Semba RD, Pee SD, Panagides D, Poly O, Bloem MW. Risk factors for xerophthalmia among mothers and their children and for mother-child pairs with xerophthalmia in Cambodia. *Arch Ophthalmol*. 2004;122:517-23. {maternal education, socioeconomic status of the mother and cultural beliefs were found to be significant risk factors for xerophthalmia; rural areas have more prevalence of xerophthalmia}
19. Schémann JF, Banou AA, Guindo A, Joret V, Traore L, Malvy D. Prevalence of undernutrition and vitamin A deficiency in the Dogon region, Mali. *J Am Coll Nutr*. 2002;21:381-7. {Consumption of yellow orange and green foods (which are good source of Vitamin A) were very low in children with Vitamin A deficiency ranging from thrice in a month to once in several months}
20. Harjes CE, Rocheford TR, Bai L, Brutnell TP, Kandianis CB, Sowinski SG, *et al*. Natural genetic variation in lycopene epsilon cyclase tapped for maize biofortification. *Science*. 2008;319:330-3. {More than half of children with vit A deficiency were predominantly fed on white maize as their staple food, which is essentially devoid of yellow carotenoid pigments, which are precursors of provitamin A.}

GROUP TASK 3: FOR GROUPS E & F

GIVEN TIME: 30 MINUTES

TASK TO BE DONE: READ THE FOLLOWING STUDY, AND WRITE THE DISCUSSION

School Absenteeism Among Children and its Correlates

Introduction: School absenteeism has been studied in detail in relation to various social and physical causes(1,2). School absenteeism has been linked to maternal education, residence, and specific illnesses like asthma, headache, abdominal pain, etc(3-7). However, role of social pressures like poverty, part-time jobs etc. has not been explored. Identification of such problems may help in predicting children at higher risk of absenting themselves and hence ensuring timely preventive interventions. But, there is paucity of literature comprehensively assessing the various factors leading to school absenteeism. So, we conducted this study to assess the magnitude of school absenteeism and to study its correlates.

Methods: A cross-sectional, school based study was conducted in three government schools in South Delhi. The absenteeism was studied over a 6 month period from July to December 2006. Total of 704 children, of both sexes in the age group 10-15 years were registered as the participants.

At enrolment, information on socio-demographic profile of the students was collected. It included age, sex, class, education and occupation of the parents, their family structure and income. The socio-economic status was calculated as per the Revised Kuppuswami's Scale for determining socio-economic status of urban families (2001).

A pre-designed questionnaire was administered to ascertain the duration of absence and the causes for absenteeism, medical and non-medical. Participants were assured of confidentiality and were inquired about school truancy and various phobias of schools, teachers and subjects. The causes of absenteeism were also ascertained by school records, leave applications and one month's recall by the students. Students, teachers and parents were interviewed whenever needed.

For the purpose of this study, significant school absenteeism is defined as "absent for more than 2 days per month (i.e. 12 days in the 6 month study period).

Data were analyzed using Stata 9.1 software.

Results

A total of 704 students were registered of which 332 (47.16%) were boys. The average absenteeism per child was 10.2%. Only 9 children did not miss a single school day. 336 (47.8%) children had significant absenteeism (absent for more than two days in a month)

Table I
Relationship of Socio-demographic Factors with Significant School Absenteeism

Factors	Total number in each group	Children with significant Absenteeism
Sex*		
Male	332	208 (61.9%)
Female	372	128 (38.1%)
Age group*		
< 14	441	250 (74.4%)
> 14	263	86 (25.6%)
Standard*		
6	132	92 (27.4%)
7	224	122 (36.3%)
8	180	68 (20.2%)
9	168	54 (16.1%)
Birth order*		
1	165	42 (12.5%)
2	276	133 (39.6%)
3	140	83 (24.7%)
4	81	40 (11.9%)
5	42	38 (11.3%)
Mother's education*		
<5 standard	277	180 (53.6%)
>5 standard	427	156 (46.4%)
Father's education*		
<8 standard	206	124 (36.9%)
>8 standard	498	212 (63.1%)
Residence		
City	227	107 (31.8%)
Urban slum	477	229 (68.2%)
Occupation		
Unskilled	62	48 (14.3%)
Semi skilled	114	81 (24.1%)
Skilled	178	83 (24.7%)
Clerk/Shop	273	112 (33.3%)
Semi Professional	77	12 (3.6%)

