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Lindström, Martin

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LUND UNIVERSITY

PO Box 117
221 00 Lund
+46 46-222 00 00

Ethnic Differences in Social Participation and Social Capital in Malmö, Sweden: A Population-Based Study

Martin Lindström¹

1 Department of Community Health
University Hospital MAS
Lund University
S 205 02 Malmö
Sweden

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Abstract

The aim of this study was to investigate ethnic differences in different aspects of social participation in Malmö, Sweden. The public health survey in Malmö 1994 is a cross-sectional study. A total of 5,600 randomly chosen individuals aged 20-80 years were asked to complete a postal questionnaire. The participation rate was 71%. The population was divided into categories born in Sweden, Denmark/Norway, other Western countries, former Yugoslavia, Poland, Arabic speaking countries and all other countries. The age-adjusted and multivariate analyses were performed using a logistic regression model in order to investigate the importance of possible confounders (age, education, economic stress and unemployment) on the differences by country of origin in different aspects of social participation. Men and women born in Arabic speaking countries and other countries (Iran, Turkey, Vietnam, Chile and subsaharan Africa) participate to a significantly lower extent in a variety of civic and social activities when compared to the reference population born in Sweden. The differences in participation in these groups compared to the group born in Sweden are observed both for social participation items at the core of the definition of social capital and cultural and other activities unrelated to social capital. This pattern is particularly pronounced for women born in Arabic speaking countries. These women even sharply differ from the participation rates of men born in Arabic speaking countries. The ethnic differences in most cases do not seem to be explained satisfactorily by education, economic stress or unemployment. However, the ethnic differences in social participation could possibly to an important extent be explained by differences in culture and the process of acculturation, although the ethnic consciousness model itself does not specify gender differences in civic and social participation.

Key words: Ethnicity, country of birth, education, social participation, social capital.

Introduction

All major reports on health promotion in recent decades have stressed the importance of community participation programs for successful health promotion programs (WHO 1981; WHO 1986; WHO 1997). Social participation has often been viewed in terms of “community participation” in the public health literature with the aim to increase community participation in order to promote health (Lipsky and Lounds 1976; Rifkin 1986; Ziguras 1992; Baum et al. 2000). People can participate in all sorts of social activities in many different forms of formal and informal social networks. The general definition of social participation is thus very wide, but it is still generally accepted and widely held that social participation is important for empowerment (Baum et al. 2000). Empowerment, in its most general sense, refers to the ability of people to gain understanding and control over personal, social, economic and political forces in order to take action to improve their life situations (Israel et al. 1994). Empowerment is an important concept in the literature concerning social and community work (Mcknight 1985; Ife 1995), health promotion (Rissel 1994; Labonte 1997) and community psychology (Rappaport 1987; Hawe 1994). Social participation also leads to increased social support and social integration, which has a positive impact on health (Rosenfeld 1997; House, Landis and Umberson 1988). Social integration was defined already by Émile Durkheim in “Le Suicide” (1897). There are two forms of social integration according to this definition: attachment and regulation. Attachment is the extent to which an individual maintains ties with members of society. Regulation involves the extent to which an individual is held in the fabric of society by its values, beliefs and norms (Turner et al. 1989; Berkman and Glass 2000). It is of interest to assess what segments of the population that participate in different civic and social activities, because social integration and social participation are closely associated with mortality (Berkman and Syme, 1979; House, Robbins and Metzner 1982; Schoenbach, Kaplan, Fredman and Kleinbaum, 1986; Kaplan et. al, 1988; Kawachi et. al., 1996; Kawachi; Kennedy, Lochner and Prothrow-Stith, 1997; Wilkinson, 1996; Kaplan, Pamuk, Lynch, Cohen and Balfour, 1996), health related behaviours, psychological pathways such as self-efficacy, self-esteem and coping effectiveness, and physiologic pathways such as immune system function and cardiovascular reactivity (Berkman and Glass 2000).

The concept of social participation has also been used with somewhat more specific connotations, most importantly in the literature concerning social capital. The concepts civic participation and social participation have been incorporated into the social capital literature both at the individual and contextual levels of analysis. The causal connections between social capital and health follow several pathways. Social capital may provide affective support and may be the source of self-esteem and mutual respect (Wilkinson, 1996; Kawachi, Kennedy and Glass, 1999). Social capital may increase access to local services (Kawachi et. al., 1999). It may also promote more rapid transmission of health information, adaptation of health behaviour norms and social control over deviant health-related behaviours (Lindström, Hanson and Östergren, 2001; Lindström and Isacsson, 2002; Lindström, Isacsson and the Malmö Shoulder Neck Study Group 2002). Finally, social capital facilitates the prevention of crime (Kennedy, Kawachi, Prothrow-Stith, Lochner and Gupta, 1998; Kawachi, Kennedy and Wilkinson, 1999; Putnam 2000). Social capital has also been shown to be significantly associated with lower total mortality, lower cardiovascular mortality and lower mortality in accidents and suicide (Kawachi et al. 1996; Kawachi et al. 1997). A society with high levels of social capital is characterised by high civic participation and high social participation in the diverse collective activities of civic society, generalised trust in other people, trust in the public institutions of society (institutional trust), political equality and social structures which enhance social interactions between citizens (Putnam 1993). Some authors mostly study social capital as a contextual trait of society (Putnam 2000; Woolcock 2001), but social capital can also be studied from a micro-perspective, for instance, how social relations and social networks are organised in local environments and in the relations between individuals (Coleman 1990; Bourdieu 1998). Social participation is thus, accompanied by trust and generalised reciprocity, the core concept within the social capital literature both theoretically and when it comes to the operationalisation of social capital in empirical studies. Social participation and trust are mutually dependent and often enhance each other (Putnam, 1993.). Some part of the social capital literature stress that social participation should be regarded as the essence of social capital rather than trust. According to both Putnam and Woolcock social capital should be defined as the formal and informal social connections between persons and groups of persons that create social contexts characterised by cooperation, mutual trust and generalised reciprocity, rather than as trust (Putnam, 2001; Woolcock, 1998; Woolcock 2001). However, other authors have stressed trust as the essence of social capital (Coleman 1990; Bourdieu 1998). This study concerns social participation, because social participation has been shown to be crucial for general information, norms concerning health related behaviours

