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“Health versus Economy”: the Recurrence of a False Dilemma in Times of Crisis. The Case of the 1991 Cholera Epidemic in Peru

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ABSTRACT

This article examines the 1991 cholera epidemic in Peru through the lens of a discursive construction of the so-called health-versus-economy dilemma. It contends that government officials and certain political sectors shaped this narrative of public health protection as a menace and incompatible with economic development in times of epidemics to shift attention away from structural responsibilities and legitimize the privileges of certain economic sectors. On the other hand, the poor urban household were charged with the responsibilities of assuming the costs of the epidemic. In doing so, the study positions the cholera epidemic as a key case for understanding how this discursive shift was produced and how it was able to function in an epidemic crisis.

Key words: Peru - Cholera epidemic - Economy - Public health

Introduction

During the COVID-19 pandemic in Peru, there was much debate between those who supported isolation measures and a strict quarantine, and those who argued that these measures would have a negative impact on the economy and, therefore, should be avoided or relaxed. This debate has been part of a recurring historical pattern during epidemics in Peru. There has been a persistent tension between the implementation of strict sanitary measures (isolation, quarantines, sanitary cordons) -historically advocated by physicians, public health experts, and health personnel- and the need to sustain economic activity and commercial circulation, usually defended by entrepreneurs, merchants and libertarian thinkers. In this article, we argue that, rather than constituting a genuine dilemma, this opposition is better understood as a narrative constructed by certain groups in times of crisis. A narrative that has reflected political priorities, social interests, and economic structures.

For example, in the nineteenth century, when maritime trade and primary exports served as the main engine of the Peruvian economy, the outbreak of epidemics of yellow fever and cholera gave rise to disputes over port quarantines. At the time, some Peruvian politicians feared that sanitary measures recommended by local and international health authorities would disrupt foreign trade, the principal source of fiscal revenue. During the mid nineteenth century Peru was experiencing a financial bonanza due to the exports of guano (a very appreciated natural fertilizer). As a result, tensions emerged among physicians, health authorities, merchants and liberal thinkers, generating intense debates in the media over the extent to which economic situation should be sacrificed to contain the spread of a disease. In 1855 the Sociedad Medica de Lima (Lima Medical Society) prepared a report on cholera and yellow fever in search of control strategies. News of an epidemic in Guayaquil (Ecuador) at the end of 1866 caused widespread fear in Peru, and in response, the government ordered strict quarantines, measures criticized in the media by certain sectors. This report was disputed by those engaged in guano exports¹. This response revealed how doctors' calls to restrict the entry of ships from affected countries clashed with economic policymakers and businessmen who feared this could harm the guano trade. Public health and economic development began to be perceived and constructed in the media and public debate as opposed to one and other.

By "discursive construction" we mean that the "health versus economy" debate is not simply a disagreement between competing ways of thinking. Rather, it is a particular way of framing and presenting a problem shaped by political and economic interests. A narrative was produced in which protecting health was assumed to require sacrificing the economy. This discourse has served to justify specific policies, prioritize certain groups over others, and deflect attention from structural responsibilities throughout history. This was particularly evident in Peru during the 1990s, when, after a decade marked by severe economic crisis and hyperinflation, a new economic model aligned

with global neoliberalism was implemented. The case examined in this article is the 1991 cholera epidemic in Peru. We are not that interested in narrating the history of the cholera epidemic, a work already done by Marcos Cueto, but focus on this debate. As has been widely demonstrated by Cueto, the 1991 cholera outbreak was not only a public health emergency, but also a moment of ideological definition regarding the role of the state in collective health². This perspective highlights how epidemic crises, far from being neutral biological events, operate as social and political arenas where the meaning of public health, state responsibility, and societal hierarchies is constantly negotiated and contested. This article also builds on George Rosen’s classic history of public health to understand it not merely as a set of technical responses to disease, but as a historically changing field in which state authority, urban reform, economic productivity, and social order are constantly negotiated³. From this perspective, the 1991 cholera epidemic in Peru did not simply reveal a conflict between medical expertise and economic activity; rather, it reactivated a longer historical tension between sanitary regulation, state responsibility, commercial circulation, libertarian thinking and social inequality. Diego Armus’s reflections on the historiography of disease in modern Latin America are particularly useful for framing this approach. Armus argues that the history of public health must be attentive to the relations between health institutions and broader economic, social, and political structures, while the sociocultural history of disease examines the ways in which illness is shaped by medical knowledge, state policies, living conditions, everyday practices, perceptions, and popular responses⁴. From this perspective, cholera cannot be reduced to a biological event caused by *Vibrio cholerae*.

