Author’s response to reviews

Title: Migrant Health in Italy: a better health status difficult to maintain. Country of origin and assimilation effects studied from the Italian Risk Factor Surveillance data.

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ANSWERS TO REVIEWERS (in capital letters)

Reviewer #1: This is an interesting work on migrant health. However, it refers to a highly selective sample of migrants and its findings cannot easily be generalised, not to the migrant population from other European countries and certainly not to migrants from other parts of the world.

THIS POINT HAS BEEN NOW ADDRESSED IN THE INTRODUCTION

Moreover, the authors refer to public health interventions taking into account different cultures, but no specific examples are given.

WE HAVE ADDED EXAMPLES

What is necessary to understand is why it seems that the migrant populations tend to adopt the bad health habits of the native population despite the fact that all health promoting actions point toward an integrated approach.

THE HYPOTHESIS, SUPPORTED BY THE LITERATURE, IT IS THE EFFECTS OF SHARING CONTEXT WITH THE LOWER CLASS OF THE HOST POPULATION. WE HAVE NOW TRIED TO BETTER EXPLAIN THIS.

It would also be interesting to refer specifically to the cultural differences of the European migrants the paper is looking at, as these may not be all that great compared to the native
population, at least not enough to explain the prevalence of the risk factors included in the analysis. It should be made clear that the paper is looking at economic migrants from European countries to distinguish from other migration groups with much different health priorities.

WE ARE LOOKING MAINLY AT ECONOMIC MIGRANT (NOT ONLY FROM EUROPEAN COUNTRIES). WE MADE CLEARER THIS POINT

Another rather weak point is the fact that the data analysed refer to the period 2008-2013 and the situation of migration in Europe and in Italy is completely different now, where the reasons of migration are totally different and along this the health profile of the migrants.

THE SITUATION IN ITALY IN NOT “COMPLETELY DIFFERENT” FROM A STATISTICAL POINT OF VIEW: THE “NEW MIGRANTS” ARE RELATIVELY FEW (3-4%) COMPARED TO THE POPULATION WE HAVE STUDIED. WE MADE CLEARER THIS POINT PRESENTING ALSO FEW STATISTICS FROM THE NATIONAL INSTITUTE OF STATISTICS

Finally, it should be made clear that there are assumptions made i.e. the language competence does not necessarily mean integration and that there are other factors that have not been considered in assessing the well-being of the migrants such as employment and family status that may affect the health behaviour of the individuals.

We agree, We changed accordingly.

Reviewer #2: Review POHM 18 00066

This manuscript presents an analysis of a large surveillance dataset from Italy, with a focus on migrants and risk factors and particularly aiming to study differences with respect to country of origin and to risk (or behaviour) convergence related to duration of stay, or "assimilation" as termed by the authors. The manuscript employs a unique data source, and provides new insight into migration health in Italy, however results largely confirm what is known globally, i.e. variation in health status with often better profiles for migrants, and ongoing risk convergence with increasing duration of stay.

Major comments

The authors do not differentiate between migrant health and refugee health. Longstanding migrants may have different entitlement as well as different health care experiences and different health problems as compared to current refugees, and this needs to be accounted for, or, if not true in Italy, clearly described.

WE ACKNOWLEDGE THAT REFUGEE AND ECONOMIC MIGRANTS CAN BE VERY DIFFERENT, WITH DIFFERENT NEEDS.
THIS POINT HAS BEEN MADE, NOW, CLEAR BOTH IN THE INTRODUCTION AND IN THE DISCUSSION, SHOWING ALSO THE (GREAT) NUMERIC DIFFERENCES BETWEEN THESE TWO GROUPS.

The statistical methods are not very described. Results do not allow to investigate sex-related differences

A BETTER DESCRIPTION OF THE STATISTICAL METHODS HAS BEEN INTRODUCED AND A GENDER ANALYSIS HAS BEEN ADDED.

Specific comments:

P4 L9: substantial variation..between health status? Please revise, probably you want to express that there are variations depending on the health outcome under consideration

REPHRASED

P4 L12: massive crisis - what are the characteristics you are alluding to? Where is the evidence for a "massive crisis", and whom does it affect. My perspective would be to refrain from dramatising terminology unless there is substantial and constructive reason to use it.

REPHRASED

P4 L19: wording: … relevant to better address public health interventions? Is it not rather that such specific knowledge may be useful to design and implement better-targeted interventions?

YES, REPHRASED.