Family size*		
<4	158	63 (18.8%)
5	227	80 (23.8%)
6	115	67 (19.9%)
7	107	61 (18.25%)
8	97	65 (19.3%)
Family income/mo (Rs.)*		
£6,10	84	78 (23.2%)
6,101-10,160	97	92 (27.4%)
10,161-15,280	115	104 (30.9%)
>15,281	408	62 (18.5%)

*P <0.01.

Male sex, increasing birth order and family size, lower parental education and income were identified to be associated with significant school absenteeism (**Table I**). Causes responsible for their school absenteeism, as reported by the students are listed in **Table II**.

Table II
Causes of School Absenteeism Reported by Students

Cause	Absentees n = 336	Others n = 368	P value
Part-time job	72 (21.4%)	0 (0%)	<0.001
Illness	182 (54.2%)	187 (50.8%)	0.37
Chronic illness	51 (15.2%)	14 (3.8%)	<0.001
Perception of ill health	150 (44.64%)	129 (35.1%)	<0.001
Family function	162 (48.2%)	115 (31.2%)	<0.001
Family illness	103 (30.6%)	62 (16.85%)	<0.001
Family problem	141 (42%)	36 (9.8%)	<0.001
School phobia	159 (47.32%)	82 (22.3%)	<0.001
School truancy	59 (17.6%)	2 (0.5%)	<0.001
School load	167 (49.7%)	121 (32.9%)	<0.001

References:

- Besculides M, Heffernan R, Mostashari F, Weiss D. Evaluation of school absenteeism data for early outbreak detection, New York City. BMC Public Health 2005; 5: 105. {a) percentage of children with school absenteeism in different schools range from 7.3% to 17.8%. b) Adolescent children were more likely to remain absent compared to younger children}
- Awasthi S, Sharma A. Survey of school health and absenteeism in Lucknow. Indian Pediatr 2004; 41: 518. {a) Prevalence of school absenteeism is 4.7%. b) Male children are more likely to remain absent

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from school}

11. Ananthakrishnan S, Nalini P. School absenteeism in a rural area in Tamil Nadu. Indian Pediatr 2002; 39: 847-850. {a) Of children with school absenteeism, 50.2% were males and 49.8% were females. b) School absenteeism is more common in younger children}
12. Kaplan BA, Mascie Taylor CG, Boldsen J. Birth order and health status in a British national sample. J BiosocSci 1992; 24: 25-33. (In first born child, school absenteeism is seen in 8%, in second order birth it is 12% and in 3rd order it is 22.4%)
13. Rumberger RW. Dropping out of high school: the influence of race, sex, and family background. Am Educ Res J 1983; 20: 199-220. {75% of children with school absenteeism were from poor families and 80% of mothers were uneducated}

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GROUP TASK 1: FOR GROUPS A & B

GIVEN TIME: 30 MINUTES

TASK TO BE DONE: READ THE FOLLOWING STUDY, AND WRITE THE DISCUSSION

Iron Deficiency as a Risk Factor for Simple Febrile Seizures- *A Case Control Study*

Introductory paragraph:

Major finding: Iron deficiency is a risk factor: (Ref: 12,13)

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Other finding: In our study, all children who had anemia also had less serum ferritin. + Compare with the findings of studies 14 & 15 and explain the possible differences using Ref16:

Link between reduced iron status and febrile seizures (Ref: 17)

**Other findings (no correlation with socio-economic status; ref: 18.
no correlation with rural or urban: ref: 19)**

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Limitations: (hospital based study and not community based)

Conclusion & further areas of research:

