

Burden of HIV disease and comorbidities on the chances of maintaining in employment in the current context in France

Running head: HIV disease, comorbidity and employment

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Abstract

Objectives: Employment status is a major predictor of health status and living conditions, especially among HIV-infected people, a predominantly working-aged population. We aimed to quantify the risk of work cessation following HIV diagnosis in France in 2004-2010 and to measure the respective burden of HIV-related characteristics and of associated comorbidities on this risk.

Design: We used data from the ANRS-COPANA multicenter cohort made of a diversified sample of recently diagnosed HIV-1-infected adults, antiretroviral treatment-naïve at baseline in 2004-2008. Detailed information on living conditions and clinical and biological characteristics were collected prospectively.

Methods: The risk of work cessation among the 376 working-aged participants employed at baseline was estimated using the Kaplan-Meier method. Characteristics associated with the risk of work cessation were identified using multivariate Cox models.

Results: The cumulative probability of work cessation reached 14.1% after 2 years and 34.7% after 5 years. Diabetes, hypertension and, to a lesser extent, signs of depression were associated with increased risks of work cessation after accounting for socio-occupational characteristics (adjusted hazard ratios [95% confidence interval]: 5.7 [1.7-18.8], 3.1 [1.5-6.4] and 1.6 [0.9-2.9], respectively). In contrast, HIV disease severity and treatment, and experience of HIV-related discrimination were not statistically associated with the risk of work cessation.

Conclusions: The risk of work cessation during the course of HIV disease has remained substantial in the most recent period in France. Comorbidities, but not characteristics of HIV disease itself, substantially affect chances of maintaining in employment. This provides insights into strategies for limiting the burden of HIV disease for individuals and society.

Keywords

Employment status; Socioeconomic factors; Comorbidity; HIV-related discrimination; France

Introduction

Employment is a major factor in maintaining income levels and living conditions, especially among persons with long-lasting chronic diseases [1]. In addition, unemployment has been shown to be an independent predictor of morbidity and mortality both in the general population [2-6] and among HIV-infected people [7, 8].

Several studies have shown evidence of adverse effects on employment status of various chronic conditions including diabetes [9-11], cardiovascular disease [12-14], cancer [15-18] or depression [19, 20]. As regard to HIV infection, few studies have investigated this topic. They have shown a phenomenon of employment loss occurring from the very first months following disease onset [21-24]. These reports, based on data collected earlier in the era of combined antiretroviral therapies (cART), i.e. in the years 1996-2004, found that HIV infection weighted on the chances of maintaining in employment through various mechanisms including disease severity and experiences of HIV-related discrimination.

Since 1996, the sustained use of cART has resulted in a marked decrease in overall and HIV-related morbidity and mortality among HIV-infected people. At the same time, the relative burden of comorbidities on health status has dramatically increased [25, 26]. As a result, the impact of HIV infection on employment may have changed, as well as the respective burden of HIV disease itself and of comorbidities on chances of maintaining in employment. Given the importance of employment issues among HIV-infected people, a predominantly working-aged population, such changes are important to be documented in order to be accounted for in the implementation of comprehensive care programs. However, data on the topic have remained scarce. The present study aimed at investigating the phenomenon of work cessation during the course of HIV disease in the recent context in France. More specifically, our objectives were to estimate the frequency of work cessation among participants of the ANRS-COPANA cohort

followed since HIV diagnosis, and to measure the respective impact of characteristics of HIV infection itself and of frequent comorbidities on this risk of work cessation during the period 2004-2010.