Methods:

The limitation to those speaking Italian is understandable but represents a particular challenge in migrant studies: is there any information how many interviews could not be done due to language restrictions? In the discussion, otherwise some info could be incorporated on the percentage of migrants not speaking Italian (from other sources)

FURTHER INFORMATION ADDED IN THE DISCUSSION SESSION

P8 Statistical methods: the ordering should be different, starting from saying how descriptive analyses and standardisation was done moving to any modelling (regarding which outcomes?) and the indicating what was used as indicating statistical significance.

Later, [p.11], conditional regression is mentioned: why is this approach used, is there a matched design? The methods section needs to be expanded to include all statistical approaches, with
sufficient explanation. Also, the term relative OR is introduced on p.11, this again is not clear and needs to be revised. The explanation given in the results belongs to the methods section.

THE METHOD SECTION HAS BEEN RE-ORGANIZED, AND THE STATISTICAL MODELS USED HAVE BEEN BETTER EXPLAINED. THE TERM “RELATIVE” ON P.11 HAS BEEN CHANGED INTO “CONDITIONAL”. EXPLANATION PREVIOUSLY IN THE RESULTS SECTIONS ARE NOW IN THE METHODS.

Please also indicate what happens with missing data in PASSI and in your analysis?

A SENTENCE, WITH APPROPRIATE REFERENCES, HAS BEEN ADDED IN THE METHOD SECTION

Results

P8 L17 First sentence is hard to understand - what does substantially mirroring mean? Is the Italian comparison population also taken from PASSI respondents, or from national statistics (as it seems)? I think that it would be good to have the demographics of Italians in PASSI as well, as participation always plays a role

REPHRASED. DATA PRESENTED ARE ONLY FROM PASSI, DATA FROM ISTAT (NOT SHOWN) DO NOT PRESENT SUBSTANTIAL DIFFERENCES.

P10 there are no real differences in education status in table 1, only perhaps in those with university degree. Restate the findings.

REPHRASED

Results for table 2: for clarity I suggest to put those variables where higher OR indicates better health or risk factor below each other, i.e. good health status and cervical cancer screening, followed by the other vars. This reduces possible confusion.

NOT SURE ABOUT THIS. WE PREFERRED A DIFFERENT LOGIC OF EXPOSITION: HEALTH STATUS PERCEPTION – MENTAL HEALTH – RISK FACTORS – ADHERENCE TO PREVENTIVE SERVICES.

P 12 authors state that the country of origin has a major influence on health behaviour and attitudes. This statement should be reviewed as it may well be factors associated with origin, including cultural values, dietary habits, health concepts, etc, and country is not much more than a proxy for this conglomerate. This is discussed a few paragraphs later in some detail. However, much of the comments in the results section along belong to the discussion.

REPHRASED AND MOVED A COUPLE OF SENTENCES IN THE DISCUSSION SECTION
Table 3: the data should be stratified by sex, and not standardized for sex, as there are possibly substantial prevalence differences by sex that cannot be seen here (and not in table 2). This is an essential change required.

ADDED IN TABLE 2B ANALYSES BY SEX

P 12 I am wondering why no regression analysis including length of stay was done for some core outcomes. The authors reserve this for future analyses, however, it seems this could still be part of the current analysis.

LENGTH OF STAY HAS BEEN ANALYZED FOR ALL THE VARIABLES CONSIDERED IN THIS STUDY. WHAT WE COULD NOT DO IS TO EXAMINE THE COMBINED EFFECT OF LENGTH OF STAY AND COUNTRY OF ORIGIN FOR THESE VARIABLES, SINCE THIS COMBINATION, FOR SEVERAL SUBGROUPS, WOULD HAVE LED TO VERY SMALL SAMPLES. WITH THE PROGRESS OF DATA COLLECTION, WE THINK IN THE FUTURE IT WILL BE POSSIBLE TO REASONABLY PERFORM ALSO THIS ANALYSIS.

Discussion:

The general direction of the discussion is clear and substantiated by the findings, highlighting advantages among migrants, while acknowledging convergence. Less clear is the relationship to health promotion activities; for example, the authors report about the increase in screening uptake and reduced socio-economic differences for cervical cancer screening, however the reference relates to colon cancer screening and not to health promotion but to another survey evaluation. Therefore, the conclusion does not fit to the core contents of the paper and needs to be rephrased.

SOME CHANGES HAS BEEN MADE. A REFERENCE HAS BEEN ADDED

Please reconsider the argument as well with regard to maintenance and strengthening of existing health resources among migrants. While it may be true that migrants contribute to overall better health indicators in a population, the picture must be balanced by particular health care and preventive needs (including language services etc.) as well as the necessity to consider the particular demographics of the group as a whole and subgroups from different countries or ethnic background.

AGREE. REPHRASED