The article combines the history of public health with political discourse analysis. It draws on ministerial speeches, the press, secondary literature, and epidemiological reports, and seeks to reconstruct how the “health versus economy” opposition was formulated. Its main contribution lies not so much in retelling the epidemic, as in showing how the onset of neoliberalism in the 1990s, public health vulnerability, and the interests of export-oriented actors and certain economic sectors gave rise to a specific political language that cast disease prevention as an ‘economic threat.’ We will focus particularly on the case of Health Minister Carlos Vidal Layseca (1931-2017) and his unwillingness to subordinate sanitary measures to macroeconomic priorities. For example, his proposal to subsidize kerosene so that poor families could boil water was rejected by the then Ministry of Economy on security grounds related to drug trafficking. However, that decision reflected the prioritization of fiscal stability over a basic public health intervention within the government. The legacy of Vidal’s work can be traced in both public health institutions and professional training. After leaving the Ministry, Vidal Layseca continued an important academic and administrative career. In 1993, he founded the Center for Public Health at the Universidad Peruana Cayetano Heredia (UPCH), and as rector from 1994 to 1999, he promoted the creation of the Faculty of Public Health and Administration and collaborated with the Pan

American Health Organization (PAHO). Participated in community health promotion networks, chaired PAHO/WHO committees, and took part in international health policy forums. Although his ministerial tenure was brief, the priorities he defended during the epidemic (prevention and equity) retained long-term relevance and influenced subsequent health policies as well as the training of health professionals.

Historical context

As has been widely documented in multiple economic and historical reports, in 1991, Peru was undergoing the worst economic and social crises in its modern history⁵. Annual inflation had reached an astronomical 7,649.6% in 1990. More than 54% of the population lived in poverty, and 23% of Peruvians were in conditions of extreme poverty, unable to meet even minimum nutritional requirements. President Alberto Fujimori, having just assumed office, implemented a drastic economic adjustment package known as the “paquetazo” (Fujimori’s economic shock package). Public services in Peru were precarious at the onset of the 1991 cholera epidemic. A World Bank report from the early 1990s indicated that only about 52 % of Peru’s total population had access to potable water, and approximately 39 % had access to sewerage systems at the time, reflecting deep deficiencies in basic services nationwide⁶. These low levels of coverage were uneven across urban and rural areas, with rural populations historically facing much more limited access to improved water sources and sanitation, contributing to differential vulnerability to water-borne diseases⁷. Although systematic national data for 1991 are limited, subsequent analyses by the WHO/UNICEF Joint Monitoring Programme show that coverage levels for improved drinking water and sanitation only gradually increased thereafter, underscoring the structural inadequacy of public services at the time⁸. Under these conditions, frequent service disruptions, unsafe storage practices, and the direct discharge of wastewater into rivers or coastal areas heightened the risk of contamination and disease transmission. These dire conditions were compounded by a high infant mortality rate of more than 50 per 1,000 live births and by underfunded and overwhelmed healthcare infrastructure⁹. The collapse of basic sanitation, public health, and social services provided a perfect storm for an epidemic. The 1991 cholera epidemic was the most vivid manifestation of this collapse.

Month (1991)	Inflation rate (%)	Cholera cases
January	17.83	1,609
February	9.42	39,590
March	7.70	80,578
April	5.84	62,458

Tab. 1. Epidemiological and economic indicators, Peru, January–April 1991: suspected cholera cases and monthly inflation rate. Sources: Carrillo C, *Rev Méd Hered*, 1991; Banco Central de Reserva del Perú, Annual Report 2000