and, ultimately, health, and because it is possible to directly promote and increase social participation to a higher extent than trust. In this social capital sense social participation is more narrowly defined as civic and social participation within organisations as well as formal and informal social networks which serve to strengthen the norms and values of society and to promote generalised trust and reciprocity between its citizens. Social participation as an aspect of social capital was originally operationalised by Putnam (1993) as number of memberships per capita in organisations and associations at the regional level. In recent years the association between social capital and different aspects of health has been extensively investigated. Social capital has by Putnam (see above) been regarded as a trait of social contexts. However, other authors have defined and studied social capital and social participation at the micro- or individual level (Coleman 1990; Bourdieu 1998). Macinko and Starfield (2001) even identify four different levels for the analysis of social capital. The first level is the macro level, i.e. countries and regions. The second meso level concerns contexts at the neighbourhood level, the third level social networks and social participation at the micro level and the fourth level individual attitudes such as psychological factors and trust. This article clearly concerns the third level, according to the Macinko and Starfield classification. Social participation items such as union meetings, meetings of other organisations, demonstrations and big gathering of relatives are relevant regarded as networks creating social capital.

It has already been noted that the definition of social participation as an aspect of social capital is more narrow than the general and very wide definition of social participation as community participation. Social participation and activities such as e.g. visiting a theatre/cinema, an arts exhibition, a church service, a sports event, a night club/entertainment or writing a letter to the editor of a newspaper/journal could be suspected in some cases to be completely solitary activities that do not comprise the transmission of the norms and values of society. Thus they do not fit the social capital definition of social participation. Furthermore, social activities such as participating in a study circle at work, a study circle outside work or attending a private party may be regarded as borderline cases, because to a great extent they may solely fit Woolcock's definition of "bonding" social capital, i.e. social capital which binds members of an already existing and well-defined social group even tighter together (Woolcock 2001). The lack of "bridging" social capital, i.e. social capital facilitating and creating connections between different groups and networks, may lead to the exclusion of individuals who are not members of the social network. This kind of exclusion has been

named “the dark side of social capital” by Putnam (2000). All these items are still included in this study for at least two reasons. First, they have previously been included as an index consisting of thirteen items investigating the association between social participation and health (see e.g. Lindström 2000). The data are thus readily available. Furthermore, these items may in some cases be regarded as indirect mediators of the norms and values of community. Second, since the data are already accessible, it would be interesting to compare patterns of social participation in activities either closely related to the key definition of social capital as opposed to activities more loosely or even unrelated to social capital.

One important group for the study of social participation as the mediator of the norms and values of community in the social capital sense are the ethnically diverse immigrant groups in Western Europe. Sweden has been a country of net immigration since the end of the second world war. Sweden is now a multiethnic society with more than one million foreign-born inhabitants. Studies have reported higher prevalences of bad self reported health (Lindström, Sundquist and Östergren 2001) and cardiovascular mortality (Sundquist and Johansson 2002) in some immigrant groups born in non-European countries such as Arabic speaking countries. The economic recession in the early 1990s caused high unemployment rates and marginalisation in some of the newly arrived immigrant groups. In some of these ethnic groups from refugee countries such as the Arabic speaking countries and some other countries in Asia and Latin America the marginalisation and lack of contact with the labour market has persisted even in the late 1990s when the unemployment rates declined in the rest of the Swedish population (Lundh C, Ohlsson R, 1999). In “Ethnic enterprise in America” (1972) Ivan Light highlighted the question “Why do some discriminated ethnic minorities or immigrant groups succeed in developing successful enterprises while others fail?”. The main conclusion was that the development of social ties and social connections, even *within* the ethnic minority group or immigrant group, was crucial for the development of successful enterprises (Light, 1972). Mark Granovetter also documented the importance of casual social contacts and weak social ties for individuals in search of employment (Granovetter 1974). It is often by means of social capital that small-business entrepreneurs mobilize financial capital- e.g. through loans and investment tips from members of the same ethnic group (Portes and Sensenbrenner 1993). Social networks are important for job opportunities even for individuals with higher education (Loury 1992). Social connections and social ties affect the life chances of the individual. Social ties can influence who gets a job, a bonus, a promotion and other employment benefits. Unemployment, marginalisation and lack of integration in society are

strongly and negatively associated with social capital (Corcoran, Datcher and Duncan 1980; Belliveau, O'Reilly III and Wade 1996; Podolny and Baron 1997; Putnam 2000; Lindström, Merlo and Östergren, 2002).