Methods

Study design

The French ANRS-C09-COPANA cohort is an ongoing prospective study conducted in 37 hospitals located all over the French territory. The cohort is made of 800 recently diagnosed (<1 year) HIV-1-infected adults, naïve of antiretroviral treatment at baseline. In the participating centres, participants have been enrolled between April 2004 and May 2008 and followed semi-annually through hospital outpatient visits thereafter. At enrolment and at each scheduled visit, detailed clinical and biological data on characteristics of HIV infection and its management, associated comorbidities, hospitalizations and health behaviours are collected through a physician-administered standard questionnaire. In addition, at enrolment and each year thereafter patients are asked to answer a self-administered questionnaire including detailed information on the various dimensions of their living conditions and depressive symptoms as measured by the French version of the Center for Epidemiologic Studies-Depression Scale (CES-D) [27].

The Paris-Cochin Ethics Committee approved the study protocol and all the participants gave their written informed consent to participate.

Variables of interest

Employment status at baseline and at each yearly follow-up was obtained from the self-administered questionnaire and categorized as follows: employed / unemployed / inactive (including participants retired, on disability or long-term (>1 year) sick leave, students and house workers). Work cessation was defined as moving from employment to either unemployment or inactivity before reaching the legal age of retirement in France, i.e. 60 years old. The date of work cessation corresponded to the date of beginning of unemployment or inactivity as reported in the self-administered questionnaire.

Sociodemographic characteristics including age, gender and educational level were collected at enrolment through the physician questionnaire, in addition to HIV transmission category. Nationality, country of birth and age at arrival in France were documented in the baseline self-questionnaire. Participants born outside of France were considered as migrants if they did not have the French nationality or, for those with the French nationality, if they arrived in France when they were older than 15 years. For those employed, occupational characteristics including occupational grade and job status were self-reported at baseline and during follow-up. Indicators of living conditions including cohabiting partnership, disclosure of HIV serostatus in close relationships (partner, family members, friends, colleague) and experience of HIV-related discrimination in the preceding year were also documented in the baseline and follow-up self-questionnaires.

Health status characteristics documented by the physician at each visit included indicators of HIV disease advancement and management (date of diagnosis, stage B or C defining illness since the last cohort visit, CD4 cell count, HIV viral load, cART prescription) and indicators of comorbidities. These included: history of diabetes and cardiovascular disease; coinfection with Hepatitis B virus (HBV) as defined by the presence of hepatitis-B surface antigens (HBsAg) or e antigens (HBeAg); coinfection with Hepatitis C virus (HCV) as defined by

a positive HCV PCR; and hypertension as defined by the prescription of an antihypertensive treatment. The presence of symptoms of depression in the preceding week was assessed by a CES-D score above 17 for men and 23 for women, the optimal cut-off scores identified in the French population {Fuhrer, 1989 #46}. At each follow-up visit the physician also reported hospitalizations having occurred since the last cohort visit, injecting drug use (IDU) and alcohol consumption.

Statistical analysis

Analyses were restricted to participants who were of working age (i.e., <60 years) at baseline, whether they were employed, unemployed or inactive. Moreover, to be included participants had to have attended at least the month 12 visit at the cut-off point of 30 June 2010. The risk of work cessation over time since enrolment among participants employed at baseline was estimated using the Kaplan-Meier method (1 minus Survival). Characteristics associated with the risk of work cessation were identified using univariate and multivariate Cox models. Both fixed and time-dependent variables were included in the models. Fixed variables included gender, age, migrant status, educational level, job status and HBV or HCV coinfection (as reported at baseline). Time-dependent variables included cohabiting partnership, disclosure of HIV serostatus, experience of HIV-related discrimination in the preceding year, stage B or C defining illness in the preceding 6 months, CD4 cell count, viral load, cART prescription, diabetes, hypertension, symptoms of depression in the preceding week and hospitalization in the preceding 6 months. For all these time-dependent covariates, we considered the value reported at the preceding visit. In the univariate step, associations of sociodemographic, occupational, living conditions, health status and health behaviours characteristics with the risk of work cessation were measured. All variables associated with the risk of work cessation with a p-value < 20% in univariate analysis were included in the multivariate model.

Statistical analyses were performed using SAS 9.2.

