Catering for vulnerable populations: customised care

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This issue of the *Journal of Primary Health Care* deals with primary and community care for a variety of vulnerable populations. It includes research that looks at a number of solutions, including targeted and tailored treatment delivered by general practitioners, practice nurses, other primary care providers and community members.

Our lead study found an estimated prevalence of hearing impairment of about one in five people in a number of Pacific Island nations, with the majority of those affected being underserved.[1] The authors call for a collaborative effort between researchers and health professionals, as well as local organisations and Pacific Island nation governments, to develop the required services. In her guest editorial, Dr Shelly Chadha from the World Health Organization identifies the lack of population-based data on hearing loss, especially in low-income countries. Information provided in such research can help prevent disabling hearing loss by developing strategies for early detection and prompt intervention.[2]

A qualitative study of general practitioner (GP) screening for sexually transmitted infections and HIV in men identified barriers in broaching sexual health issues in men who may be at risk, suggesting that this may be a priority topic for continuing medical education.[3] Another study examines the attendees of Dunedin's free clinic, concluding that this service is meeting health needs of some of the most vulnerable people in society.[4]

Raval et al.[5] have explored ways of communicating cardiovascular risks and possible treatments in different ethnic groups, as well as aspects of decision-making. Māori, Pacific and Indian patients significantly preferred explanations using pictures, especially 100-people chart formats, over numbers, and Pacific and Indian patients also preferred the GP to make the decision rather than shared doctor/patient decision-making. There is no one ideal way, however, and a combination of methods should be used routinely, with some tailoring to individual patients.

Nurses are increasingly providing customised care in community settings. Primary care nurses have an expanded role in diabetes management. However, a baseline study shows that specialist nurses have more access to clinical information, such as body mass index (BMI) and HbA1c than practice nurses. District nurses reported having even less access to this information, indicating the need for systems enabling communication between primary and secondary services to improve community-based care of these patients.[6] Nurses administering medications under standing orders is another way to provide care for at-need patients when no GP is available. A study found that standing orders are used extensively by nurses in primary care settings, but highlighted the need for doctors to support their use, provide evidence-based orders, and have confidence in their nurse colleagues who have advanced skills training.[7]

Community initiatives may also help improve the health of at-risk populations. A feasibility study of an after-school group exercise programme for underactive Māori and Pacific high school students was successful in getting the young people to participate and demonstrated some improvement in cardiorespiratory markers, hence warranting further investigation.[8] In a *Viewpoint* article, Perez and Kidd discuss the untapped community-based resource of using peer support workers in mental health care, possibly working through non-government organisations.[9] While acknowledging the potential barriers of lack of training and funding, peer support workers can assist patients with long-term moderate to severe mental illness to engage with primary health care services and keep appointments.

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Three articles this issue address the needs of another population—pregnant women. An audit conducted in Auckland hospitals found suboptimal antenatal screening for *Chlamydia trachomatis*, and offers a number of recommendations to improve the screening rate.[10] Guest ethicist Susan Hatters Friedman explores the ethics of treating or not treating depression in pregnancy, and communicating the relative risks posed to mother and foetus of both options.[11] Finally, our *Back to Back* debate this issue focuses on whether lead maternity care should be embedded within general practice. GP Dr Ben Gray makes the case for midwives working as part of the primary care team, with integrating services enabling a holistic approach to care of the woman and sometimes of her other children.[12] The Chief Executive of the New Zealand College of Midwives, Karen Guilliland, on the other hand, views pregnancy as a significant life event, with the midwife firmly embedded in the community.[13]

Overall, the message in this issue is clear. To meet the primary health needs of our communities, especially those who are most needy, vulnerable or marginalised, we need the involvement and collaboration of a number of care providers. As well as our GPs and practice nurses, a wide range of other providers and services are required, with careful tailoring of interventions for targeted populations.

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Erratum: *Back to Back* column in our December 2014 issue —correction to reference

The column contribution authored by Campbell Murdoch should be correctly cited as:

Murdoch JC. Having interprofessional education during the undergraduate years is essential for building teamwork skills in general practice—the 'no' case. J Prim Health Care. 2014;6(4):333–335.