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.

Current evidence suggests that this is not happening. The U.S. Agency for International Development has made millions of dollars available for "child survival programs," defined as programs extending oral rehydration therapy (ORT) and immunization. None of these funds are available for water and sanitation programs. In part, as noted above, this is because water and sanitation programs have been presented or viewed as technological systems, products, or hardware and not as health and development interventions. Until those responsible for water and sanitation and those involved in primary health care understand how water and sanitation improve the prospects for child survival—for example, how ORT without water and sanitation is at best a secondary intervention—and can convey that message to policymakers in governments and parents in rural communities, the existing situation is not likely to change. (For a closer look at the impact of better water supplies and sanitation upon health, see the article by John Briscoe, A Role for Water Supply and Sanitation in the Child Survival Revolution, on pages 93–105 of this issue.)

This reality should not cause us to lose heart. Indeed, the current concern about ensuring survival of the world's children, especially those living in rural areas, should provide an opportunity to involve primary health care workers in water and sanitation programs, and should help to make parents aware of and participants in these activities. It remains to be determined how this mission can best be accomplished. It is certain, however, that rural populations must be involved in all phases of the programs, that both intersectoral and intrasectoral cooperation must be ensured, and that those responsible for health must view water and sanitation not as an auxiliary or independent program, but as an integral part of a comprehensive undertaking.

Source: T. Elliott and J. B. Tomaro; Water Supply and Sanitation and Primary Health Care: A Discussion; paper presented at the Regional Symposium on Water Supply and Sanitation, an Element of Primary Health Care, held at Guatemala City, Guatemala, on 10–14 November 1986; Pan American Health Organization, 1986.