

Enhancing access to HIV pre-exposure prophylaxis (PrEP) through a community-based project in New Zealand

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ABSTRACT

Introduction. New Zealand has maintained a low HIV prevalence through comprehensive screening, treatment, and prevention programmes. However, challenges remain with access to pre-exposure prophylaxis (PrEP) for at-risk populations, particularly men who have sex with men (MSM). **Aim.** This study aimed to evaluate the implementation and outcomes of a community-based project that expanded PrEP access via a Standing Order authorising peer HIV testers and pharmacists to initiate short-term PrEP prior to general practitioner follow-up. **Methods.** Conducted between May 2020 and July 2021, the project involved collaboration between a community-based HIV support organisation, a general medical practice, and a community pharmacy in Auckland. Participants received an initial 10-day PrEP supply following a negative HIV rapid test and screening for contraindications, with follow-up laboratory testing and prescriptions managed by the practitioner and pharmacist team. **Results.** Thirty-six clients enrolled (aged 22–60 years). Most identified as European ($n = 16$), Asian ($n = 10$), or Māori ($n = 8$). No participants seroconverted to HIV during the study. Six sexually transmitted infections were diagnosed and treated. A degree of hepatocellular damage was reported in one participant, and mild but transient liver enzyme elevation occurred in a further five participants. No renal toxicity was recorded. The mean duration of PrEP use was approximately 12 months. **Discussion.** This project demonstrated that community-initiated PrEP under a Standing Order can be a safe, acceptable, and effective method for expanding HIV prevention services amongst MSM. This model supports future policy directions to broaden PrEP access through trained pharmacists and community channels.

Keywords: community pharmacy, HIV prevention, New Zealand, pre-exposure prophylaxis, PrEP, primary care, sexual health, standing order.

Introduction

HIV prevalence in New Zealand (NZ) remains low due to publicly funded prevention, treatment, and screening, with ~3500 people on antiretroviral therapy. Harm reduction and structural reforms, including needle exchange programmes, sex work decriminalisation, and effective perinatal screening, have kept transmission low in key groups, though rates remain higher among men, particularly men who have sex with men (MSM).^{1–3} Diagnoses have fallen since the 2016 peak (195 cases; 138 in MSM), with 80 new cases (68 in men) and 74% of locally acquired infections in 2025.⁴

Ongoing risks include tourism – overseas-acquired HIV made up one-third of cases in 2025 – and seasonal labour migration, particularly from Fiji, where HIV cases are rising, partly linked to increased methamphetamine injection use.^{4,5}

In 2023, NZ adopted a national plan aligned with UNAIDS targets, aiming, by 2030, to maintain low incidence in key groups, eliminate mother-to-child transmission, and reduce locally acquired infections by 90% from 2010 levels.^{1,4,6} The plan prioritises pre-exposure prophylaxis (PrEP), targeting a 95% uptake among those at risk; however, uptake remains low at 25% of target in 2020, with barriers still limiting primary care access.^{1,7–9} In 2020, a community-based PrEP project was established to enable PrEP initiation using

WHAT GAP THIS FILLS

What is already known: The Dean Street sexual health clinic in England exemplifies a decentralised, nurse-led model of PrEP delivery, and across the wider United Kingdom extension of PrEP provision through community pharmacies has been signalled. Similar initiatives have been described across a range of countries, with initiation of PrEP by a health professional. Notably, however, initiation of PrEP by non-healthcare personnel, as it has been uniquely used in this project in New Zealand, has not been reported on.

What this research adds: This study demonstrates that task-shifting, i.e. delegated responsibility for initiating PrEP, especially amongst a high-risk group of men who otherwise find it difficult to access an effective means of preventing acquiring HIV infection, can be considered as a safe and effective HIV-prevention strategy.

a Standing Order. This article evaluates the project, reports outcomes, and examines implications for improving HIV prevention access.

Method

Peer testers at Body Positive NZ were authorised via a Standing Order to provide MSM with an immediate PrEP supply on request. After a negative rapid HIV test and brief verbal screening (including contraindications), clients received a 10day PrEP starter pack and a laboratory form for baseline tests.