The 1991 cholera outbreak

In February of 1991 a historical outbreak of cholera began that affected more than 300,000 people only in that year¹⁰. It spread rapidly through Latin America, disrupting regional trade, travel, diplomatic relations and most important, threatening people's health and life. Cholera is a disease that mainly affects lower socio-economic populations that lack adequate water supplies and inadequate sanitation. All these factors, plus a unique culinary tradition of having raw fish as the main and most popular consumed dish in Coastal Peru called “ceviche” (a dish made with raw fish marinated in lime), created the perfect environment for *Vibrio Cholerae* to infect a great number of people. President Fujimori was in his first term of office when the 1991 cholera outbreak began. Fujimori inherited a country immersed in a chaotic economy and isolated from international financial support because of the poor economic results and protectionist measures of the governments that preceded him. The “paquetazo” Fujimori decreed to stabilize the chaotic economic situation impacted harshly in Peruvian families. The prices of gasoline, rice, sugar and cooking gas escalated, while kerosene, used as cooking fuel by most shanty-town dwellers, increased dramatically. As Marcos Cueto well describes in his book *El regreso de las epidemias: Salud y sociedad en el Perú del siglo XX*: the filth, backwardness, misery and overall misfortune, a terrible hyperinflation, terrorism and the collapse of authority which Peru experienced since the 1980s created the perfect environment for the cholera outbreak. However, Peru had a surprisingly low mortality rate. The low mortality was product of the remarkable efforts made by the health sector authorities to inform the population (health education) and disseminate the standard first line treatment procedure of prompt rehydration¹¹. The explosive spread of cholera in Peru occurred initially in large poor urban populations¹². As has been studied by Cueto, immediately after the epidemic began, health authorities identified water and sewage as the main sources: they recommended boiling drinking water and improving excreta disposal to interrupt transmission. The sales of ceviche were banned, fish from Chimbote (the centre of the Peruvian fishing industry) was confiscated and incinerated, and cevicherías (restaurants that specializes in ceviche) were closed, leading to the so-called ‘ceviche war’¹³. However, scientific research suggests that the risk associated with properly prepared ceviche is low. One experiment showed that marinating fish in lime juice eliminates more than 99.9% of *Vibrio cholerae* in a short time¹⁴. This means that citric acid rapidly inactivates the bacterium; furthermore, in practice, no major outbreaks linked to seafood were documented in Peru in 1991. The dominant mode of transmission was contaminated water. Therefore, although marinated fish was presumed to be a potential vehicle, there is no solid evidence that ceviche was an actual focus of cholera – instead, social fear led to its prohibition –¹⁵. The cholera epidemic that began in Peru in late January 1991 spread rapidly both geographically and numerically, reflecting deep structural vulnerabilities in water and sanitation infrastructure. According to official data from the Peruvian Ministry

of Health, by early July 1991 the epidemic had resulted in 316 299 suspected cases, 87 659 hospitalizations, and 2 193 deaths, with an overall case-fatality rate of approximately 0.97 %¹⁶. Other international reports place the total number of suspected cholera cases in Peru during 1991 at 322 562, with 2 909 deaths, reaffirming the extensive reach and severe burden of the outbreak across the country's regions¹⁷. The epidemic did not remain confined to the coast. Within a few weeks, cases were reported in the highlands and the jungle, and cholera began to appear in neighboring countries, with Ecuador, Colombia, Bolivia, and Chile reporting outbreaks soon after the initial Peruvian wave. This rapid territorial expansion underscores how water-borne transmission, driven by contaminated drinking water and inadequate sewage disposal, was the dominant mode of spread, rather than isolated foodborne vectors¹⁸. Mortality rates in jungle areas were low due to the rehydration measures that were implemented. It is important to note that the Amazonian region posed challenges. The difficult geography and scattered population made it hard for health personnel to reach affected areas and distribute supplies. Moreover, many indigenous riverine communities consume untreated river water and have limited access to healthcare services, which facilitated the transmission of the disease. As studied by Ghersi and Ñaupari, for instance, it was observed that jungle cities with deficient potable water systems experienced more prolonged epidemics, whereas in areas with secure water supply, cholera was contained more quickly¹⁹.

Political responses from the Ministry of Health

On February 8 of 1991, the government declared a state of emergency for 120 days and a US\$ 4 million special fund was set up to control the epidemic. As studied by various authors, the Fujimori administration operated within a framework marked by a strong concentration of power in the executive branch and a profound distrust toward intermediary institutions – such as professional associations, unions, and even technical ministries – perceived as obstacles to the efficiency of state reform. This institutional configuration significantly limited the autonomy of the Ministry of Health during the 1991 cholera crisis. Although the government's immediate response was formally led by the Ministry of Health under Dr. Carlos Vidal Layseca – a distinguished public health specialist and former official of the Pan American Health Organization – the broader political context of authoritarian technocracy and fiscal austerity constrained his capacity to implement independent and comprehensive public health strategies²⁰. Cholera crisis was unfolding amid Peru's worst economic crisis in modern history, which compounded institutional fragility and eroded the material conditions necessary for effective epidemic control. When Dr. Vidal assumed the ministry, the Peruvian health system was bankrupt; and during this crisis the cholera outbreak occurred. The main aim of Dr. Vidal was to prevent the high mortality rates, 30 to 50 per cent, predicted based on previous outbreaks in other parts of the world.