Studies in the USA have shown ethnic differences in social capital measured as different aspects of political and social participation. Both African Americans and Latinos are less active in politics than Anglo-Whites. However, when the factors that foster participation in politics, i.e. measures of socioeconomic status such as education, family income and skills exercised on the job and in organisations, are taken into consideration the differences often disappear (Verba, Schlozman, Brady and Nie 1993; Verba Lehman Schlozman and Brady, 1995). These findings that measures of individual status tend to explain race differences in participation has been named the socioeconomic (SES) model (Park and Vargas-Ramos 2002). One revision of the SES model in the field of political participation is the ethnic group consciousness model, which came about because of the SES model's inability to account fully for the engagement of low socioeconomic status groups (Verba and Nie 1972). The ethnic group consciousness may contribute to a sense of political inefficacy, political mistrust and perceived political deprivation which in turn induces political involvement (Bobo and Gilliam 1990; Bobo 1998). Bobo and Gilliam (1990) have e.g. found that black Americans participate to a higher extent than white Americans of the same socioeconomic status, a finding that they attribute to a particular aspect of group consciousness-empowerment. Another study in the USA has shown that inequalities between different socioeconomic groups were more strongly associated with self reported health among Anglo-Whites than among African Americans (Blakely, Kennedy and Kawachi, 2001).

In Europe, a continent that has been characterised by intense immigration for several decades, a surprisingly low number of studies have been conducted concerning ethnic differences in social participation and social capital. The importance of social networks in explaining ethnic differences in employment and connections with the labour market has been stressed in the case of Sweden (Bevelander, Carlson and Rojas, 1997). Citizen involvement in groups and networks also has a socialisation effect that spurs growth of social capital, which has consequences for the political system (Cigler and Joslyn 2002). A recent study in the USA has shown that socioeconomic inequality in political participation/voting in elections is associated with poor self reported health, independently of both income inequality and state median household income (Blakely, Kennedy and Kawachi, 2001). Data on electoral participation in

Malmö as well as other big cities in Sweden has also shown very low rates of electoral participation in administrative areas exclusively populated by immigrants in the city of Malmö in southern Sweden (Malmö Statistical Yearbook, Supplement 1994, 1998). A recent study in Malmö in southern Sweden also showed large differences between different ethnic groups in social participation. Of all men born in Sweden 28.7% had low social participation in 1994. The corresponding proportions for men born in Denmark/Norway was 23.9%, men born in other Western countries 27.3%, Yugoslavia 44.3%, Poland 13.2%, Arabic speaking countries 68.4% and all other countries (mostly Chile, Iran, subsaharan Africa, Turkey and Vietnam) 35.9%. The proportions with low social participation were similar among women: born in Sweden 26.3%, Denmark/Norway 34.7%, other Western countries 30.3%, Yugoslavia 37.2%, Poland 37.7%, Arabic speaking countries 79.5% and all other countries 41.4% (Lindström and Sundquist, 2002). Social participation was measured as an index variable (if three activities/items or less during the past year: low social participation; if four or more: high social participation) consisting of organisational activities (union meetings, meetings of other organisations, study circles at work or other study circles), cultural activities (theatre/cinema, arts exhibition), church, sports event, having submitted an article to a newspaper/journal, participated in demonstration, night club entertainment, big gathering of relatives and/or private party. Some of these activities and measures of social participation are clearly in accordance with the core definition of social capital, while some other activities could better be described as either cultural activities, particularly theatre/cinema and arts exhibition, or borderline cases (see above). It would thus be highly interesting both from a social science and from a public health perspective to analyse ethnic differences in each of the different activities/items in the social participation index variable in order to separate the activities closely related to social capital from e.g. cultural activities.

The city of Malmö in southern Sweden has a higher proportion of immigrants than the rest of Sweden. The proportion of persons with foreign origin increased in Malmö from 17% in 1986 to 24% in 1994. The Malmö population is thus well suited for the study of ethnic differences in social participation and social capital. The rates of unemployment have also during the past three decades been higher in Malmö than in Sweden. Unemployment is higher in some ethnic groups than in the group born in Sweden (Lundh and Ohlsson 1999). One hypothesis in this study is that there is a negative association between unemployment and social participation, unemployment leading to lower levels of social participation. The second hypothesis is that ethnic groups born outside Europe which are already known to have higher rates of

unemployment have lower social participation than the group born in Sweden. The third hypothesis is that the socioeconomic (SES) model, i.e. adjusting for socioeconomic factors such as education, economic stress and unemployment, may explain the lower rates of social participation. In contrast, the lack of effect of adjustment for socioeconomic factors on the ethnic differences in social participation would support the ethnic consciousness model.

