

"The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization, and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this Charter, Health for All by the Year 2000 will become a reality."

Source: World Health Organization, Health and Welfare Canada, and Canadian Public Health Association; *Ottawa Charter for Health Promotion*, Ottawa, Canada, 1986.

AIDS IN MEXICO

As of 11 February 1987, about 32,000 cases of acquired immune deficiency syndrome (AIDS) had been reported by the nations of the Americas to WHO. Over nine-tenths of these had been detected in the United States, which had reported a total of 29,536 cases. In terms of cases reported to WHO, Mexico (with 249 reported cases) ranked fifth, behind the United States, Brazil (1,012 cases), Canada (809 cases), and Haiti (785 cases). The following report deals with the 98 cases that were reported in Mexico from the time of the first known case in 1980 until 16 April 1986.

At the present time Mexico's General Epidemiology Bureau receives reports on AIDS patients diagnosed by hospitals belonging to the Health Ministry system, as well as those cared for in IMSS (Mexican Social Security Institute) and ISSSTE (Government Employees Social Security and Services) hospitals. All records and data are updated as soon as new reports of AIDS are received.

The first known case of AIDS in Mexico (the case with the earliest onset) occurred in a Haitian student 27 years of age who was living in Mexico City and who began to experience his first symptoms in 1980. No cases were recorded in 1981, but four cases were recorded in 1982, 13 in 1983, 12 in 1984, 49 in 1985, and 19 up to 16 April 1986. These 98 cases were recorded in 17 states, the largest number being found in the Federal District (Table 1).

Regarding the patients' sex and age (Table 2), only four were females, the youngest being a girl 13 years of age who contracted the disease through a blood transfusion. There were no cases in the 15-19 group, 30 cases (31%) in the 20-29 group, 47 cases (48%) in the 30-39 group, and 11 (11%) in the 40-49 group. Only four cases were reported in people over 49 years old. Almost 80% of these reported cases occurred in patients between 20 and 39 years of age. (The ages of four patients are unknown.)

Regarding preferred sex practices, 58 of the 98 patients were homosexual males and 25 of the other male patients

TABLE 1. Classification of the 98 Mexican AIDS cases reported up to 16 April 1986, by reporting state.

State	AIDS cases reported	
	No.	%
Federal District	38	39
Jalisco	17	18
Northern Baja California	6	6
Michoacán	6	6
Coahuila	5	5
Chihuahua	4	4
México	4	4
Veracruz	3	3
Guanajuato	2	2
Hidalgo	2	2
Morelos	2	2
Nuevo León	2	2
Yucatán	2	2
Aguascalientes	1	1
Campeche	1	1
Colima	1	1
Puebla	1	1
Sinaloa	1	1
Total	98	100

Sources: Instituto Mexicano de Seguridad Social (IMSS); Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado (ISSSTE); Secretaría de Salud (SS).

TABLE 2. Classification of the 98 Mexican AIDS cases studied, by sex and age group.

Age group (in years)	Sex		Cases reported	
	Male	Female	No.	%
< 15	1	1	2	2
15-19	0	0	0	0
20-29	28	2	30	31
30-39	46	1	47	48
40-49	11	0	11	11
≥ 50	4	0	4	4
Unknown	4	0	4	4
Total	94	4	98	100

Sources: IMSS, ISSSTE, SS.

TABLE 3. Occupations of the 98 AIDS patients studied.

Occupation	Sex	No. of patients
Student	M	4
	F	1
Hairdresser	M	4
Clerk	M	4
Flight attendant	M	4
Lawyer	M	3
Actor	M	3
Dentist	M	3
Housewife	F	2
Dancer	M	2
Cook	M	2
Accountant	M	2
Cosmetologist	M	2
Draftsman	M	2
Elementary schoolteacher	M	2
Tourist manager	M	2
Blue collar worker	M	2
Pilot	M	2
Business manager	M	1
Construction worker	M	1
Architect	M	1
Accountant's assistant	M	1
Varnish applier	M	1
Driver	M	1
Storekeeper	M	1
Dietologist	M	1
Nuclear energy worker	M	1
Engineer	M	1
Pastry cook	F	1
Waiter	M	1
Machine operator	M	1
Advanced student of architecture	M	1
Fisherman	M	1
Advertising agent	M	1
Retired	M	1
Public relations, Fisheries Department	M	1
Psychologist	M	1
Electrical technician	M	1
Radiology technician	M	1
Not investigated		31

Sources: IMSS, ISSSTE, SS.

said they were bisexual. (In the Mexican social environment it is quite hard for someone to openly admit to being homosexual.) It was not possible to determine 11 male patients' sexual preferences, but homosexuality was suspected in six cases. The remaining four cases occurred in apparently heterosexual females who contracted the disease through blood transfusions.