Results

Sample characteristics

A total of 622 participants were included. Among them, 376 (60.4%) were employed at baseline and thus constituted the population at risk of employment loss in our study. As of 30 June 2010, these 376 participants had been followed during a median time of 37.0 months (IQR 24.8 to 53.2) and had attended a median of 6 semi-annual scheduled outpatient visits after enrolment. Therefore, at the cut-off point time, all of them had attended the month 12 (M12) visit, 327 had attended the M24 visit, 217 the M36 visit, 134 the M48 visit, 67 the M60 visit and 20 the M72 visit.

The 622 participants constituted a diversified sample of HIV-infected patients, with 29.9% women and 40.5% migrants (58.4% originating from sub-Saharan Africa). The majority had been HIV-infected through homo/bisexual (44.5%) or heterosexual (44.2%) contacts. Only 5 participants reported having ever used injecting drugs. As shown in Table 1, women and migrants were underrepresented in the subgroup of participants employed at the time of enrollment in the cohort (19.2 versus 46.3% and 23.7 versus 66.3%, respectively). Compared to participants without employment, the 376 employed participants were also older (median age 36 versus 33 years, respectively) and more educated (91.2% with more than elementary or middle school level versus 68.7%, respectively). In majority, they were employed as clerks or associate professionals or technicians (61.7%) and held a permanent salaried position (71.6%). In addition, compared to participants without employment, those employed at baseline were more likely to live with a partner (57.7% versus 51.2%, respectively) and to have disclosed their

HIV serostatus to their close circle of family, friends or colleagues (78.7% versus 58.5%, respectively). Only a minority in both groups reported having ever experienced HIV-related discrimination at enrolment.

Overall, median time between HIV diagnosis and the first cohort visit was 4.5 months (4.5 and 4.3 months, respectively, among participants with and without employment at baseline). At their first visit, employed participants were significantly less likely than those without employment to have full-blown AIDS (5.1% versus 10.6%, respectively), severe immunosuppression with a CD4 cell count of less than $200/\text{mm}^3$ (15.4% versus 23.2%, respectively) or a viral load higher than $5\log_{10}\text{copies/mL}$ (21.5% versus 29.8%, respectively). They were also less likely to have HBV or HCV coinfection (2.4% versus 8.9%, respectively) and symptoms of depression (31.6% versus 42.7%, respectively). Overall, 32.6% of participants initiated cART within the 3 months following enrolment.

Work cessation

Overall, among the 376 participants employed at baseline, 67 stopped working before they reached the age of 60 years: 58 became unemployed, 4 retired, 3 left on long-term sick leave, and 2 went back to training. Work cessation occurred after a median follow-up time of 20.3 months (IQR 10.2 to 33.9). The cumulative probability of work cessation reached 5.4% (95% confidence interval [CI] [3.0 to 7.6%]) at M12, 14.1% [10.2 to 17.8%] at M24, 18.7% [13.9 to 23.2%] at M36, 23.1% [17.3 to 28.5%] at M48 and 34.7% [24.0 to 43.9%] at M60.

Among the 67 participants who experienced work cessation, 24 (35.8%) subsequently returned to work during follow-up. Return to work occurred within a median time of 11.5 months (IQR 8.0 to 16.3) after cessation of the previous work. At the cut-off point time, 20 of

these 24 were still employed. Thus, of the 376 participants employed at baseline, a total of 47 (12.5%) were still out of employment at the end of follow-up.