The aim of this study is to investigate differences between ethnic groups in different aspects of social participation, both social participation in a wider sense and social participation in accordance with the definition of social capital and other aspects of social participation. The aim is also to assess the potential importance of education, economic stress and unemployment for the differences in social participation between different ethnic groups in Malmö.

Material and Methods

Study population

The public health survey in Malmö 1994 is a cross-sectional study. A total of 5,600 persons born in 1913, 1923, 1933, 1943, 1953, 1963, 1968 and 1973 were randomly selected from the general Malmö population and asked to complete a postal questionnaire in the spring of 1994. In each age group, 700 persons (350 men and 350 women) were invited. Four letters of reminder were also sent to the respondents. A total of 3,861 persons answered the questionnaire, although 73 were incomplete. Since approximately 3% were abroad during the time of the investigation, a total of 5,422 persons had the opportunity to answer the questionnaire. Consequently, the participation rate was 71%.

Definitions

There are 83 different *countries of origin* among the respondents. They were categorised into seven categories: born in Sweden, born in Denmark/Norway, born in other Western countries (Finland, Iceland, the countries within the European community, Switzerland, the USA, Canada, New Zealand, Australia), born in former Yugoslavia (including Slovenia, Croatia, Bosnia Hercegovina, Serbia, Kosovo, Macedonia, Montenegro), born in Poland, born in Arabic speaking countries and born in all other countries (e.g. the rest of Eastern Europe, Chile, Iran, Turkey, Vietnam). The main reason for this categorisation was the aim to define country of origin categories large enough to achieve satisfactory statistical power for the analyses and homogeneous enough to be meaningfully discussed in a cultural perspective.

Social participation describes how actively the person takes part in the activities of formal and informal groups as well as other activities in society. The questions concerned whether the respondents had participated in the following activities during the past year:

-study circle/course at work place

-other study circle/course

- union meeting
- meeting of other organisations
- theatre/cinema
- arts exhibition
- church
- sports event
- letter to editor of a newspaper/journal
- demonstration
- night club/entertainment
- big gathering of relatives
- private party
- none of these activities during the past year.

All analyses were stratified by *sex*.

Age was categorised from the outset by the selection of only the birth years 1913, 1923, 1933, 1943, 1953, 1963, 1968 and 1973 in the random selection of the study population.

Education was categorised by length of education. The respondents were classified into three groups: a) more than 12 years, b) 10-12 years, or c) 9 years of education or less.

Economic stress (the ability to pay bills) was measured by an item with four alternative answers: "Never problems to pay bills", "Very seldom", "Half the year" and "Every month".

Unemployment was categorised according to unemployment or no unemployment. The participants not unemployed were either housewives, active participants in the workforce (self employed or employed), sick leave pensioners or students. In tables 4 and 5 the unemployed are compared to the employed.

Statistics

Prevalences (%), crude odds ratios (OR) and 95% confidence intervals (95% CI) (OR:s and 95% CI:s not shown in tables 1 and 2, only significance at 5% significance level) were calculated in order to analyse associations between country of origin and social activities. Prevalences (%) of unemployment (among participants born in 1933, 1943, 1953, 1963, 1968 and 1973) were calculated for men and women according to the ethnic categories. Prevalences (%), crude odds ratios (OR) and 95% confidence intervals (95% CI) (OR:s and 95% CI:s not shown in tables 4 and 5, only significance at 5% significance level) were calculated in order to analyse associations between the different aspects of social activities/social participation and age, education, economic stress and unemployment (unemployed compared to all employed in the case of unemployment). The age-adjusted and multivariate analyses were performed using a logistic regression model in order to investigate the potential importance of possible confounders (age, education, economic stress and unemployment) on the differences in the different social activities between the country of origin categories. The statistical analysis was performed using the SPSS software package (Norusis 1999).

Results

Table 1 shows that a significantly higher proportion of men born in Denmark/Norway had participated in union meetings, meetings of other organisations and big gathering of relatives during the past year compared to the male reference group born in Sweden. Men born in other Western countries had written an article submitted to a newspaper/journal and had participated in a demonstration to a significantly higher extent than the Swedish born male reference group during the past year. Men born in Yugoslavia had visited a theatre/cinema and an arts exhibition to a significantly lower extent than the male reference group born in Sweden. On the other hand, both men born in Yugoslavia and men born in Poland had attended service in church and participated in a demonstration to a significantly higher extent during the past year. Men born in Arabic speaking countries had visited a theatre/cinema, visited an arts exhibition, attended church, visited a sports event, visited a night club/entertainment, visited a big gathering of relatives and participated in a private party to a significantly lower extent than the male reference population born in Sweden. Men born in all other countries had participated in a meeting of other organisations, visited a night club/entertainment and participated in a private party to a significantly lower extent, but participated in a demonstration to a significantly higher extent than the reference population. Almost 75% of all men born in Arabic speaking countries were born in 1953, 1963 or 1968. The differences in age composition between the other ethnic groups were much smaller. The proportion of men with >12 years of education was higher among men born in Poland (41.2%), and other countries (34.3%) than among men born in Sweden (24.9%). Men born in other Western countries and Yugoslavia had >12 years of education to a somewhat lesser extent than men born in Sweden. On the other hand, the proportion with >12 years of education was somewhat higher in the Arabic speaking and other countries groups. Of all men born in Sweden 74.4% never had problems with paying their bills during the past year. The corresponding proportions were lower in all other ethnic groups: Denmark/Norway 62.1%, other Western countries 60.5%, Yugoslavia 54.4%, Poland 40.4%, Arabic speaking countries 27.3% and other countries 42.3%. A 5.4% proportion of men born in Sweden had problems paying their bills every month compared to 38.2% of all men born in Arabic speaking countries and 19.6% of men born in all other countries. (Age, education and economic stress not shown in table 1 because they have already been published in reference Lindström and Sundquist, 2002)