Following epidemiological analyses of the introduction and transmission of the disease in Peru, and evidence that approximately 90 per cent of clinical histories among patients with *Vibrio cholera* infection in the coastal cities of Chimbote and Chancay, reported recent consumption of “ceviche”, immediate public health measures were implemented. These included prohibitions on the consumption of raw foods, recommendations to boil drinking water, and restrictions on the consumption of raw shellfish and fish harvested near coastal sewage discharge areas. Together these measures aimed to limit transmission, alongside the rapid treatment of new cases using oral rehydration therapies, the WHO recommended first-line treatment for cholera²¹.

These therapies were simple, inexpensive, and highly effective in replacing the fluids, salts, and electrolytes lost through diarrhea. Depending on the patient’s clinical condition and ability to tolerate oral intake, treatment was administered either orally or intravenously. In addition to rehydration therapy, antibiotics were used to reduce bacterial shedding and transmission. The prompt implementation of rehydration therapy, together with the Ministry of Health’s prior experience in managing large-scale diarrheal diseases among children, helps explain, at least in part, the relatively low mortality rate observed during the epidemic.

The Ministry also ensured free access to treatment and established specialized hospital areas known as Cholera Treatment Units. These units were staffed by personnel using protective equipment, including aprons and gloves, and following strict hygiene protocols. Patients were treated in beds adapted with a central opening connected to containers with disinfectant solutions (lye) to safely collect excreta. These units operated in coordination with emergency personnel and the rest of the hospital staff²².

The Ministry’s recommendations were supported by international agencies, including the World Health Organization, several European countries, and the health authorities from the Andean Pact, as well as countries such as Chile, Brazil, Cuba, and the United States, which provided financial and technical assistance. The Ministry also brought in a team of Cuban specialists in tropical medicine. At the national level, provincial authorities, medical associations, local health officials, water companies, and the media reinforced public health messaging—sometimes with a degree of exaggeration, but often effectively amplifying preventive behaviors. nonetheless in ways that proved helpful.

As Marcos Cueto mentions in his work:

Local newspapers underlined the need for and the ways of boiling water, washing hands, using latrines, preparing domestic serum, using lye as an antiseptic, and avoiding fish, shellfish and vegetables...The mayor of Trujillo recommended not to eat “ceviche” and shellfish, the mayor of Catacaos, Chiclayo and Ferreñafe banned the food street vendors; the prefect of Lambayeque closed the beaches to holiday makers and a provincial mayor in Lambayeque strictly prohibited eating fish because it trans-

mitted cholera; In Trujillo 2500 kilograms of fish were seized and burned ‘because it was not suitable for human consumption, and because it came from Chimbote’²³.

Donzelot’s analysis of modern social intervention is useful for interpreting this domestic dimension of the cholera response. In *The Policing of Families*, he argues that nineteenth-century welfare and sanitary practices marked a transition from a government of families to a “government through the family,” in which the household became a relay for social, educational, moral, and hygienic imperatives²⁴. This perspective helps clarify the logic of the Peruvian campaign in 1991. Recommendations to boil water, wash hands, prepare oral rehydration solution, disinfect domestic spaces, use latrines, and modify food practices were epidemiologically necessary, but they also transferred part of the burden of prevention to the family, including poor households that lacked secure access to potable water, sewerage, and stable public services. Thus, the epidemic response relied on the family and community organizations as practical instruments of public health, while simultaneously exposing the structural failure of the state to provide the material conditions required for hygiene.

On the other hand, as signaled by Cueto, hospitals received a growing number of patients up to four times greater than the number of beds and staff available. In several cities, staff had to be taken from other hospital services to look after cholera patients, some hospitals focused only on patients stricken with the disease, and the physicians requested the help of one relative per patient. During the outbreak, hospitals had to attend to many patients, and they started to fall short of beds, supplies and medications. They called for staff from other services and volunteers from the same community. A solidarity chain was created involving governmental and non-governmental institutions and the community. Different community-based organizations like the communal kitchens, “clubs of mothers”, etc., were strongly supported by the health ministry. Their job was of vital importance for the control of the outbreak²⁵.

