This week in the BMJ

Swimming pools provide health benefits

Swimming pools in remote Aboriginal communities in Western Australia decrease skin infections and ear disease and improve children’s quality of life. Lehmann and colleagues (p 415) assessed the prevalence of pyoderma (“skin sores”) and perforations of the tympanic membrane in young people (aged under 17) before and after swimming pools were opened in two remote Aboriginal communities. Pyoderma, tympanic membrane perforation, and skin infections decreased by up to 50% after the swimming pools were introduced. Children’s school attendance also improved because of a “no school, no pool” policy. Indigenous Australian children have high rates of pyoderma, which can lead to chronic renal disease and rheumatic heart disease. The authors say that swimming in a salt water pool provides the equivalent of a nasal and ear washout and cleans the skin.

Better research about Canadian aboriginal populations is needed

Published research on Canadian aboriginal populations does not match the demographic distribution and pattern of diseases in these populations. Young (p 419) reviewed 254 journal articles on Canadian aboriginal health and found that Métis, urban residents, and First Nations people not living on reserves were severely under-represented. Inuit were overstudied relative to their share of the aboriginal population. Women and children were poorly represented in the articles. Injuries, which account for a third of all aboriginal deaths in Canada, were studied in only eight papers. The author says that an explicit process for prioritising research is needed, such as that proposed by the Global Forum for Health Research.

Sexual problems are common in general practice patients

<table>
<thead>
<tr>
<th>Satisfaction with sex life in previous 4 weeks (%)</th>
<th>Women</th>
<th>Men</th>
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</thead>
<tbody>
<tr>
<td>Dissatisfied</td>
<td>33.2</td>
<td>28.0</td>
</tr>
<tr>
<td>Neither satisfied nor dissatisfied</td>
<td>17.6</td>
<td>8.4</td>
</tr>
<tr>
<td>Satisfied</td>
<td>49.2</td>
<td>63.6</td>
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</tbody>
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Sexual dysfunction is more common in people attending general practitioners than would be deduced from their general practice notes. In a cross sectional study, Nazareth and colleagues (p 423) assessed the sexual health of 1512 young sexually active adults in Canada, and Australia share these problems but few seek professional help. Those who do mostly go to their general practitioner.

Indigenous health needs innovative thinking

In the Education and Debate section of this week’s theme issue on indigenous health, authors from New Zealand, Canada, and Australia share their best practices and proposals for change. Foliaki and Pearce (p 437) discuss how the prevention and control of diabetes in Pacific people must take account of the political and economic conditions for improving
health, as well as emphasising the role of individuals in changing their lifestyles and health habits. Bloomfield and Logan (p 439) argue that a quality improvement framework is a better approach to healthcare priority setting and funding decisions than is the explicit prioritisation processes that have recently taken place in New Zealand. McPherson and colleagues (p 443) show how developments at national and local levels have reduced the disparities in life expectancies and health among indigenous people in New Zealand. On p 445 Cunningham and colleagues discuss the tripartite memorandum of understanding on indigenous health research signed by Australia, Canada, and New Zealand, which aims to share information and expertise on health research funding.