Factors associated with the risk of work cessation over time

As shown in Table 2, in multivariate analysis the risk of work cessation was associated with individuals' sociodemographic and occupational characteristics: participants aged 30-39 years had a higher risk of work cessation compared to those aged 40-49 years (adjusted Hazard Ratio [aHR] 3.1, 95% CI [1.5 to 6.5]). The risk of work cessation was also higher in participants with a primary level of education (aHR 2.6 [1.0 to 6.7]) and, to a lesser extent, in those with a technical education (aHR 2.1 [0.9 to 5.1]) compared to participants who attended college or university. In addition, job status was associated with the risk of work cessation, those being self-employed (aHR 6.1 [1.7 to 21.7]), holding a temporary job contract (aHR 8.8 [3.1 to 24.8]) or holding a permanent position in the private sector (aHR 2.8 [1.1 to 7.6]) experiencing a higher frequency of work cessation compared to those holding a permanent position in the public sector. Participants living on their own also tended to stop their work more frequently than those living with a partner (aHR 1.6 [0.9 to 2.9]). Women and migrants were at a higher risk of work cessation in univariate analysis; though, these associations were no longer significant after adjustment for educational level and employment status.

Accounting for sociodemographic and occupational characteristics, the risk of work cessation was significantly higher among participants with diabetes (aHR 5.6 [1.7 to 18.5]) and among those with hypertension (aHR 3.1 [1.5 to 6.4]) compared to those free of these comorbidities. Symptoms of depression also tended to be associated with an increased risk of work cessation (aHR 1.7 [0.9 to 2.9]). In contrast, HIV disease severity, as measured either clinically (i.e. occurrence of a stage B or C defining illness in the preceding 6 months) or biologically (i.e. CD4 cell count $<350/\text{mm}^3$ or viral load $\geq 5\log_{10}$ copies/mL), was not associated

with a significant increase in the risk of work cessation. Experience of HIV-related discrimination was not statistically associated with the risk of work cessation either, nor was cART prescription or hepatitis coinfection.

Sensitivity analysis

Predictors of work cessation may be different according to various factors including individuals' willingness to maintain in employment and the type of work contract (permanent vs. temporary). To estimate the impact of these differences on our results we performed two sensitivity analyses: 1) censoring work cessations that are likely to have been chosen, i.e. those followed by a return to training or by retirement; 2) excluding individuals with a temporary job contract for whom work cessation was likely to result from the termination of their contract. In both analyses, diabetes and hypertension remained associated with an increased risk of work cessation. Furthermore, the associations between indicators of HIV disease severity and work cessation remained non-significant.

Discussion

HIV infection most often occurs in early adulthood, and the majority of HIV-infected individuals are of working age. Therefore, employment constitutes a major dimension in the life of HIV-infected people, and understanding the ways by which the disease interferes with employment may provide insights into strategies for limiting the burden of HIV disease for individuals and society. This requires the availability of longitudinal datasets documenting both clinical, biological and socio-occupational aspects. Information on socio-occupational characteristics are generally not routinely collected in hospital databases; as a result, studies on the impact of HIV infection on employment have remained limited in the recent period, despite

the dramatic changes having occurred regarding the course of the disease. To our knowledge, our study is the first to prospectively document this major issue in the current context of sustained use of cART.

Our results provide evidence for the existence of a phenomenon of work cessation starting from the very first months following HIV diagnosis and persisting during the five subsequent years in the current context in France, suggesting substantial social and economic consequences for patients, employers and society. Accounting for individuals' sociodemographic and occupational characteristics, HIV disease advancement and treatment, and self-reported experience of HIV-related discrimination do not appear to be significant predictors of work cessation. In contrast, comorbidities frequently associated with HIV disease including diabetes, hypertension and depression substantially affect the chances of maintaining in employment during the course of HIV infection.

The ANRS-COPANA cohort constitutes a unique source of information to appropriately investigate the social aspects of HIV infection. Indeed, information collected prospectively from the early time of HIV diagnosis includes detailed data both on social, occupational and health characteristics. In addition, the cohort is made of a diversified sample of HIV-infected patients: overall, women account for 30% of the participants, migrants (mostly from Sub-Saharan Africa) for 41%, and MSM for 64%. Such diversity suggests that the ANRS-COPANA cohort provides insights into the situation of the different socially contrasted subgroups of patients encountered in France as in many other European settings. The employment rate at baseline in the whole cohort (62.9%) was close to the rate of 59.3% estimated among people diagnosed HIV-infected in France in 1994-2003 in the ANRS-VESPA survey [28], suggesting that the study population also provides a good reflect of the employment situation of HIV-infected people in France. The longitudinal design of the ANRS-COPANA cohort allowed us to consider covariates

as time-dependent variables, thus accounting for underlying dynamic processes. Covariates were systematically measured previous work cessation (at baseline or at the time of the preceding visit), suggesting that the associations we show are unlikely to reflect reverse causality or contemporaneity. However, it must be acknowledged that, as in any single observational study, causality cannot definitely be established.