This grassroots-oriented campaign, characterized by voluntarism, improvisation, and minimal resources, extended beyond the Ministry of Health to include non-governmental institutions such as the Catholic Church, fire brigades, and a network of survival organizations largely led by women – communal kitchens, mothers’ clubs, and self-help groups – that had emerged in previous years as responses to structural poverty²⁶. Despite these collective efforts and the technical success in limiting the outbreak’s mortality, Dr. Carlos Vidal’s initiatives encountered growing resistance from influential economic actors and members of the cabinet. His proposals were received with suspicion or outright rejection, reflecting the political cost of confronting dominant economic interests. The lack of institutional support, particularly from within the executive branch, revealed the structural limits of a public health rationality in a state increasingly subordinated to macroeconomic imperatives. This tension between epidemic control and economic orthodoxy ultimately curtailed the sustainability of

the response and precipitated Vidal's resignation, marking the triumph of fiscal and commercial priorities over preventive public health policy.

We will give some details on how the public health authorities and society reacted to this outbreak, despite the absence of preventive measures taken to avoid the appearance of it. We will also show some of the different socio-economic and political problems Dr. Carlos Vidal, Former Minister of Health of that time had to deal with. For this I will use as primary sources a copy of Dr. Vidal's speech while he was health minister, some exchanged emails with Dr. Vidal, and some newspaper articles from that time such as Vidal Layseca, Carlos, personal communication with the author. (Two e-mails. Dates: 5/03/04 and 4/29/04²⁷; Vidal Layseca, Carlos. *El cólera y el país en que vivimos*. Conferencia presentada en la Universidad del Pacífico; marzo de 1991²⁸; Lima, Perú.) Dr. Vidal's attitude towards the outbreak was of complete transparency and ethically correct, as he knew that cholera is so easily communicable and that Peru needed the support of the international community he was constantly informing about the situation, and created an effective information system among the South American countries. This transparency was helpful in reaching an effective and quick response to the outbreak resulting in low mortality in the whole continent and avoiding cholera becoming an endemic disease in Central and South America. This transparency towards the international community and the quick response to the outbreak was seen as a threat by some big trading companies from the fishing and agricultural sectors, some critics even argue that the ministry should have been hidden or change the diagnosis of cholera to avoid a reaction from the international community and with that the economic consequences. Pattern of neglecting the problem that has not been unusual along epidemics history.

After realizing that he did not have the support from the president and some other members of its cabinet for his working plan, including the new ministry of economy cutting the health budget, Dr. Vidal ended up resigning to the ministry. After this, the programme implemented by him lost its drive, and became more disorganized. After weeks of debate over whether the public should consume raw fish or not, Carlos Vidal Layseca submitted his resignation on February 18. International media reported that he resigned due to ‘disagreements’ within the cabinet regarding the fight against cholera. In his resignation letter and interviews, he stated that he had succeeded in ‘containing the spread’ of the epidemic along the coast despite the conditions of the health system.

The ‘economy versus health’ debate

In our opinion, the dilemma is false, as there is no natural opposition between the two. Investing in public health and a healthy population are essential for a productive economy; a poorly managed epidemic that becomes endemic or spreads to more countries and regions is detrimental to the economy. Considering that epidemics tend to hit the most economically vulnerable populations the hardest (in this case, migrants and

people working in the informal economy), the debate, in any case, may be more technical regarding how the state and society mitigate the economic costs of an epidemic. Denying or minimizing elements that could spread the disease, due to their potential commercial effects is, in the short term, more economically damaging. The debate stems from a false dichotomy and a fallacy: assuming there are only two mutually exclusive options—protecting health or protecting the economy—when both are structurally intertwined. Without some decent health, there is an inadequate workforce, less consumption, and poorly sustained production. Without epidemic control, the economy doesn't recover; it deteriorates. Epidemics are also economic crises *per se*. The history of public health supports this argument. As George Rosen's classic account of the sanitary movement shows, modern public health emerged in close relation to urban growth, industrialization, labour organisation, water supply, sewerage, health administration, and political economy²⁹. In the Latin American context, Cueto and Palmer similarly show that medicine and public health were central to the formation of modern states, citizenship, international health agendas, and responses to social inequality³⁰. Ana María Carrillo's work on Porfirian Mexico further demonstrates that public health reforms were shaped by both scientific concerns and economic and political priorities³¹. The Peruvian debate of 1991 did not oppose health to the economy in abstract terms; rather, it revealed conflicts over which economic interests would be protected, which forms of sanitary intervention would be considered legitimate, and which populations would bear the costs of epidemic vulnerability.