Table 2 shows that women born in Denmark/Norway had participated in a union meeting, visited a theatre/cinema and participated in a private party during the past year to a significantly lower extent than the female reference population born in Sweden in the crude (not age adjusted) analysis. Women born in other Western countries did not significantly differ from the reference population in any activities. Women born in Yugoslavia had visited a theatre/cinema and an arts exhibition to a significantly lower extent than the reference population. Women born in Poland had participated in a union meeting, a meeting of any other organisation, visited a theatre/cinema, visited a sports event, visited a night club/entertainment and participated in a private party to a significantly lower extent than the reference population. On the other hand, they had visited church to a significantly higher extent during the past year than the reference population. Women born in Arabic speaking countries and all other countries had the lowest rates of participation of all participants. They had participated in a union meeting, a meeting of any other organisation, visited a theatre/cinema, visited an arts exhibition, attended church service, visited a sports event, visited a night club/entertainment, participated in a big gathering of relatives and participated in a private party to a significantly lower extent than the Swedish born female reference population during the past year. In addition, women born in Arabic speaking countries had also participated in a study circle at work to a significantly lower extent. A 75% fraction of all women born in Arabic speaking countries were born in 1963, 1968 and 1973. Lower proportions of women born in Yugoslavia (7.9%) and Arabic speaking countries (18.4%) had >12 years of education, while higher proportions of women born in Poland (31.1%) and other countries (31.1%) had >12 years of education compared to the female reference group born in Sweden. Of all women born in Sweden 71.2% never had problems with paying their bills during the past year. The corresponding proportions were lower in all other ethnic groups with the exception of women born in other Western countries: Denmark/Norway 53.1%, other Western countries 73.1%, Yugoslavia 48.0%, Poland 36.9%, Arabic speaking countries 26.2% and other countries 39.0%. A 5.7% proportion of women born in Sweden had problems paying their bills every month compared to 16.9% of women born in Yugoslavia, 17.1% of women born in Poland and 38.2% of women born in Arabic speaking countries. (Age, education and economic stress not shown in table 2 because they have already been published in reference Lindström and Sundquist, 2002).

Table 3 shows that men aged 20-60 years born in Denmark/Norway, other Western countries, Poland and Arabic speaking countries had significantly increased prevalences of unemployment compared to men born in Sweden. Women born in Yugoslavia, Poland and other countries also had significantly higher prevalences of unemployment at the 5% significance level compared to women born in Sweden.

Tables 4 and 5 show that persons born in 1973 were significantly more likely to attend theatre/cinema, arts exhibition, sports events, night club/entertainment, big gathering of relatives and private party than middle-aged and older people. In contrast, persons born in 1973 were significantly less likely to attend study circles at work and union meetings than persons born in other age groups belonging to the active work force ages. The group with >12 years of education was more likely to attend a study circle at work, other study circles, meetings of other organisations than unions, theatre/cinema, arts exhibition, church, sports event, night club/entertainment and private party than the group with an education of 9 years or less among both men and women. Among men the group with highest education had also written a letter to the editor of a newspaper/journal to a higher extent than the group with the lowest education. Among women the group with highest education had attended a union meeting to a significantly higher extent than the group with the lowest education. The group with ability to pay bills every month had significantly higher social participation in particularly meetings of other organisations than unions, theatre/cinema and night club/entertainment than the group which experienced economic stress among both men and women. On the other hand, the group with economic stress had participated in a demonstration to a significantly higher extent than the group with no economic stress. Unemployed men and women had lower rates of social participation in most activities compared to self employed and employed men and women, respectively.

Tables 6 and 7 show that adjustment for age only to some extent altered the patterns of differences in participation between the ethnic groups. In most cases adjustment for age resulted in not significant crude differences becoming significant. Only in the case of men born in all other countries as participants in study circles at workplace and in the case of church attendance among men born in Yugoslavia did crude significant differences become not significant after adjustment for age. In eleven other cases among men and ten cases among women crude not significant results became significant after adjustment for age. Further adjustments for education, economic stress and unemployment did not alter the

general pattern of ethnic differences in social activities/social participation, although marginal alterations in the patterns of ethnic differences appeared, although significant differences compared to the reference group born in Sweden were reduced to non significance among men when unemployment was introduced in the multivariate model. The general pattern of significantly lower rates of social activities/social participation in the ethnic groups born in Arabic speaking countries and other countries, especially for women, remained throughout the multivariate analyses