Our results indicate that the risk of work cessation during the course of HIV infection has remained substantial in the recent period in France, with more than one third (34.7%) of patients having ended the job they held at the time of HIV diagnosis after five years. A previous study showed that in France, employment rate was lower in HIV-infected people than in the general population, probably as a result of decreased chances of maintaining in employment for the former [28]. In the present study the extent to which the rate of work cessation was higher than in the general population, reflecting the overall burden of HIV infection on work cessation, could not be examined. Only a formal comparison to the frequency of work cessation during the same time period in HIV-uninfected people with comparable positions on the labor market would allow the quantification of this burden.

Although substantial, the rate of work cessation in our study appears lower than reported earlier in the cART era in France. Indeed, in our study 12.5% of patients initially employed were out of employment almost 3 years after HIV diagnosis; this proportion was twice higher (25.0%) among participants of the ANRS-PRIMO cohort employed at the time of enrolment in 1996-2002, although they had been enrolled an earlier stage of the disease, i.e. primary HIV infection, and followed during a shorter time (2.5 years in median) [21]. In addition, data from the ANRS-VESPA survey showed that among people diagnosed HIV-infected in France in 1996-2002 while they were employed, 32.4% had lost their employment 4 years later [22]. Some cases of work cessation might have been underreported in the ANRS-COPANA database. This is

particularly the case for episodes of work cessation occurred early in the course of HIV infection, i.e. previous enrolment in the cohort, and for those of short duration. However, similar sources of underestimation might have biased estimates of work cessation rates in previous studies as well; thus, the lower frequency of work cessation we report is likely to reflect an actual decreasing burden of HIV disease on work cessation with the sustained use of cART.

Our results do not provide evidence for a significant role of HIV-related characteristics on the risk of work cessation in the current context in France. This finding is consistent with a recent study showing that employment status was not associated with the level of CD4 cell count among HIV-infected outpatients followed in 2008-2009 in the UK [29]. In contrast, HIV disease severity and reported experience of HIV-related discrimination were found to be significant predictors of work cessation earlier in the cART era [21-24]. Such a discrepancy is likely to reflect changing barriers and attitudes to continued employment during the course of HIV disease in the most recent period. Of note, in the present study we focused on the termination of the job held at the time of enrolment in the cohort. Thus, our results pertain to HIV-infected patients employed at the time of HIV diagnosis, a subgroup more privileged than those out of employment as regard to position on the labor market (i.e., more likely to be middle-aged educated French-native men), HIV disease severity and comorbidity. Although we did not find any significant role of HIV disease characteristics on the risk of work cessation in this specific subgroup of patients employed at baseline, the existence of a significant impact of these characteristics on employment status of patients unemployed at the time of HIV diagnosis cannot be ruled out. Future studies need to investigate the determinants of access to and maintain in employment during the course of HIV disease among patients unemployed at the time of HIV diagnosis.

Physical and mental health impairments related to longstanding illnesses such as cardiovascular disease, diabetes or depression are known to be significant predictors of unemployment in the general population [19, 20, 30, 31]. In a previous study, such chronic conditions have also been found to weight on the chances of maintaining in employment among HIV-infected people, independently of HIV disease characteristics [21]. Here we found that unlike HIV disease severity and reported experience of HIV-related discrimination, comorbidities including diabetes, hypertension and symptoms of depression were associated with an increased risk of work cessation during the course of HIV infection. This suggests that comorbidities constitute major barriers to continued employment among HIV-infected people in the current context in France,.

