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.