Discussion

Men and women born in Denmark/Norway, other Western countries and Yugoslavia as well as men born in Poland and other countries only slightly differed in social participation from the reference group born in Sweden. Men and women born in Arabic speaking countries as well as women born in Poland and other countries had significantly lower levels of civic and social participation than the reference group born in Sweden. Women born in Arabic speaking countries had significantly lower levels of participation in most civic and social activities. They differed from men born in Arabic speaking countries by also having significantly lower levels of participation than the female reference group born in Sweden in study circles, union meetings and meetings of other organisations. Particularly women born in Poland, Arabic speaking countries and other countries seem to have low social participation in both activities such as union meetings, meetings of other organisations and big gathering of relatives directly related to the core definition of social participation as an aspect of social capital as well as more general aspects of participation such as cultural activities (theatre/cinema and arts exhibition), sport events, night club entertainment, and private party. These patterns largely, although not completely, remained in the age-adjusted and multivariate models.

Non-participation is not likely to have produced serious selection bias in this study. The proportion of individuals born in other countries than Sweden was 24% in Malmö in 1994 according to the population register covering the entire population. The 26.7% proportion of individuals born in other countries than Sweden rather seems to represent a slight overrepresentation of the foreign born part of the Malmö population in the age brackets included in this study. Furthermore, the distribution of the country of origin categories is similar to that observed in the general Malmö population for all the ethnic groups (Axén and Lindström, 2002; Malmö Statistical Yearbook 1994). There may theoretically also be some underrepresentation of those having lived for a comparatively short period in Sweden. However, this theoretical problem of a possibility of underrepresentation of newly arrived immigrants would most likely result in an underestimation of the different aspects of social participation observed in the study, because newly arrived immigrants would plausibly have lower levels of social participation than other immigrants. The 71% participation rate is also satisfactorily high.

The validity of the social participation index variable has previously been reported to be high (Hanson, Östergren, Elmståhl, Isacsson and Ranstam, 1997). The reliability of the different social participation items has previously been assessed by testing the test-retest stability of 200 respondents in the Malmö Shoulder Neck Study, MSNS (for a description of the MSNS see Lindström and Isacsson, 2002; Lindström, Isacsson and the Malmö Shoulder Neck Study Group, 2002). The test-retest stability of most of the items was reasonably high. The kappa coefficients were 0.63 for study circle at work, 0.70 for other study circle, 0.88 for union meeting, 0.63 for other meeting, 0.81 for theatre/cinema, 0.80 for arts exhibition, 0.85 for church, 0.69 for sports event, 0.88 for writing and submitting an article to a newspaper/journal, 0.80 for demonstration, 0.63 for night club/entertainment, 0.70 for big gathering of relatives and 0.51 for private party (Lindström, Isacsson and Elmståhl, 2003). There is no obvious reason to believe that this study would have been subject to differential misclassification between the ethnic groups, with the exception of church attendance. The church item did not include/express the possibility of having participated in a religious service in a mosque. This is possibly one reason why men and women born in Arabic speaking countries and women born in all other countries have significantly lower levels of church attendance during the past year in this study.

Age, sex, education, economic stress and unemployment might be confounders of the associations between country of origin and social participation. Adjusting for age, education, economic stress and unemployment, however, only marginally affected the estimates. The concept of socioeconomic status (SES) entails three principal dimensions: occupational status, education and income. Education is directly used in the analyses in this study. Economic stress is included as an approximation of income measuring poverty and economic hardship but not affluence, while the data set does not contain any good measure of occupational status. A previous study on the Malmö Diet and Cancer (MDCS) material has shown a correlation coefficient $r=0.7$ between education and occupational status in Malmö during the same period (Lindström 2000).

Ethnicity is a concept that is difficult to define. It relates to many different concepts, e.g. race, country of origin, religion or language, that characterise particular groups. In this study ethnicity was defined as country of origin/country of birth. This definition has obvious limitations, but nevertheless provides some useful information concerning the social participation of different ethnic groups in Sweden. The ethnic groups born in

Denmark/Norway and Poland are without doubts very homogeneous regarding both language and culture. The groups born in other Western countries and Arabic speaking countries are homogeneous compared to the other groups of this study to a satisfactory extent regarding language and culture. In contrast, the ethnic groups born in Yugoslavia and other countries are very heterogeneous. However, for statistical power reasons the groups born in e.g. different countries within former Yugoslavia as well as Chile, Iran, subsaharan Africa, Turkey and Vietnam could not be analysed separately.

Studies of migrants are prone to mistaken conclusions, since both culturally determined factors inherited in the country of origin as well as current living conditions, e.g. economic conditions, in the new home country may affect the behaviour of the immigrants (Friis, Yngve and Persson, 1998). Education, which may have been achieved either in the country of birth or in the new country, also influences the extent to which a person takes part in different civic and social activities (Verba S, Lehman Schlozman K, Brady H, 1995). Adjusting for education, economic stress and unemployment, however, only marginally affected the original crude and age adjusted estimates to a limited extent. Especially adjustment for unemployment changed the significant ethnic differences among men born in Yugoslavia (sports event), men born in other Western countries (big gathering of relatives and private party), men born in Denmark/Norway (private party) and men born in Arabic speaking countries (no activity) into non significance at the 5% significance level compared to men born in Sweden.