Employment discontinuation during the course of HIV infection may result from various pathways. Physical and mental functioning, workplace discrimination, difficulties to combine job demands in addition to disease management may directly weight on the chances of maintaining in employment, resulting in involuntary work cessations. Such involuntary work cessations may also result from non-health-related factors, e.g. the termination of a temporary work contract. On the other hand, employment discontinuation may result from a reasoned choice of leaving employment, e.g. for people who wish to go back to training or to retire or for those who can afford to live on their partner's (or other supportive person's) income. In our study, back to training and retirement only accounted for 6 of the 67 work cessations; furthermore, living with a partner tended to be associated with a decreased risk of work cessation. This suggests that this phenomenon of planned work cessation is probably limited. Moreover, sensitivity analyses showed that the burden of HIV-related characteristics and comorbidities on the chances of maintaining in employment remained unchanged when potentially planned work cessations were censored and individuals with a temporary work contract were excluded, thus supporting our results.

In conclusion, the present study provides evidence that the risk of work cessation during the course of HIV infection has remained substantial in the most recent period in France. Social and economic consequences for patients, employers and society are likely to be important and should be addressed at different levels including clinical settings, employers and social workers. A particular attention should be paid to prevent HIV-infected patients affected by comorbidities from leaving employment.

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Table 1 – Baseline characteristics of participants with and without employment at the time of enrollment in the cohort

		Employment status at baseline				p ^a
		With Employment (N=376)		Without Employment (N=246)		
		#	%	#	%	
Age	<30 years	82	21.8	82	33.3	<0.01
	30-39 years	149	39.6	103	41.9	
	40-49 years	104	27.7	40	16.3	
	50-59 years	41	10.9	21	8.5	
Women		72	19.2	114	46.3	<0.01
Migrants		89	23.7	163	66.3	<0.01
Educational level	Elementary or Middle school	33	8.8	77	31.3	<0.01
	Trade school	82	21.8	32	13.0	
	High school	75	20.0	49	19.9	
	College or University	181	48.1	81	32.9	
	Missing	5	1.3	7	2.9	
Occupational grade	Managers, Craftsmen	22	5.9	-	-	-
	Executive	56	14.9	-	-	
	Associate professionals or technicians	103	27.4	-	-	
	Clerks	129	34.3	-	-	
	Manual workers, Farmers	64	17.1	-	-	
	Missing	2	0.5	-	-	
Job status	Self-employed	34	9.0	-	-	-
	Permanent contract, public sector	86	22.9	-	-	
	Permanent contract, private sector	183	48.7	-	-	
	Temporary contract	73	19.4	-	-	
Cohabiting partnership		217	57.7	126	51.2	<0.01
HIV status kept secret		80	21.3	102	41.5	<0.01
Experience of HIV-related discrimination		29	7.7	25	10.2	0.29
Clinical stage	A	337	89.6	212	86.2	0.02
	B	19	5.1	8	3.3	
	C	19	5.1	26	10.6	
CD4 cell count (/mm ³)	<200	58	15.4	57	23.2	<0.01
	200-349	78	20.7	66	26.8	
	350-499	117	31.1	55	22.4	
	≥500	123	32.7	68	27.6	
Viral load (log ₁₀ copies/mL)	<5	293	78.6	172	70.2	0.02
	≥5	80	21.5	73	29.8	
HBV or HCV coinfection		9	2.4	22	8.9	<0.01
Diabetes		8	2.1	3	1.2	0.54
Hypertension		26	6.9	14	5.7	0.54
Symptoms of depression ^b		119	31.6	105	42.7	<0.01

^a Chi² test or Fisher's exact test as appropriate^b CES-D score above 17 for men and 23 for women

Table 2 – Characteristics associated with the risk of work cessation among the 376 participants employed at baseline