Follow-up care was managed by the GP practice and pharmacy, with a 90-day prescription issued once eligibility (including a confirmed negative HIV test and a renal function test) was met. Ongoing monitoring followed clinical guidelines, with results reviewed by the pharmacy and practice nurse before repeat prescribing.¹⁰

Regular meetings between the GP practice, pharmacy, and community organisation supported quality control and process improvements (e.g. lab testing, prescribing, costs, and stock management). Privacy concerns led to discreet packaging, alternative delivery addresses, and secure communication, increasing administrative workload.

Data were collected through usual standard processes across all three agencies. Body Positive's testing service, governed by Auckland Sexual Health Service, adapted their standard documentation to include PrEP access and consent for anonymised data use. Participants were enrolled with the GP practice and pharmacy, with records kept per NZ health data standards and unique IDs assigned before analysis.

Ethic approval for this study was obtained from the Auckland University of Technology Ethics Committee (AUTEC); reference 21/346, on 23 September 2021.

Results

Participants

Thirty-six clients enrolled between May 2020 and July 2021, with COVID-19 disruptions. Two additional men qualified for but declined PrEP, and 30 were first-time users. Participants were mostly European ($n = 16$), with others Asian ($n = 10$) or Māori ($n = 8$); one identified as African and one did not disclose ethnicity. Ages ranged from 22 to 60 years (mean 34, median 32), with most in their 30s. Two participants discontinued PrEP (at 2 and 6 months), three paused then restarted, and three transferred care to their own GPs. All participants were followed up to exit or to December 2022, with 28 men still using this service at that time. The project continues to date, but data from additional clients were not included due to ethics approval limits.

Key laboratory findings

No HIV positive results were returned by any participants at any time during the study period. During the study period, two clients tested positive for syphilis, two for chlamydia, one for gonorrhoea, and one for HSV Type 1.

Hepatitis B monitoring was conducted due to potential flares after stopping PrEP; no participants required vaccination. Eleven were Hepatitis A-reactive, and none were Hepatitis C-reactive. Liver function was monitored; five participants showed elevated levels that later normalised. One case of hepatocellular damage led to stopping PrEP and further clinical management. As PrEP is contraindicated with $\text{eGFR} < 60 \text{ mL min}^{-1} \text{ per } 1.73 \text{ m}^2$, renal function was monitored; no participants required discontinuation for renal issues.

Duration of prevention and adverse events

Most participants planned daily PrEP use at enrolment; four intended event-based dosing and three were unsure. At repeat prescribing, three later reported event-based use as the reason they did not yet require refills. Duration of preventive therapy varied widely—from a single 10-day supply to nearly 900 days (mean 426 days, ~ 1 year). The most common supply was one 90-day prescription ($n = 7$).

Adverse events were rare, with three cases reported: self-resolving memory loss, fatigue in a participant with comorbidities, and insomnia that resolved with short-term treatment.

Discussion

This project aimed to improve timely, safe PrEP access for MSM via a community-based model, using a Standing Order within a GP- and pharmacy-governed framework.

Outcomes

The primary outcome of this project was to improve access to PrEP, including domains of appropriateness, acceptability, and affordability, with the broader aim of reducing the risk of HIV transmission.

Limitations in timely access to health care remain evident across NZ, with patients often waiting weeks rather than days to secure a GP appointment.¹¹ The Burnett Foundation Aotearoa identifies only 30 'PrEP-friendly' providers among approximately 400 primary care clinics in Auckland; the existence of such a list underscores that healthcare environments are not universally safe. MSM may still encounter clinical resistance to PrEP, alongside broader anti-sexuality rhetoric encountered in social media spaces.¹² Six participants reported prior failed attempts to obtain PrEP, citing prescriber inexperience and, in some cases, discrimination.