The ethnic differences in civic and social participation may also be explained by differences in culture and acculturation. The concept of acculturation denotes the transformation that groups and individuals go through when they come into contact with another culture. Acculturation can occur both at the group level (economic, technological, political, cultural and social changes) and at the individual level (changes in values, attitudes, behaviours and identity) (Pudarcic 2002). The only measure of acculturation included in the public health survey in Malmö in 1994 was year of migration to Sweden. The distribution of the year of migration to Sweden variable in different ethnic groups has already been reported in a previous study (Lindström and Sundquist 2001). A vast majority of both men and women born in Denmark/Norway, other Western countries, Yugoslavia and Poland had immigrated to Sweden before 1985. In contrast, 86.0% of all men and 95.5% of all women born in Arabic speaking countries had migrated to Sweden in 1985 or later. The group born in all other countries had migrated to Sweden before and after 1985 to the same extent. Acculturation

could partly account for the ethnic patterns and differences in different civic and social activities observed in this study. However, the sex differences within the Arabic speaking group, in which men had the same participation patterns as men born in Sweden when it comes to union meetings as well as meetings of other organisations and in study circles, while women had significantly lower participation in these activities than women born in Sweden, probably reflects cultural differences originating in the countries of birth. The literature on different aspects of social participation in Arabic speaking countries is extremely scarce, but another study based on the public health survey in Malmö 1994 that concerned ethnic differences in the lack of access to a regular doctor showed that women born in Arabic speaking countries and all other countries reported lack of access to a regular doctor to a significantly higher extent than the female reference group born in Sweden. In contrast, no such ethnic differences were observed among men (Axén and Lindström, 2002). Language (in this case Swedish as opposed to Arabic) was not included in the 1994 public health questionnaire. The questionnaire was sent to the respondents without any translation help. Sweden provides courses in Swedish for immigrants, "Svenska för invandrare", and some of the introductory courses are even mandatory. As the persons who were chosen as respondents were randomly chosen from the population register of Malmö, they must have been living in Sweden for at least a year.

The results of this study suggest that neither the SES model nor the ethnic consciousness model can account for the patterns of ethnic differences in different aspects of civic and social participation in Malmö in southern Sweden. Adjustment for socioeconomic factors such as education, economic stress and unemployment in the multivariate analyses did not generally affect the patterns of ethnic differences in different aspects of civic and social participation, a finding which makes the SES model explanation less plausible. Cultural differences between the ethnic groups may explain the differences in participation and may be in accordance with the ethnic consciousness model. However, the accordance with the ethnic consciousness model is only partial, because the ethnic consciousness model does not specify that there should be gender differences between men and women. The gender specific differences in the Arabic speaking category suggest the use of a gender specific model to interpret and understand the ethnic differences in civic and social participation in Sweden and probably many other West European countries with high migration rates from e.g. Arabic speaking countries in recent decades. The all other countries category is just an aggregate of very different countries, which makes it harder to draw any inferences concerning specific countries. Some countries

in this aggregate category may differ from other countries. The findings of low participation in most social activities for women born in Arabic speaking countries and all other countries correspond very well with previous findings of low levels of leisure-time physical activity (Lindström and Sundquist 2001) as well as lack of access to a regular doctor within the health care system (Axén and Lindström 2002) for these groups compared to women born in Sweden.

There has been a discussion concerning what kinds of civic and social participation that promotes health (Baum et al. 2000). This study shows that particularly women born in Poland, Arabic speaking countries and all other countries have lower participation than women born in Sweden in most civic and social activities. It does not seem to be of importance whether these variables are “core” variables directly depicting social capital, more indirectly connected with social capital or unconnected with social capital.

The individuals who migrate from their country of birth to another country or even another part of the world, are generally more healthy than those who do not migrate from their native country, although this “healthy migrant effect” tends to wear off with time (Williams, 1993). One important reason seems to be that psychosocial and economic conditions in the new country sometimes affect the health status in a deteriorating and unhealthy way. The results of this study concerning men and women from both Arabic speaking and all other countries strengthen the notion that such structural improvements as the integration of some immigrant groups in Swedish society and their increased participation on the Swedish labour market are absolutely crucial even in a public health perspective. Unemployment should be reduced, because unemployment is significantly associated with lower levels of most forms of social participation and thus with bad health. Another policy implication concerns the focus on cultural barriers for women against social participation.

Conclusion. This study has shown that men and women born in Arabic speaking countries and other countries (Iran, Turkey, Vietnam, Chile and subsaharan Africa) participate to a significantly lower extent in a variety of civic and social activities when compared to the reference population born in Sweden. The differences in participation in these groups compared to the group born in Sweden is observed both for social participation items at the core of the definition of social capital and cultural and other activities unrelated to social capital. This pattern is particularly pronounced for women born in Arabic speaking countries.

