Firdausi Qadri and colleagues (July 8, p 1362) reported results from a trial of the oral cholera vaccine, which included an arm combining the oral cholera vaccine with an intervention promoting handwashing and drinking water treatment at home. The authors reported no significant protective effect of the behaviour change intervention over that of the vaccine alone. Despite the authors’ cautions against drawing conclusions from a study that had no independent water and hygiene intervention arm, media sources misrepresented the results as "...the oral vaccine worked way better than...getting people to wash their hands and drink clean water". 1

Receipt of the intervention for behaviour change was contingent on the oral cholera vaccine, biasing any interpretation of its independent effectiveness, and was a poor proxy for access to potable water, soap, and sanitation, which eliminated cholera from much of the world more than a century ago. 2

2 months after vaccination, participants were offered a handwashing station, a sachet of soap, and a bottle of soapy water, and were trained in the use of these items. 4 months after vaccination, chlorine for water treatment was introduced and its use promoted. No measures of intervention uptake or compliance were described.

Access to safe water, sanitation, and hygiene benefits people’s health and quality of life beyond cholera risk reduction. Oral cholera vaccines can serve as a complementary method for cholera prevention and control while countries progress towards universal provision of safe water and sanitation, but the vaccine alone will never provide broad health and social benefits. We must accelerate the evidence-based scale-up of access to safe water, sanitation, and hygiene and of wise use of the oral cholera vaccine wherever cholera transmission persists.

The authors reported no significant protective effect of the behaviour change intervention over that of the vaccine alone. Despite the authors’ cautions against drawing conclusions from a study that had no independent water and hygiene intervention arm, media sources misrepresented the results as "...the oral vaccine worked way better than...getting people to wash their hands and drink clean water". 1

Receipt of the intervention for behaviour change was contingent on the oral cholera vaccine, biasing any interpretation of its independent effectiveness, and was a poor proxy for access to potable water, soap, and sanitation, which eliminated cholera from much of the world more than a century ago. 2 months after vaccination, participants were offered a handwashing station, a sachet of soap, and a bottle of soapy water, and were trained in the use of these items. 4 months after vaccination, chlorine for water treatment was introduced and its use promoted. No measures of intervention uptake or compliance were described.

Access to safe water, sanitation, and hygiene benefits people’s health and quality of life beyond cholera risk reduction. Oral cholera vaccines can serve as a complementary method for cholera prevention and control while countries progress towards universal provision of safe water and sanitation, but the vaccine alone will never provide broad health and social benefits. We must accelerate the evidence-based scale-up of access to safe water, sanitation, and hygiene and of wise use of the oral cholera vaccine wherever cholera transmission persists.

The authors reported no significant protective effect of the behaviour change intervention over that of the vaccine alone. Despite the authors’ cautions against drawing conclusions from a study that had no independent water and hygiene intervention arm, media sources misrepresented the results as "...the oral vaccine worked way better than...getting people to wash their hands and drink clean water". 1

Receipt of the intervention for behaviour change was contingent on the oral cholera vaccine, biasing any interpretation of its independent effectiveness, and was a poor proxy for access to potable water, soap, and sanitation, which eliminated cholera from much of the world more than a century ago. 2 months after vaccination, participants were offered a handwashing station, a sachet of soap, and a bottle of soapy water, and were trained in the use of these items. 4 months after vaccination, chlorine for water treatment was introduced and its use promoted. No measures of intervention uptake or compliance were described.

Access to safe water, sanitation, and hygiene benefits people’s health and quality of life beyond cholera risk reduction. Oral cholera vaccines can serve as a complementary method for cholera prevention and control while countries progress towards universal provision of safe water and sanitation, but the vaccine alone will never provide broad health and social benefits. We must accelerate the evidence-based scale-up of access to safe water, sanitation, and hygiene and of wise use of the oral cholera vaccine wherever cholera transmission persists.