Only 25 of the 98 patients admitted to using drugs, and in most (14) cases the drug was marijuana. Use of intravenous drugs was reported in seven cases. Four patients said they had used nitrates for their vasodilating and relaxing effects.

Another important consideration is whether AIDS patients lived or traveled outside the country and whether they had homosexual contacts with foreigners. Fifty-eight patients (78%) reported that they had lived or traveled outside of Mexico, primarily in the United States but also in some cases in Canada or Europe. This information was not requested in 24 cases, mostly those reported before 1984, because this variable's importance had not been recognized. Sixteen of the 98 patients said they had not traveled outside Mexico.

Regarding the occupation of AIDS patients, occupational information was not obtained for 31 patients because the importance of this information was not initially recognized. As Table 3 indicates, the 67 patients from whom occupational data were collected showed a range of occupations that was quite extensive.

Table 4 lists the clinical conditions exhibited by the 98 patients when their cases were reported. An interesting finding that differed from the U.S. experience was that a significant number of these Mexican patients (nine of them) contracted tuberculosis, especially the generalized type, because of their deficient immunologic systems. The remaining 89 patients exhibited 36 cases of opportunistic infections alone, seven cases of Kaposi's sarcoma alone, 10 cases of Kaposi's sarcoma associated

TABLE 4. Classification of the 98 AIDS cases studied, by the patient's clinical condition.

Clinical condition	No. of cases reported
Opportunistic infections	36
Tuberculosis (generalized)	9
Kaposi's sarcoma	7
Kaposi's sarcoma plus opportunistic infections	10
<i>Pneumocystis carinii</i> pneumonia	5
<i>Pneumocystis carinii</i> pneumonia plus opportunistic infections	8
Cytomegalovirus pneumonia	1
C.N.S. lymphoma	1
ARC	6
Not determined	15
Total	98

Sources: IMSS, ISSSTE, SS.

with opportunistic infections, eight cases of *Pneumocystis carinii* pneumonia associated with opportunistic infections, and five cases of *Pneumocystis carinii* pneumonia alone. One patient had cytomegalovirus pneumonia, one had a central nervous system lymphoma, and six had AIDS-related complex (ARC). The clinical conditions of 15 patients could not be ascertained, although they are assumed to have had some opportunistic infections.

As of 16 April 1986, 51 of the 98 patients were known to have died; 25 patients were in hospitals, under treatment at home, or considered under control; the status of 22 patients was unknown. Overall, the available data suggest that the death rate in Mexico as of 16 April 1986 was comparable to that reported for U.S. patients up to late 1985.

A review of the 51 reported deaths shows that the survival time from diagnosis to death was as follows: seven patients (14%) died in the first three months after being seen at a medical facility; 10 patients (20%) lived four to six months; 16 patients (32%) lived for seven to 12 months; seven patients (14%) lived for 13 to 18 months; three patients (6%) survived for two years, and four patients (7%) survived for more than two years. The length of survival of the four other deceased patients is uncertain.

Source: Alfonso González Galván, Acquired immune deficiency syndrome in Mexico, *Border Health* 2(4):18-28, 1986.

HEALTH, DRINKING-WATER, AND SANITATION IN RURAL AREAS

While the association between water supply and sanitation programs and better health status is widely accepted among health professionals, in certain areas, especially rural ones, this relationship is not well understood. Rural populations value water resources highly, and any number of examples can be cited that indicate the lengths to which rural communities will go and the amounts each will pay to obtain a more accessible water source or to enhance the utility of an existing supply—but water in this context and without accompanying sanitation measures will not necessarily improve the health status of rural communities.

Such improvement will only come about if the community is the participant as well as the beneficiary of the program, and if a direct link is forged between primary health care on the one hand and water and sanitation programs on the other. Since parents do place a high value on the welfare of their children and do respect the community health worker (often the only health care provider at the village level), it is incumbent upon those responsible for primary health care, water supply, and sanitation to define and establish an effective collaboration.