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EDITORIAL ANALYSIS

The Monsoon Killer We Do Not Plan For: Snakebite and Disaster Preparedness

DOWN TO EARTH

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THE LIFT LINE

A disaster that arrives on schedule every single year is not a disaster; it is a decision.

WHY THIS EDITORIAL MATTERS FOR YOUR EXAM

Snakebite envenoming is a World Health Organization-listed Neglected Tropical Disease, and India carries close to half the world's burden. The most widely cited estimate, from the Million Death Study and repeated in India's own National Action Plan, puts Indian deaths at roughly 58,000 a year, with perhaps three times as many people left permanently disabled, amputated, blinded or with chronic kidney damage. That figure is an estimate derived from verbal-autopsy modelling, not a count, and it should be cited as such, precisely because official hospital reporting captures only a fraction of it. What is not in doubt is the seasonality: bites surge with the monsoon, when flooded burrows push snakes into homes and fields and farmers wade through standing water. Yet snakebite appears in almost no state disaster management plan and in few monsoon health preparedness circulars.

GS Paper 2: issues relating to the development and management of the health sector; government policies and interventions and issues arising out of their design and implementation; the mechanisms and institutions for the protection of the vulnerable.

GS Paper 3: disaster and disaster management; the shift from relief-centric to preparedness-centric approaches under the Disaster Management Act, 2005 (https://ujiyari.com/terms/disaster-management-act-2005/).

For **Prelims**, hold: the National Action Plan for Prevention and Control of Snakebite Envenoming, launched by the Union Health Ministry in March 2024, adopting a One Health approach with the target of halving snakebite deaths by 2030, in line with the WHO's global 2030 goal; snakebite declared a notifiable disease, with states directed to report every case and death; the "big four" venomous snakes of India, the Indian cobra,

the common krait, Russell's viper and the saw-scaled viper, which the standard Indian polyvalent anti-snake venom is raised against; and the National Disaster Management Authority and State Disaster Management Authorities under the Disaster Management Act, 2005.

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BACKGROUND AND CONTEXT

India already has the policy document. NAPSE, launched in 2024, is a serious, One Health-framed plan that names the right levers: surveillance, antivenom availability, trained health workers, community awareness and coordination across health, wildlife and agriculture. Snakebite has since been made notifiable, which is the precondition (https://ujiyari.com/vocab/precondition/) for knowing anything at all. The failure is downstream, at implementation, and it is a failure of a very particular kind: the failure to treat a predictable seasonal spike as a preparedness problem.

Compare how the state handles two monsoon-linked killers. For dengue, districts run pre-monsoon fogging drives, stock platelets, and issue circulars in May. For snakebite, which kills far more Indians, there is typically no pre-monsoon stocking audit, no verification that primary health centres hold in-date polyvalent antivenom, no mapping of which facility can actually administer it and manage the anaphylaxis that antivenom itself can cause, and no referral chain. The victim, usually a barefoot agricultural worker bitten at dusk in a field or while sleeping on the floor, is then routed through a traditional healer, then a PHC that has no vials, then a community health centre that has vials but no doctor confident to use them, and reaches a district hospital several hours after the venom has begun its work. The clock, not the snake, does the killing.

THE CORE ARGUMENT / ISSUE

The gap is at the primary health centre, not the medical college

Antivenom works, and it is cheap relative to what it saves, but it is time-dependent. Every hour of delay raises the dose needed and the risk of death or amputation. That makes the decisive variable the distance from the bite to the first facility that can infuse antivenom with adrenaline and airway support standing by. Concentrating antivenom in district hospitals and medical colleges optimises for the wrong thing: it protects the vial and loses the patient. The PHC and CHC, closest to where bites happen, are exactly where stock, protocol and confidence are thinnest.

Regional venom variation blunts the antivenom

India's standard polyvalent ASV is manufactured largely from venom sourced from a narrow geography, historically around Tamil Nadu. Venom composition varies substantially across the country, so the same product is markedly less effective against, for instance, some Russell's viper and krait populations elsewhere in India. This is not an argument against ASV; it is an argument for region-specific venom sourcing, expanded venom banks and, in the medium term, recombinant and monoclonal antivenoms that do not depend on horse immunisation at all.