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GROUP TASK 2: FOR GROUPS C & D

Discussion:

Introductory paragraph:

Major finding:

**Prevalence of Xerophthalmia is 9.1%; add Ref: 10, 11 and 14 (a);
give reasons, if findings are different.**

**Other finding: (Vitamin A def increases with age; add ref: 15.
Prolonged breast feeding rate beyond two years is high; add ref:
16)**

**Other finding (Severe forms of vitamin A deficiency such as corneal
ulceration and keratomalacia are less in the study population)
(Ref: 17)**

**Other finding (relationship of vitamin A deficiency with maternal
illiteracy, poverty and rural areas): (add Ref: 18)**

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Other finding (intake of vitamin A rich foods is less; add ref: 19, 14 (b)).

Other finding (White maize eating is common, which contains less vitamin A): add Ref: 20.

Concluding sentence:

Limitations for the study: diet intake was assessed by 24 hour recall method: (add ref: 14 c)

Suggestions for future: (Fortification of white maize with vitamin A; health education to public about balanced diet; training of peripheral health workers)

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GROUP TASK 3: FOR GROUPS E & F

School Absenteeism Among Children and its Correlates

Discussion

Introduction:

Major finding: The average absenteeism per child in our study is 10.2%.

Add ref: 8 (a) and then 2 (a).

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Other finding: comment on male sex, age group, birth order, parents' education and income, school phobia, school truancy, school load and absenting for family reasons; add ref: 8 (b), 11(b), 12, 13, 2(b), 11(a); quote the possible reasons:

Other finding (child labour 21%; quote the possible reasons):

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Other finding (family problems 42%; quote the possible reasons)

Limitations of our study (Study done in Govt. schools only):

Conclusion and suggestions:

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SESSION EVALUATION:

No.	SESSIONS	Very Useful	Useful	Not useful
1.	Writing Summary			
2.	Formatting using template			
3.	Conversion of Dissertation into Journal article			
4.	Final Check			

Facilitating Factors:

Hindering Factors:

Overall Opinion:

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Date: 24.08.2018

SESSION EVALUATION:

No.	SESSIONS	Very Useful	Useful	Not useful
1.	Writing Summary	✓		
2.	Formatting using template	✓		
3.	Conversion of Dissertation into Journal article	✓		
4.	Final Check	✓		

Facilitating Factors:

learn how to use zotero citations,
a gift

Hindering Factors:

Overall Opinion:

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SESSION EVALUATION:

No.	SESSIONS	Very Useful	Useful	Not useful
1.	Writing Summary		/	
2.	Formatting using template		/	
3.	Conversion of Dissertation into Journal article		/	
4.	Final Check		/	

Facilitating Factors:

Hindering Factors:

Overall Opinion:

Good.

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SESSION EVALUATION:

No.	SESSIONS	Very Useful	Useful	Not useful
1.	Writing Summary		/	
2.	Formatting using template		/	
3.	Conversion of Dissertation into Journal article		/	
4.	Final Check		/	

Facilitating Factors:

Hindering Factors:

Overall Opinion:

good

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SESSION EVALUATION:

No.	SESSIONS	Very Useful	Useful	Not useful
1.	Writing Summary		✓	
2.	Formatting using template		✓	
3.	Conversion of Dissertation into Journal article		✓	
4.	Final Check		✓	

Facilitating Factors:

Hindering Factors:

Overall Opinion:

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SESSION EVALUATION:

No.	SESSIONS	Very Useful	Useful	Not useful
1.	Writing Summary		✓	
2.	Formatting using template	✓		
3.	Conversion of Dissertation into Journal article	✓		
4.	Final Check		✓	

Facilitating Factors:

Short and useful talks.