In this case, even in the interior of the cabinet Dr. Vidal did not have full support. He gave an example on a speech delivered at the Universidad del Pacífico where he suggested and demanded a bill to lower the price of kerosene to allow poor people to boil water. The Ministry of economy violently opposed him, arguing that lowering the price of kerosene would help the drug dealers in their illicit acts (kerosene is an important ingredient for the production of cocaine). Dr. Vidal had to deal with powerful interest groups such as fishing companies and international trading companies. His opponents blame him for the economic consequences of the epidemic. For the Ministry of Fishing, Peru would lose US\$3 million from not exporting 50,000 tons of fish-derived products. According to a more detailed estimate, the overall losses incurred because of cholera could split into the impact the outbreak had in terms of foreign markets (particularly in regard to tourism, and the export of fish and agricultural products), which came to slightly over US\$175 million, and its impact on the home market (fishing for human consumption, the sale of food on the streets, and indirect costs in health and treatment of the sick), which came to US\$337,112³².

The recommendation from the health minister, of not eating "ceviche" transformed the proposed national war against cholera into a tug-of-war between the Health Ministry and other governmental ministries and private economic interests. The Peruvian press called this 'the ceviche war'. These governmental ministries and private economic

interests argue that the consumption of “ceviche” was not a problem, and in an irresponsible act they attempted to ease the local and international pressure by showing Fujimori and the ministers of fishing and agriculture appeared, in front of journalists, eating “ceviche”, advocating that seafood was not infected with the bacteria. This attitude showed differences in the thoughts and goals of the President and its cabinet members. His act was an irresponsible move, as it set a dangerous precedent for the public. There is a big difference between the “ceviche” eaten by the president and its ministers, and the “ceviche” that is served by the food street vendors. One difference as described by Dr. Vidal is that there is a ceviche of the poor and a ceviche of the wealthy: the ceviche of the poor is the one made with seafood obtained close to the coast, where the presence of the bacteria is more probable, that does not happen with the seafood obtained far from the coast line. The other factor is that raw fish marinated with lime juice is likely to inactivate *Vibrio cholerae* depending upon the period that seafood is exposed to the acid. But these factors were not taken in consideration by the President and some of its ministers, they just appeared eating ceviche in a fancy restaurant, since they were more worried about the macro-economic and political consequences of the outbreak, instead of being worried about the impact on the population’s health and the economic situation of the low income communities, the most affected by the outbreak. They had to stop working while they were sick, not receiving any money in that period of time given the reality of an informal economy in Peru, 70% of Peruvians work in the informal sector, hence, they cannot access formal workers benefits such as a medical leave.

Conclusion

The health-versus-economy dilemma during the 1991 cholera epidemic did not emerge spontaneously. Rather, it was the product of a series of political decisions and public narratives that converged within a context of structural crisis in the country. In the early 1990s, Peru was undergoing a severe recession marked by hyperinflation, widespread poverty, and the social consequences of the ‘paquetazo’. Within this setting, the outbreak of a massive epidemic forced the health system to respond rapidly, while simultaneously placing key economic sectors—such as fishing, agricultural exports, and tourism—under considerable pressure. Official discourse began to frame the crisis as a dilemma when sanitary measures—such as banning the consumption of raw fish and shellfish or recommending that people avoid ceviche—directly affected strategic industries. The Ministry of Fisheries and business associations interpreted these measures as a threat to foreign trade and macroeconomic stability. At that point, the debate over public health shifted onto a political and economic plane: protecting health was presented as equivalent to sacrificing the national economy. Media coverage amplified this tension. The so-called “cevi-

the war” was not merely a gastronomic controversy, but a symbolic episode that revealed how the debate was publicly constructed and how, in theory, the country had to choose between safeguarding public health and keeping the economy afloat. This episode shows that the health-versus-economy debate does not stem from a natural contradiction, but from political narratives constructed in moments of crisis. As Cueto suggests, epidemics reveal the relationship between economic and living conditions³³. This dilemma functions as a discursive tool that legitimizes state priorities and shifts structural responsibilities. The Peruvian case illustrates how, in public health emergencies, the defense of the national economy has historically shaped policymaking, even when doing so places the protection of public health under strain.