LINK IN THE CHAIN	PRESENT REALITY	WHAT PREPAREDNESS REQUIRES
Prevention	Barefoot field work, floor sleeping, no lighting	Boots and torches, raised sleeping, bed nets, mechanised handling
First response	Traditional healer, tourniquets, cutting and sucking	Trained community responders; immobilise and transport, no tourniquet
Transport	Private vehicle, hours lost	Dedicated 108-type response with a snakebite protocol
First facility	PHC often without in-date ASV or protocol	Pre-monsoon stocked PHC, trained staff, adrenaline ready
Antivenom	Single polyvalent product, geographic mismatch	Region-specific venom sourcing; next-generation antivenoms
Data	Under-reported; notifiable only recently	Real-time notification feeding a district heat map
Compensation	Discretionary, uneven across states	Uniform ex gratia, treated as a disaster-linked death

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It is a disease of the rural poor, and that explains the neglect

Snakebite victims are disproportionately agricultural workers, forest-dependent communities, women collecting fuel and fodder, and children. They are poor, rural and politically quiet, and the deaths are dispersed across thousands of villages rather than concentrated in one visible event. A flood that kills fifty people in one district produces a national response; snakebite kills a comparable number every few days across the country and produces none. Neglect here is not an oversight; it is a predictable consequence of who dies.

HOW TO THINK ABOUT THIS (ANALYTICAL FRAME)

Use the distinction, central to the Disaster Management Act, 2005, and to the Sendai Framework, between a hazard and a disaster. A hazard becomes a disaster only where vulnerability (https://ujiyari.com/vocab/vulnerability/) and low coping capacity meet it. Snakes are the hazard and they are constant. The disaster is manufactured by barefoot labour, unlit paths, empty PHC shelves and a broken referral chain, all of which are policy variables. The transferable rule: any recurring, seasonal, predictable mortality event should be governed as a preparedness problem with a pre-positioned response, not as a series of individual medical emergencies. If you can forecast it, you can plan for it, and if you can plan for it and do not, the deaths are attributable to the plan's absence.

THE DIAGRAM IN WORDS

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Monsoon -> flooded burrows and standing water -> snakes displaced into homes and fields -> bite, usually a barefoot agricultural worker at dusk or a person sleeping on the floor -> delay chain: traditional healer + tourniquet + private transport + PHC with no in-date ASV + CHC with no trained prescriber -> venom time advances -> death or permanent disability -> break the chain at four points: prevention (boots, torches, raised sleeping) + trained community first response (immobilise and transport) + pre-monsoon ASV stocking and staff training at PHC/CHC + notifiable-disease data feeding a district heat map -> NAPSE target of halving deaths by 2030 becomes reachable

WAY FORWARD

1. **Put snakebite in the State Disaster Management Plan.** Direct every SDMA to include snakebite as a recognised seasonal hazard with a pre-monsoon action calendar, mirroring the flood preparedness cycle, so the response is pre-positioned rather than improvised.
2. **Audit and stock antivenom at the PHC, before the monsoon.** Make in-date polyvalent ASV, adrenaline and a written anaphylaxis protocol a mandatory pre-monsoon checklist item at every PHC and CHC in high-burden districts, with the audit published.
3. **Train the first responder, and the first prescriber.** Certify community-level responders in immobilise-and-transport first aid, actively unteaching tourniquets and incision, and train PHC medical officers and nurses to initiate ASV rather than reflexively refer.
4. **Fix the antivenom itself.** Fund region-specific venom sourcing, expand venom banks beyond a single geography, and back Indian research into recombinant and monoclonal antivenoms.
5. **Make the notification real.** Enforce snakebite notification down to the sub-centre, publish district-level incidence, and use it to target stocking, since a disease that is not counted is never budgeted for.
6. **Standardise compensation and rehabilitation (https://ujiyari.com/vocab/rehabilitation/).** Provide uniform ex gratia and disability rehabilitation across states, recognising that a surviving amputee has lost a livelihood, not merely a limb.

PYQ LINKAGE AND PRACTICE

UPSC has asked about the shift from a relief-centric to a preparedness-centric approach to disaster management, about the state of India's primary health infrastructure, and about the health burden of the rural poor. This editorial links those to a killer that sits precisely at the intersection of health and disaster management and is owned fully by neither.

Practice question: "Snakebite envenoming is a predictable, seasonal, preventable mass-mortality event, yet it is absent from India's disaster preparedness architecture." Examine the reasons for this neglect and suggest an implementation framework for the National Action Plan for Prevention and Control of Snakebite Envenoming. (250 words, 15 marks)

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Sources: *Down To Earth (https://www.downtoearth.org.in/)*, *PIB, Ministry of Health and Family Welfare (https://www.pib.gov.in/PressReleasePage.aspx?PRID=2013803)*, *NCDC, NAPSE document (https://ncdc.mohfw.gov.in/)*

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