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Sandflies and Surveillance: The Chandipura Outbreak Response

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Sandflies and Surveillance: The Chandipura Outbreak Response

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Every fact web-verified against primary sources

> *The Union Health Ministry deployed a National Joint Outbreak Response Team to Gujarat and Rajasthan on August 5, 2026 for the ongoing Chandipura Virus Disease outbreak. Gujarat has the highest caseload this monsoon, with 184 suspected infections, 35 laboratory-confirmed cases and 22 child deaths, and seven children still under treatment.*

THE OUTBREAK

MEASURE	GUJARAT, MONSOON 2026
Suspected infections	**184**
Laboratory-confirmed cases	**35**
Child deaths	**22**
Still under treatment	7

The gap between 184 suspected and 35 confirmed is not a discrepancy. Acute Encephalitis Syndrome is a **syndromic** case definition, meaning a child presenting with fever and altered consciousness is counted as a suspected case pending laboratory confirmation of the specific pathogen, of which there are many. Reporting the syndromic count alongside the confirmed count is correct surveillance practice and should not be read as over-counting.

THE VIRUS

ATTRIBUTE	DETAIL
Family and genus	***Rhabdoviridae***, genus ***Vesiculovirus***
Named after	**Chandipura village, Maharashtra**, where it was first identified in **1965**
Vector	**Sandflies of the genus *Phlebotomus***
Disease	**Acute Encephalitis Syndrome (AES)**
Affected group	Overwhelmingly **children under 15**
Vaccine	**None licensed**
Specific antiviral	**None**; management is supportive
Course	Rapid, with death frequently within 24 to 48 hours of onset in severe cases

Two features explain why case fatality is so high. First, there is **no specific treatment**, so outcomes depend entirely on supportive intensive care. Second, the illness progresses **very fast**, which means the interval within which referral to a facility capable of providing that care can make a difference is short, often a matter of hours.

The vector distinction matters too. *Phlebotomus* sandflies are **not mosquitoes**, and the control measures differ. Sandflies breed in cracks and crevices in mud walls, in organic debris and in animal shelters rather than in standing water, so the anti-larval and source-reduction measures built around mosquito control do not transfer. Indoor residual spraying of the right surfaces, and plastering or sealing of wall cracks, are the relevant interventions, and they are labour-intensive and household-by-household.

THE RESPONSE ARCHITECTURE

BODY	ROLE
NJORT, National Joint Outbreak Response Team	Deployed to Gujarat and Rajasthan for outbreak investigation, epidemiological assessment, clinical management, laboratory coordination, vector surveillance and public health measures
NCDC, National Centre for Disease Control	Coordinates the **Integrated Disease Surveillance Programme** with state surveillance units
ICMR-NIE, Chennai	National Institute of Epidemiology
ICMR-NIVCR, Puducherry	Vector control research
ICMR-NIV, Pune	Virology and laboratory confirmation
ICMR-NIPCR, Hyderabad	Research support
ICAR-NIVEDI, Bengaluru	Veterinary epidemiology and disease informatics

The presence of **ICAR-NIVEDI**, an agricultural-research-council veterinary institute, alongside five medical-research bodies is the **One Health** signature of this response, and it is the detail most worth carrying into an answer. One Health treats human, animal and environmental health as a single system. For a sandfly-borne virus whose vectors breed in and around animal shelters, and whose ecology is bound up with livestock keeping and rural housing, an exclusively human-health response would miss half the transmission environment.

THE ANALYTICAL POINT

India's **disease surveillance architecture works**. The Integrated Disease Surveillance Programme detected the cluster, laboratory confirmation followed through the ICMR network, and a joint national team was deployed within the outbreak season. That is a functioning system, and the honest assessment says so.

The gap is at the **other end**. Chandipura outbreaks recur, predominantly in the same regions, predominantly in the same monsoon window, predominantly among the same age group. Recurrence in a known season, a known geography and a known demographic is the signature of a **prevention** failure rather than a detection failure.

Two interventions follow, and neither is technological:

Pre-monsoon vector control. Sandfly control undertaken before the transmission season, targeting the specific breeding habitat, is the intervention with the strongest claim. It is unglamorous, requires household-level access, and produces no visible outcome when it works, which is exactly why it is chronically under-

resourced.

Referral pathways. Because deterioration is rapid and treatment is supportive, survival depends on how quickly a child reaches a facility with paediatric intensive care. Strengthening AES referral protocols at primary and community health centre level, with pre-designated referral facilities and transport, addresses the fatality rate directly even without a vaccine.

The broader institutional context is the **National One Health Mission**, which is the framework within which precisely this kind of cross-sectoral coordination is meant to become routine rather than outbreak-triggered.

UPSC RELEVANCE

GS Paper 2: Issues relating to development and management of social sector services relating to health; government policies and interventions; centre-state coordination in health administration.

GS Paper 3: Science and technology; disaster management as applied to biological emergencies.

Prelims pointers:

- **Chandipura virus**: family ***Rhabdoviridae***, genus ***Vesiculovirus***; identified **1965**, named after **Chandipura village, Maharashtra**.
- Vector: **sandflies of the genus *Phlebotomus*, not mosquitoes**. Breeding habitat is cracks and crevices, organic debris and animal shelters, not standing water.
- Causes **Acute Encephalitis Syndrome**, predominantly in **children under 15. No licensed vaccine and no specific antiviral**; management is supportive.
- Gujarat, monsoon 2026: **184 suspected, 35 confirmed, 22 child deaths**.
- Surveillance runs under the **Integrated Disease Surveillance Programme**, coordinated by the **National Centre for Disease Control**.
- The response draws on **ICMR-NIE Chennai, ICMR-NIVCR Puducherry, ICMR-NIV Pune, ICMR-NIPCR Hyderabad** and **ICAR-NIVEDI Bengaluru**; the last is the **One Health** element.
- Other notable Rhabdoviridae: **rabies virus** belongs to the same family, genus *Lyssavirus*.

UPSC RELEVANCE

Gujarat, monsoon 2026, 184 suspected, 35 laboratory-confirmed, 22 child deaths, 7 under treatment. A National Joint Outbreak Response Team was deployed to Gujarat and Rajasthan on 5 August 2026.

Chandipura virus, family Rhabdoviridae, genus Vesiculovirus, identified 1965 at Chandipura village, Maharashtra. Transmitted by *Phlebotomus* sandflies. Causes Acute Encephalitis Syndrome, overwhelmingly in children under 15. No vaccine, no specific antiviral, supportive management only, rapid progression.

sandflies breed in wall cracks, organic debris and animal shelters, not in standing water, so mosquito-control source reduction does not transfer. Indoor residual spraying and sealing of wall crevices are the relevant measures.

IDSP surveillance coordinated by NCDC; laboratory and research support from ICMR-NIE Chennai, ICMR-NIVCR Puducherry, ICMR-NIV Pune and ICMR-NIPCR Hyderabad; ICAR-NIVEDI Bengaluru supplies the veterinary and One Health arm.

AES is a syndromic case definition, so a suspected-case count will always exceed the pathogen-confirmed count. That is correct practice, not over-reporting.

Sources: Ministry of Health and Family Welfare, National Centre for Disease Control, Indian Council of Medical Research

Source: Sandflies and Surveillance: The Chandipura Outbreak Response — Ujiyari.com | Free UPSC & State PCS Current Affairs

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