		# with work cessation	Univariate	Multivariate ^a	
			HR [95% CI]	HR [95% CI]	p
Gender ^b	Women	19	1.7 [1.0-2.9]	1.1 [0.6-2.2]	0.77
	Men	48	1	1	-
Age ^b	<30 years	11	1.2 [0.5-2.5]	1.8 [0.7-4.5]	0.22
	30-39 years	32	1.8 [0.9-3.3]	3.1 [1.5-6.5]	0.003
	40-49 years	14	1	1	-
	50-59 years	10	2.5 [1.1-5.5]	1.9 [0.8-4.7]	0.14
Migrant ^b	Yes	24	1.9 [1.1-3.1]	1.3 [0.6-2.6]	0.48
	No	43	1	1	-
Educational level ^b	Primary school	11	2.6 [1.3-5.3]	2.6 [1.0-6.7]	0.05
	Trade school	15	1.4 [0.7-2.5]	2.1 [0.9-5.1]	0.08
	High school	14	1.4 [0.7-2.6]	1.3 [0.6-2.9]	0.45
	College or University	27	1	1	-
	Missing	0	-	-	-
Job status ^b	Self-employed	9	5.2 [1.8-15.6]	6.1 [1.7-21.7]	0.005
	Permanent contract, public sector	5	1	1	-
	Permanent contract, private sector	26	2.4 [0.9-6.2]	2.8 [1.1-7.6]	0.04
	Temporary contract	27	8.1 [3.1-21.1]	8.8 [3.1-24.8]	<0.001
Cohabiting partnership ^c	No	35	1.7 [1.0-2.7]	1.6 [0.9-2.9]	0.09
	Yes	30	1	1	-
	Missing	2	0.8 [0.2-3.6]	0.9 [0.2-3.9]	0.89
HIV status kept secret ^c	Yes	15	2.7 [1.5-5.0]	1.6 [0.8-3.4]	0.21
	No	52	1	1	-
Experience of HIV-related discrimination in the preceding year ^c	Yes	8	1.7 [0.8-3.6]	1.6 [0.7-3.6]	0.26
	No	59	1	1	-
Stage B or C defining illness in the preceding 6 months ^c	Yes	4	2.2 [0.8-6.2]	1.3 [0.4-4.3]	0.67
	No	63	1	1	-
CD4 cell count ^c	<350/mm ³	22	1.4 [0.8-2.3]	1.4 [0.8-2.4]	0.24
	≥350/mm ³	45	1	1	-
Viral load (log ₁₀ copies/mL) ^c	≥5	6	1.1 [0.5-2.7]	-	-
	<5	61	1	-	-
Prescription of cART ^c	Yes	28	0.8 [0.5-1.3]	-	-
	No	39	1	-	-
HBV or HCV coinfection ^b	Yes	1	1.3 [0.2-9.8]	-	-
	No	66	1	-	-
Diabetes ^c	Yes	4	4.3 [1.6-11.9]	5.6 [1.7-18.5]	0.005
	No	63	1	1	-
Hypertension ^c	Yes	14	2.4 [1.3-4.4]	3.1 [1.5-6.4]	0.002
	No	53	1	1	-
Symptoms of depression in the preceding week ^{c,d}	Yes	23	1.5 [0.9-2.5]	1.7 [0.9-2.9]	0.07
	No	44	1	1	-
Hospitalization in the preceding 6 months ^c	Yes	7	2.2 [1.0-4.9]	1.1 [0.4-2.9]	0.84
	No	60	1	1	-

HR Hazard Ratio; CI Confidence Interval

^a Cox model adjusted for gender, age, migrant status, educational level, job status, cohabiting partnership, HIV-related discrimination, stage B or C defining illness, CD4 cell count, diabetes, hypertension, symptoms of depression and hospitalization^b As reported at baseline (fixed) ^c As reported at the preceding visit (time-dependent) ^d CES-D score above 17 for men and 23 for women

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