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Bibliography, references and notes

- Andonair Villegas JP, El año de la peste peruana: el cólera de 1991. *El Comercio* [Internet] 2020 Mar 15 [cited 2026 Jan 7]. Available from: <https://elcomercio.pe/archivo-elcomercio/el-ano-de-la-pest-peruana-el-colera-de-1991-noticia/>
- Armus D, La enfermedad en la historiografía de América Latina moderna. *Asclepio* 2002;54(2):41-60.
- Banco Central de Reserva del Perú. Annual Report 2000 [Internet] Lima: BCRP; 2000 [cited 2026 Jan 7]. Available from: <https://www.bcrp.gob.pe/eng-docs/Publications/Annual-Reports/2000/Annual-Report-2000-01.pdf>
- Carrillo AM, Economía, política y salud pública en el México porfiriano (1876-1910). *Hist Cienc Saude Manguinhos* 2002;9 Suppl:67-87.
- Carrillo C, El Instituto Nacional de Salud y la epidemia de cólera. *Rev Méd Hered* [Internet], 1991 [cited 2026 May 13];2(2). Available from: <https://revistas.upch.edu.pe/index.php/RMH/article/view/339>
- Cueto M, El regreso de las epidemias: salud y sociedad en el Perú del siglo XX. Lima: Instituto de Estudios Peruanos; 1997.
- Cueto M, Epidemias, salud global y virus emergentes: una perspectiva histórica. Lima: Instituto de Estudios Peruanos; 2020.
- Cueto M, Palmer S. *Medicine and Public Health in Latin America: A History*. Cambridge: Cambridge University Press; 2015.
- Defensoría del Pueblo. El derecho al agua en zonas rurales: caso de municipalidades distritales. Informe Defensorial No. 124. Lima: Defensoría del Pueblo; 2018.
- Donzelot J, *The Policing of Families*. Hurley R (translator.), New York: Pantheon Books; 1979.

FAO/WHO Global Forum of Food Safety Regulators. Experience of the cholera epidemic in Peru 1991. Rome: FAO/WHO; 2002.

Gherzi E, Ñaupari H, Agua sucia: cólera en Perú. Las causas y los responsables. In: Okonski K, Hidalgo JC (eds), Salud y medio ambiente: mitos y realidades. London: International Policy Network; 2005.

Gorriti G, Más de 70.000 personas afectadas por el cólera en Perú tras una semana de rebrote de la epidemia. El País [Internet] 1991 Mar 16 [cited 2026 Jan 7]. Available from: https://elpais.com/diario/1991/03/16/sociedad/669078001_850215.html.

Instituto Nacional de Estadística e Informática. Censo nacional de población y vivienda 1993. Capítulo 36: saneamiento básico [Internet]. Lima: INEI; 2001 [cited 2026 Jan 7]. Available from: https://www.inei.gov.pe/media/MenuRecursivo/publicaciones_digitales/Est/Lib0015/cap-36.htm

Mata L, Vives M, Vicente G, Extinction of *Vibrio cholerae* in acidic substrata: contaminated fish marinated with lime juice (ceviche). Rev Biol Trop [Internet] 1994 [cited 2026 Jan 7];42(3):479-485. Available from: <https://pubmed.ncbi.nlm.nih.gov/7501869/>.

Rosen G, A History of Public Health. Expanded ed. Baltimore: Johns Hopkins University Press; 1993.

Ulloa CJ, La epidemia. Gac Med Lima 1868 Mar 31;(269):182-184.

Valdivia M, Sensacionalismo, prejuicios y estereotipos en los diarios limeños durante la epidemia de cólera de 1991 [thesis]. Lima: Pontificia Universidad Católica del Perú; 2014.

Vidal Layseca C, El cólera y el país en que vivimos. Conference presented at Universidad del Pacífico; Lima, March 1991.

World Bank. Waterborne diseases in Peru [Internet]. Washington (DC): World Bank; 1993 [cited 2026 Jan 7]. Available from: <https://documents.worldbank.org/en/publication/documents-reports/documentdetail/559041468758369091/waterborne-diseases-in-peru>

World Health Organization; UNICEF. Estimates on water and sanitation coverage for Peru. Geneva: WHO/UNICEF Joint Monitoring Programme; 2010.

