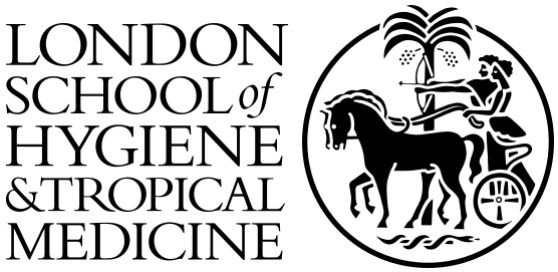

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Letters

Learning from low income countries: what are the lessons?: Community oral rehydration units can contain cholera epidemics

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EDITOR—Cholera is closely linked to social, economical, and political change, and outbreaks still occur.[1] After a century of absence, cholera occurred unexpectedly in the American continent in 1991.[2] Peru was the first country to report cases and was the most severely affected by the epidemic, in case numbers (300 000 in the first year) and economic impact on tourism and the imposition of food embargoes. In the first weeks 45 000 cases were counted each week.[3] The case fatality rate was only 0.7%, the lowest rate in South America during 1991-4 and one of the lowest ever reported.[4 5]

Public consciousness and prompt rehydration treatment, in a system with a strategy already in place for diarrhoeal diseases, were the key factors behind the successful rapid medical response to the epidemic in Peru. Training campaigns were carried out among mothers belonging to popular voluntary organisations. Extensive oral rehydration units had been established since 1980 in periurban health centres to deal with childhood diarrhoeal diseases. Later, oral rehydration units were extended to the paediatric departments of hospitals and then to all populations on a large scale.[4]

The cholera epidemic of 1991 taught Peru how to use clinical and epidemiological information and make the most of a system already in place. Sharing this lesson may reduce the countries affected by current cholera outbreaks.

Footnotes

- Competing interests None declared.

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