Hindering Factors:

Overall Opinion:

good

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1.	Writing Summary		/	
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4.	Final Check		/	

Facilitating Factors:

Hindering Factors:

Overall Opinion:

Good

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2.	Formatting using template		✓	
3.	Conversion of Dissertation into Journal article		✓	
4.	Final Check		✓	

Facilitating Factors:

Hindering Factors:

Overall Opinion:

Good

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Facilitating Factors:

Hindering Factors:

Overall Opinion:

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Date: 24.08.2018

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No.	SESSIONS	Very Useful	Useful	Not useful
1.	Writing Summary	✓		
2.	Formatting using template	✓		
3.	Conversion of Dissertation into Journal article	✓		
4.	Final Check	✓		

Facilitating Factors:

Hindering Factors:

Overall Opinion:

good

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SESSION EVALUATION:

No.	SESSIONS	Very Useful	Useful	Not useful
1.	Writing Summary	✓		
2.	Formatting using template	✓		
3.	Conversion of Dissertation into Journal article	✓		
4.	Final Check		✓	

Facilitating Factors:

Hindering Factors:

Overall Opinion:

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SESSION EVALUATION:

No.	SESSIONS	Very Useful	Useful	Not useful
1.	Writing Summary		✓	
2.	Formatting using template		✓	
3.	Conversion of Dissertation into Journal article	✓		
4.	Final Check	✓		

Facilitating Factors:

Hindering Factors:

Overall Opinion:

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SESSION EVALUATION:

No.	SESSIONS	Very Useful	Useful	Not useful
1.	Writing Summary	✓		
2.	Formatting using template	✓		
3.	Conversion of Dissertation into Journal article	✓		
4.	Final Check	✓		

Facilitating Factors: —

Hindering Factors: —

Overall Opinion: Good.

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1.	Writing Summary	✓		
2.	Formatting using template	✓		
3.	Conversion of Dissertation into Journal article	✓		
4.	Final Check	✓		

Facilitating Factors:

Hindering Factors:

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Overall Opinion:

Thank you very much for giving importance to all the relevant topics. Please continue this kind.



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No.	SESSIONS	Very Useful	Useful	Not useful
1.	Writing Summary	✓		
2.	Formatting using template	✓		
3.	Conversion of Dissertation into Journal article	✓		
4.	Final Check	✓		

Facilitating Factors:

Indepth explanation about Article Submission,

Hindering Factors:

Overall Opinion:

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This is to certify that Dr.....

attended the..... Value added Course on Protocol Writing

held at MGMC&RI, Puducherry on..... as a Participant

Dean
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Pillaiyarkuppam, Pondicherry - 607 403
Co-Ordinator
Medical Education Unit

REGISTRAR
SRI BALAJI VIDYAPEETH
(Deemed University u/s 3 of UGC ACT, 1956)
Pillaiyarkuppam, Puducherry - 607 402



Value added course on Protocol Writing

Time: 2.00 - 4.00 PM

Enrolled student list

Venue: MEU

S.No	UIN No	Name	Department	20/08/18	21/08/18	22/08/18	23/08/18	24/08/18
1	1601021001	Dr. Daggupati Harith	Anesthesiology	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
2	1601021002	Dr. Gobinath	Anesthesiology	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
3	1601021003	Dr. Arthi. P. R	Anesthesiology	[Signature]	ABSENT	[Signature]	[Signature]	[Signature]
4	1601021004	Dr. Govind Shaji	Anesthesiology	[Signature]	ABSENT	[Signature]	[Signature]	[Signature]
5	1601021005	Dr. Anwar Basha S	Anesthesiology	[Signature]	ABSENT	[Signature]	[Signature]	[Signature]
6	1601021006	Dr. Abhimanyu Singh	Anesthesiology	[Signature]	ABSENT	[Signature]	[Signature]	[Signature]
7	1601051001	Dr. Sridhar .D	Com. Medicine	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
8	1601051002	Dr. Chithra .B	Com. Medicine	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
9	1601051003	Dr. Surendran .V	Com. Medicine	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
10	1601061001	Dr. Midhun T.T	DVL	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
11	1601061002	Dr. Sameer Firoz	DVL	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
12	1601061003	Dr. Roshni K	DVL	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
13	1601061004	Dr. Sapna Muralidhar Goutham	DVL	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
14	1601071001	Dr. Roby Thomas Koshy	ENT	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
15	1601071002	Dr. Raamdeepak K.K	ENT	[Signature]	[Signature]	ABSENT	[Signature]	[Signature]
16	1601091001	Dr. Bhargav Kiran Gaddam	Gen. Medicine	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
17	1601091002	Dr. Mohammed Feros A.S	Gen. Medicine	[Signature]	[Signature]	ABSENT	ABSENT	ABSENT
18	1601091003	Dr. Mote Srikanth	Gen. Medicine	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
19	1601091004	Dr. Mohamed Kasim A	Gen. Medicine	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
20	1601091005	Dr. Sujjay .J	Gen. Medicine	[Signature]	[Signature]	ABSENT	[Signature]	[Signature]
21	1601091006	Dr. Anirudhya .J	Gen. Medicine	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
22	1601091007	Dr. Yugandhar Tummalam	Gen. Medicine	[Signature]	ABSENT	[Signature]	[Signature]	[Signature]
23	1601091008	Dr. Siddharth	Gen. Medicine	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]