Cost at key points in the supply chain remains a barrier to accessing health care in NZ, and PrEP is no different. State-subsidised primary health care in NZ is via capitation-based funding to general practice and normally covers at least part of the cost of a consultation with a primary care level; however, it requires enrolment of the client with a single practice. This meant that for any client not enrolled in the participating practice, an out-of-pocket fee-for-service was charged, and for a few participants this was unaffordable. Although PrEP is funded via the Pharmaceutical Schedule (with pharmacy dispensing fees), reduced drug costs were offset by rising administrative expenses (e.g. lab follow-up and dispensing).

Increasing PrEP access aims to reduce HIV transmission. Although causality cannot be proven, all participants remained HIV-negative, and more frequent testing likely improves early detection. No evidence of treatment failure or resistance emerged, and increased STI testing also supported early detection, with a low STI incidence observed.

Structure and processes

This project relied on collaboration between a pharmacy, GP practice, and community organisation, aiming to embed it into routine care and management pathways. Delivery was supported by tele-consultations, electronic lab requests and results, and e-prescribing. Early phases required extra resourcing for meetings and privacy safeguards, but this decreased as processes stabilised. Partner tracing, though infrequent, was time-consuming and added to GP practice costs and initial workload.

Most clients preferred to stay enrolled with their regular GP for general care while using the project provider for PrEP; two returned to their own GPs for ongoing prescriptions.

Experience from other countries

Although informal 'buyers' clubs' exist, no literature describes legally sanctioned access to PrEP outside clinical settings or via non-clinical providers. In contrast, alternative models, such as pharmacist- or nurse practitioner-led services, have been implemented internationally.¹²

The Dean Street model in England uses nurse-led PrEP provision in a central London sexual health clinic and is a key example of decentralised, community-based prevention.^{13,14} It operates under a patient group direction (PGD), allowing qualified healthcare professionals to supply medicines; unlike this project's Standing Order, PGDs do not permit non-healthcare providers to initiate PrEP.¹⁵ In Wales and other parts of the United Kingdom, consideration has been given to extending PrEP provision to community pharmacies in 2025–26.^{16,17}

In the US, some states allow pharmacists to provide PrEP under frameworks similar to NZ's Standing Order, whereas in Canada (e.g. Alberta and Quebec) pharmacists can prescribe it. Pilot initiatives in several African and other low- and middle-income countries are also using community pharmacy models to expand PrEP access.^{18–21}

Implications for policymakers—potential to upscale PrEP accessibility

Achieving a 90% reduction in locally acquired HIV will require stronger collaboration across primary care and allied health in NZ, alongside evolving care models. Recent moves to expand pharmacist-led PrEP access align with this project's findings, supporting wider community pharmacy provision under consideration by Medsafe and PHARMAC.²² Effective PrEP delivery requires non-judgmental, stigma free HIV testing and contextual awareness,^{1,13,23} and providers need training and understanding of the PrEP care continuum.²⁴ A two-year review at Dean Street noted only a small proportion of PrEP users presenting with complex issues (mainly abnormal renal function or side effects), similar to findings in this project; however, clear management and referral pathways are essential.²⁵

Strengths and limitations

The success of this project depended on strong collaboration and trust, particularly given the stigma surrounding HIV and the involvement of unfamiliar providers. The Standing Order provided an effective governance framework to improve access but is unlikely to be sustainable long term due to administrative, legal, and accountability challenges. More integrated models, such as pharmacy- or

sexual health-based services, may offer more sustainable solutions.

Technology enables streamlined PrEP provision; however, siloed funding within NZ primary health care continues to pose challenges, particularly in achieving equitable access across socioeconomic groups, and does not reflect the fluid, multi-provider care common among MSM and similar populations. Expanding pharmacy-based PrEP access, including lab testing, must be built into existing funding models to avoid shifting costs to patients and undermining equity.

Conclusion

No participants seroconverted during the study period, and adverse effects were minimal. Enhanced access to PrEP can be delivered safely and effectively, particularly in settings where locally acquired infections remain concentrated among MSM.

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Data availability. In accordance with the study's ethics approval and the participants' privacy policy and informed consent, the data from this study cannot be shared. Information may be available from the corresponding author on reasonable request.

Conflicts of interest. The authors declare that they have no conflicts of interest.

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