1. Ulloa CJ, La epidemia. Gac Med Lima 1868 Mar 31;(269):182-184.
2. Cueto M, Epidemias, salud global y virus emergentes: una perspectiva histórica. Lima: Instituto de Estudios Peruanos; 2020. p. 10.
3. Rosen G, A History of Public Health. Expanded ed. Baltimore: Johns Hopkins University Press; 1993. Chapter 6.
4. Armus D, La enfermedad en la historiografía de América Latina moderna. Asclepio 2002;54(2):41-60.
5. Banco Central de Reserva del Perú. Annual Report 2000 [Internet]. Lima: BCRP; 2000 [cited 2026 Jan 7]. Available from: <https://www.bcrp.gob.pe/eng-docs/Publications/Annual-Reports/2000/Annual-Report-2000-01.pdf>.
6. World Bank. Waterborne diseases in Peru [Internet]. Washington (DC): World Bank; 1993 [cited 2026 Jan 7]. Available from: <https://documents.worldbank.org/en/publication/documents-reports/documentdetail/559041468758369091/waterborne-diseases-in-peru>.
7. Defensoría del Pueblo. El derecho al agua en zonas rurales: caso de municipalidades distritales. Informe Defensorial No. 124. Lima: Defensoría del Pueblo; 2018.
8. World Health Organization; UNICEF. Estimates on water and sanitation coverage for Peru. Geneva: WHO/UNICEF Joint Monitoring Programme; 2010.
9. Instituto Nacional de Estadística e Informática (INEI). Censo nacional de población y vivienda 1993. Capítulo 36: saneamiento básico [Internet]. Lima: INEI; 2001 [cited 2026

- Jan 7]. Available from: https://www.inei.gob.pe/media/MenuRecursivo/publicaciones_digitales/Est/Lib0015/cap-36.htm.
10. Carrillo C, El Instituto Nacional de Salud y la epidemia de cólera. *Rev Méd Hered* [Internet] 1991 [cited 2026 May 13];2(2). Available from: <https://revistas.upch.edu.pe/index.php/RMH/article/view/339>.
 11. Cueto M, El regreso de las epidemias: salud y sociedad en el Perú del siglo XX. Lima: Instituto de Estudios Peruanos; 1997.
 12. Gorriti G, Más de 70.000 personas afectadas por el cólera en Perú tras una semana de rebrote de la epidemia. *El País* [Internet]. 1991 Mar 16 [cited 2026 Jan 7]. Available from: https://elpais.com/diario/1991/03/16/sociedad/669078001_850215.html.
 13. Cueto M, Ref. 11.
 14. Mata L, Vives M, Vicente G, Extinction of *Vibrio cholerae* in acidic substrata: contaminated fish marinated with lime juice (ceviche). *Rev Biol Trop* [Internet] 1994 [cited 2026 Jan 7];42(3):479-485. Available from: <https://pubmed.ncbi.nlm.nih.gov/7501869/>.
 15. Valdivia M. Sensacionalismo, prejuicios y estereotipos en los diarios limeños durante la epidemia de cólera de 1991 [thesis]. Lima: Pontificia Universidad Católica del Perú; 2014.
 16. Carrillo C, Ref. 10.
 17. FAO/WHO Global Forum of Food Safety Regulators. Experience of the cholera epidemic in Peru 1991. Rome: FAO/WHO; 2002.
 18. Ibid.
 19. Ghersi E, Ñaupari H, Agua sucia: cólera en Perú. Las causas y los responsables. In: Okonski K, Hidalgo JC (ed.), *Salud y medio ambiente: mitos y realidades*. London: International Policy Network; 2005.
 20. Andonaire Villegas JP, El año de la peste peruana: el cólera de 1991. *El Comercio* [Internet] 2020 Mar 15 [cited 2026 Jan 7]. Available from: <https://elcomercio.pe/archivo-elcomercio/el-ano-de-la-pesto-peruana-el-colera-de-1991-noticia/>.
 21. Cueto M, Ref. 11. p. 117.
 22. Cueto M, Ref. 11. p. 117.
 23. Cueto M, Ref. 11. p. 117.
 24. Donzelot J, *The Policing of Families*. Hurley R, translator. New York: Pantheon Books; 1979. pp. 90-94.
 25. Cueto M, Ref. 11. p. 117.
 26. Ibid., p. 118.
 27. Vidal Layseca C, Personal communication with the author. 2004 Mar 5 and 2004 Apr 29.
 28. Vidal Layseca C, El cólera y el país en que vivimos. Conference presented at Universidad del Pacífico; Lima, March 1991.
 29. Rosen G, Ref. 3. Chapter 6.
 30. Cueto M, Palmer S, *Medicine and Public Health in Latin America: A History*. Cambridge: Cambridge University Press; 2015. Introduction and Chapter 5.
 31. Carrillo AM, *Economía, política y salud pública en el México porfiriano (1876-1910)*. *Hist Cienc Saude Manguinhos* 2002;9 Suppl:67-87.
 32. Cueto M, Ref. 11. p. 121.
 33. Cueto M, Ref. 11.

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