REGISTRAR
 SRI BALAJI VIDYAPEETH
 (Deemed University) Act 3 of UGC ACT, 1956
 C with 'A' Grade
 Piliyarkuppam - 607 402.

DEPUTY PRINCIPAL (Academics)
 MGMCRI, PUDUCHERRY

REGISTRAR
 SRI BALAJI VIDYAPEETH
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 Piliyarkuppam - 607 402.



Venue: MEU

Time: 2.00 - 4.00 PM

S.No	UIN No	Name	Department	20/08/18	21/08/18	22/08/18	23/08/18	24/08/18
24	1601091009	Dr. Chandrasekar .K. T	Gen. Medicine	Chandrasekar	Chandrasekar	Chandrasekar	Chandrasekar	Chandrasekar
25	1601091010	Dr. Sureshkumar. S	Gen. Medicine	Suresh	Suresh	Suresh	Suresh	Suresh
26	1601101001	Dr. Abhishant .P	Gen. Surgery	Abhishant	Abhishant	Abhishant	Abhishant	Abhishant
27	1601101002	Dr. Anupriya .R	Gen. Surgery	Anupriya	Anupriya	Anupriya	ABSENT	Anupriya
28	1601101003	Dr. Venkateshen P	Gen. Surgery	Venkateshen	Venkateshen	ABSENT	ABSENT	ABSENT
29	1601101004	Dr. Pugazharasan .M	Gen. Surgery	A	Pugazharasan	Pugazharasan	Pugazharasan	Pugazharasan
30	1601101005	Dr. Gowtham .K	Gen. Surgery	K.Gowtham	K.Gowtham	K.Gowtham	K.Gowtham	K.Gowtham
31	1601101006	Dr. Ajay .P	Gen. Surgery	Ajay	Ajay	Ajay	Ajay	Ajay
32	1601101007	Dr. Prethivee .N	Gen. Surgery	Prethivee	Prethivee	ABSENT	Prethivee	Prethivee
33	1601101008	Dr. Chidambara Thanu .T	Gen. Surgery	Chidambara	ABSENT	ABSENT	ABSENT	Chidambara
34	1601101009	Dr. Barath .K	Gen. Surgery	Barath	Barath	ABSENT	Barath	Barath
35	1601101010	Dr. Balaji Rajavarman. H	Gen. Surgery	ABSENT	ABSENT	ABSENT	ABSENT	ABSENT
36	1601121001	Dr. Nikita	OB & GY	Nikita	Nikita	Nikita	Nikita	Nikita
37	1601121002	Dr. Shruthi Rajendran	OB & GY	Shruthi	Shruthi	Shruthi	Shruthi	Shruthi
38	1601121003	Dr. Podili Prudvi Rani	OB & GY	Podili	Podili	Podili	Podili	Podili
39	1601121004	Dr. Ishwarya L.D	OB & GY	A	ABSENT	ABSENT	ABSENT	ABSENT
40	1601121005	Dr. Devarasetty Shravani	OB & GY	D.Devarasetty	D.Devarasetty	D.Devarasetty	Shravani	Shravani
41	1601121006	Dr. Prathima .A	OB & GY	Prathima	Prathima	Prathima	Prathima	Prathima
42	1501121001	Dr. Ashwin Rao	OB & GY	A	ABSENT	Ashwin	Ashwin	Ashwin
43	1601131001	Dr. Senthil Prasad R	Ophthal	Senthil	Senthil	Senthil	Senthil	Senthil
44	1601131002	Dr. Reshma Shaji	Ophthal	Reshma	Reshma	Reshma	Reshma	Reshma
45	1601131003	Dr. Kannegolla Anudeep	Ophthal	Anudeep	Anudeep	Anudeep	Anudeep	Anudeep
46	1601131004	Dr. Vasantha Kumar	Ophthal	Vasantha	ABSENT	Vasantha	Vasantha	Vasantha