**POEM**

New antipsychotic drugs are slightly better than older ones

**Question** Are the newer antipsychotics more effective than the old ones? Do they cause fewer extrapyramidal symptoms?

**Synopsis** In this meta-analysis, the authors included studies that directly compared new generation antipsychotic drugs (NGA), such as clozapine and olanzapine, with low potency conventional ones (LPA), such as chlorpromazine and thioridazine. Their primary intent was to compare side effects and their secondary intent was to evaluate efficacy. In addition to the usual searches, they accessed many other databases and the Cochrane register of randomised schizophrenia trials. Additionally, they contacted manufacturers and first authors of included papers to track down unpublished studies. They used the Jadad scale to assess the quality of the 31 included trials (with 2320 patients). All data were independently extracted by two investigators, but these investigators don't describe their process of conflict resolution. The mean Jadad score was 3.4 (on a scale of 0 to 5) and no study had a score lower than 2. A funnel plot (a way of assessing potential publication bias) suggests that studies showing no benefit of NGA, with respect to extrapyramidal symptoms, may not have been found. The authors found no such bias with any other of their outcomes. They converted the dosing of the low potency agents to the equivalent dose of chlorpromazine and then stratified the studies by those using less than 600 mg chlorpromazine equivalent per day and those using 600 mg or more. In 11 studies of clozapine, fewer extrapyramidal effects occurred with clozapine than with LPA (number needed to treat (NNT) 7; 95% confidence interval 4 to 25). Other comparisons found no difference in extrapyramidal effects. In the studies comparing lower doses of LPA, 295 of 584 (51%) patients taking NGA had no clinically significant response compared with 314 of 538 (58%) taking LPA (NNT 13; P = 0.02). In the studies using higher doses of LPA, the response was 156 of 234 (67%) and 218 of 248 (88%) showing no clinically significant response, respectively (NNT 5; P = 0.004). Even stratified by dose, there was significant heterogeneity.

**Bottom line** In head to head trials, newer antipsychotic agents are slightly more effective than the older, low potency antipsychotic agents. Among the newer agents, only clozapine has fewer extrapyramidal side effects.

**Level of evidence** 1a (see www.infopoems.com/resources/levels.html); systematic reviews (with homogeneity) of randomised controlled trials.


* Patient-Oriented Evidence that Matters. See editorial (BMJ 2002;325:983)

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**Editor’s choice**

Learning from indigenous people

“It would have been far better for the New Zealanders as a people if they had never seen a European,” wrote a missionary; William Colenso, in 1865. When James Cook “discovered” New Zealand in 1769 there were estimated to be 200 000 Maori. By 1860 there were 35 000. Today Maori have a life expectancy about eight years less than the non-indigenous population. Next month’s Asia Pacific Forum on Quality Improvement in Health Care will be opened in Auckland with a traditional Maori greeting, and the forum will consider not only how the health of Maori and other indigenous peoples might be improved but also how everybody in health care can learn from indigenous cultures.

There are some 350 million indigenous people, representing over 5000 cultures in 70 countries on every continent. They are ancient peoples who found a way to live in harmony with their environment. These “primitive” people lived in environments—deserts, deep forests, marshes, and tundra—where “advanced” people cannot easily survive. The lives of individuals may have been short, but indigenous people did not destroy their environment.

The arrival of colonists has always meant death and destruction for indigenous people. This happens not just because of guns, infection, destroyed lifestyles, exploitation, poverty, and political oppression but because of a deep spiritual oppression that comes from having your sovereignty and culture subjugated. The answer to improving the health of indigenous people may lie less in increasing their access to modern health services and more in their rediscovering cultural values and ways. Eriana Turia—associate minister for health in New Zealand and “a descendant of the tribal peoples of Ch rangnui, Ngata Apa, Ngati Rangi, Ngati Rangi, and Ngati Tiniwharetoa”—describes how “as part of our drive towards self-reliance . . . our people decided to take our health into our own hands” (p 456).

Trying to fit into the government systems didn’t work, but a breakthrough came when Maori health workers and officials developed their own strategy—He Korowai Oranga. The central idea is whanau ora—families supported to achieve maximum health and well being. The focus is shifted from the individual to the whanau, meaning that the strategy can embrace all the factors that affect health and tackle complex problems like family violence.

Such developments can provide rich opportunities for pakeha (Europeans) to learn. When I lived in New Zealand in 1978 the Treaty of Waitangi signed between Maori and Europeans in 1840 seemed part of history, but now its principles of “partnership, participation, and consultation” are part of everyday life and used in creating health policy (p 439). Romanticism would like an impossible return to precolonial days. Practicality calls for learning from indigenous people.

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