Most People With HIV Initiating Cancer Treatment in Zimbabwe Lack Key HIV Clinical Data

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BACKGROUND

Siloed HIV and cancer services complicate delivery of cancer treatment for people with HIV (PWH) in Zimbabwe.

Oncology providers use information on CD4 count, HIV viral suppression, and antiretroviral therapy regimen to inform cancer treatment planning. Lack of access to this information can lead to uncertainty and delays in clinical decision making.

METHODS

RESEARCH SITE

The Parirenyatwa Group of Hospitals Radiotherapy Centre (RTC) is one of two public cancer treatment facilities in Zimbabwe. Located in Harare, the RTC serves 2/3 of Zimbabwe's population.

PARTICIPANTS

We enrolled 150 adult PWH initiating cancer treatment at the RTC between November 2024 – August 2025. Participants had new cancer diagnoses; we excluded those with benign diagnoses or cancer recurrence.

DATA COLLECTION

We reviewed RTC patient charts and patient-held HIV records to collect cancer and HIV clinical data at cancer care visits prior to treatment initiation. We administered questionnaires to collect demographic and socioeconomic data and information about HIV care engagement. We identified participants with complete HIV clinical information (CD4 count, HIV VL, ART regimen) available at cancer clinical visits prior to treatment initiation.

ANALYSIS

We used generalized linear models with Poisson distribution and robust variance to identify characteristics associated with complete HIV clinical data.

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KEY FINDINGS

For most PWH with cancer in Zimbabwe:

Cancer treatment planning begins without full HIV clinical data available to oncology care teams

Higher likelihood of complete HIV data among:

Those with more education, residence in Harare, and regular HIV clinic near residence

RESULTS

Characteristics of PWH Initiating Cancer Treatment at PGH RTC in Harare, Zimbabwe November 2024 – August 2025, N=150

Demographic Characteristics	*n*	*%*
Sex		
Male	23	15.3
Female	127	84.7
Age		
50 or younger	76	50.7
51 or older	74	49.3
Highest Level of Education Completed		
Primary	40	26.7
Secondary or higher	108	72.0
Residence, Prior to Cancer Diagnosis		
Outside Harare Province	109	72.7
Within Harare Province	41	27.3
Engagement in HIV Care		
Most Recent HIV Clinic Visit		
≤ 1 month prior to RTC registration	77	51.3
> 1 month prior to RTC registration	73	48.7
Location of Most Recent HIV Clinic Visit		
Outside residence city/village	54	36.2
In the same city/village as residence	95	63.8
ART Status		
On ART	148	98.7
Not on ART	2	1.3
Completeness of HIV Data		
Both CD4 and VL Missing	54	36.0
Missing CD4 Only	28	18.7
Missing VL Only	24	16.0
Both CD4 and VL Available	44	29.3
Cancer Etiology		
Infection-Related[1]	123	82.0
HPV-Related[2]	116	77.3

[1]Cancers likely related to oncogenic viral infection (Epstein-Barr virus, human papillomavirus (HPV), Hepatitis B & C viruses, and Kaposi sarcoma-associated herpesvirus): Hodgkin and non-Hodgkin lymphomas, anal, cervical, penile, and vulvovaginal cancers, liver cancers, and Kaposi sarcoma
[2]Anogenital cancers likely related to HPV infection: anal, cervical, penile, and vulvovaginal cancers

RESULTS CONT.

Characteristics Associated With Complete HIV Clinical Information at RTC Registration (N=150)

	PR (95% CI)	*p*	*aPR (95% CI)*	*p*
Sex				
Male	Ref.	0.9		
Female	0.96 (0.49–1.88)			
Age				
≤ 50	Ref.	0.8		
≥ 51	0.94 (0.57–1.54)			
Education				
Primary	Ref.	0.02	Ref.	0.02
Secondary or higher	2.81 (1.19–6.66)		2.56 (1.15–5.72)	
Residence				
Outside Harare	Ref.	0.004	Ref.	0.001
Within Harare	2.02 (1.25–3.26)		2.17 (1.38–3.43)	
Most Recent HIV Visit				
Within prior month	Ref.	0.6		
>1 month prior	1.16 (0.70–1.90)			
HIV Clinic Location				
Outside residence city/village	Ref.	0.02	Ref.	0.008
Within residence city/village	2.56 (1.28–5.11)		2.47 (1.26–4.84)	
Cancer Etiology				
Infection-Related	Ref.	0.3		
Not Infection-Related	0.75 (0.42–1.32)			

Final model adjusted for education, residence, HIV clinic location
aPR: adjusted prevalence ratio; 95% CI: 95% confidence interval

CONCLUSIONS

This study highlights gaps in communication of key HIV-related clinical information across siloed service delivery systems.

Because PWH are at disproportionate risk of poor outcomes after cancer diagnosis compared to those without HIV, it is critically important that they not face delays in treatment decision-making and provision of care due to lack of information on immune status.