VICE PRINCIPAL (ADMINISTRATIVE)
MGMC&RI, PUDUCHERRY

REGISTRAR
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MEDICAL EDUCATION UNIT, MGMCRI

Value added course on Protocol Writing



Venue: MEU

Time: 2.00 - 4.00 PM

S.No	UIN No	Name	Department	20/08/18	21/08/18	22/08/18	23/08/18	24/08/18
47	1601131005	Dr. Shruthy Vaishali R	Ophthal	Present	Present	Present	Present	Present
48	1601141001	Dr. Arjun Sarvesh I	Ortho	Present	ABSENT	Present	Present	ABSENT
49	1601141002	Dr. Roshan Raj K.M	Ortho	Present	ABSENT	Present	Present	Present
50	1601141003	Dr. Pradeepkumar .T	Ortho	Present	Present	Present	ABSENT	Present
51	1601151001	Dr. Zaheen Zehra. N	Paediatrics	Present	Present	Present	Present	Present
52	1601151002	Dr. Ravi Kumar .S	Paediatrics	Present	Present	Present	Present	Present
53	1601151003	Dr. Rasika Priya D	Paediatrics	Present	Present	Present	Present	ABSENT
54	1601151004	Dr. Kannan .C	Paediatrics	Present	Present	Present	Present	ABSENT
55	1601161001	Dr. Shameera Begum M	Pathology	Present	Present	ABSENT	Present	Present
56	1601161002	Dr. Varughese Padinjattadathu George	Pathology	Present	Present	Present	Present	Present
57	1601161003	Dr. Janani. M	Pathology	Present	Present	Present	Present	Present
58	1601191001	Dr. Suriyakumar .T	Psychiatry	T.S	T.S	T.S	T.S	T.S
59	1601191002	Dr. Natasha Celia Saldanha	Psychiatry	NCS	NCS	NCS	NCS	NCS
60	1601211001	Dr. Thiyagesa Devaganapathy .S	TBCD	A	ABSENT	ABSENT	ABSENT	ABSENT
61	1601211002	Dr. Karthikeyan K	TBCD	A	ABSENT	ABSENT	ABSENT	ABSENT
62	1601201001	Dr. Sanmathi .A	Radiology	Present	Present	Present	Present	Present
63	1601201002	Dr. Sahana. S	Radiology	Present	Present	Present	Present	Present
64	1601201003	Dr. Abhilash .P	Radiology	Present	Present	Present	Present	Present
65	1601201004	Dr. Mohit N	Radiology	Present	Present	Present	Present	Present
66	1601201005	Dr. Aparaj Bhuyan	Radiology	Present	Present	Present	Present	Present
67	1601201006	Dr. Sathagurunath-P A	Radiology	Present	Present	Present	Present	Present

REGISTRATION NO. P
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VICE PRINCIPAL (CURRICULUM)
 MGMCRI, PUDUCHERRY.