These women even sharply differ from the participation rates of men born in Arabic speaking countries because men of Arabic origin participate in union meetings, meetings of other organisations and study circles to approximately the same extent as men born in Sweden, while women of Arabic origin participate to a significantly lower extent than women born in Sweden in such activities. These ethnic differences in most cases do not seem to be explained satisfactorily by education, economic stress or unemployment, although unemployment was significantly associated with low levels of most forms of social participation. However, the ethnic differences in social participation could possibly to a high extent be explained by differences in culture and the process of acculturation (partly dependent on the length of time spent in Swedish society), although the ethnic consciousness model itself does not specify gender differences in civic and social participation.

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References

- Axén E, Lindström M (2002). Ethnic differences in self-reported lack of access to a regular doctor: A population-based study. *Ethnicity and Health* 7(3): 195-207.
- Baum F, Bush RA, Modra CC, Murray CJ, Cox EM, Alexander KM, Potter RC (2000). Epidemiology of participation: An Australian community study. *Journal of Epidemiology and Community Health* 54: 414-23.
- Belliveau MA, O'Reilly III CA, Wade JB (1996). Social capital at the top: Effects of social similarity and status on CEO compensation. *Academy of Management Journal* 39: 1568-1593.
- Berkman LF, Glass T (2000). Social integration, social networks, social support, and health. In Berkman LF, and Kawachi I (eds), *Social Epidemiology*. Oxford: Oxford University Press, pp. 137-173.
- Berkman LF, Syme SL (1979). Social networks, host resistance and mortality: A nine-year follow-up study of Alameda county residents. *American Journal of Epidemiology*, 109, 186-204.
- Bevelander P, Carlson B, Rojas M (1997). *I krusbärsländets storstäder. Om invandrare i Stockholm, Göteborg och Malmö (In the big cities of the land of the gooseberries. On immigrants in Stockholm, Gothenburg and Malmö)*. Stockholm: SNS Förlag.
- Blakely TA, Kennedy BP, Kawachi I (2001). Socioeconomic inequality in voting participation and self-rated health. *American Journal of Public Health*, 91(1), 99-104.
- Bobo L, Gilliam FD Jr (1990). Race and sociopolitical participation, and black empowerment. *Political Science Review* 84: 377-393.
- Bobo L (1998). Group conflict, prejudice, and the paradox of contemporary racial attitudes. In: (Eds:) PA Katz, DA Taylor, *Eliminating Racism: Profiles of Controversy* (pp. 85-114). New York: Plenum.

Bourdieu P (1998). *Acts of Resistance. Against the new myths of our time*. Cambridge: Polity Press.

Cigler AJ, Joslyn M (2002). Groups, social capital, and democratic orientations. In (Eds.) Cigler AJ, Loomis BA, *Interest Group Politics*. Washington DC: CQ Press, 2002.

Coleman JS (1990). *Foundations of Social Theory*. Cambridge and London: The Belknap Press of Harvard University Press.

Corcoran M, Datcher L, Duncan G (1980). Most workers find jobs through word of mouth. *Monthly Labor Review*, August: 33-35.

Durkheim E (1897), (1951). *Suicide: a study in sociology*. Glencoe, IL: Free Press.

Friis R, Yngve A, Persson V (1998). Review of social epidemiologic research on migrants' health: findings, methodological cautions, and theoretical perspectives. *Scandinavian Journal of Social Medicine*, 26, 173-180.

Granovetter M (1974). *Getting a job*. Cambridge, Mass: Harvard University Press.

Hanson BS, Östergren P-O, Elmståhl S, Isacsson S-O, Ranstam J (1997). Reliability and validity assessments of measures of social network, social support and control- results from the Malmö Shoulder and Neck Study. *Scandinavian Journal of Social Medicine*, 25: 249-257.

Hawe P (1994). Capturing the meaning of "community" in community intervention evaluation: some contributions from community psychology. *Health Promotion* 9: 199-210.

House J, Robbins C, Metzner HL (1982). The association of social relationships and activities with mortality: prospective evidence from the Tecumseh community health study. *Am J Epidemiol* 116: 123-140.

House J, Landis K, Umberson D (1988). Social relationships and health. *Science* 241: 540-5.

Ife J (1995). *Community development. Creating community alternatives- vision, analysis and practise*. Melbourne: Longman.

Israel B, Checkoway B, Schulz A, Zimmerman M (1994). Health education and community empowerment: conceptualizing and measuring perceptions of individual, organizational and community control. *Healty Education Quarterly* 21: 153.

Kaplan GA, Salonen JT, Cohen RD, Brand RJ, Syme SL, Puska P (1988). Social connections and mortality from all causes and from cardiovascular disease: Prospective evidence from Eastern Finland. *American Journal of Epidemiology*, 128(3), 370-380.

Kaplan GA, Pamuk E, Lynch JW, Cohen Rd, Balfour JL (1996). Income inequality and mortality in the United States. *British Medical Journal*, 312, 999-1003.

Kawachi I, Colditz GA, Ascherio A, Rimm E, Giovannucci E, Stampfer MJ, and Willett WC (1996). A prospective study of social networks in relation to total mortality and cardiovascular disease in men in the USA. *Journal of Epidemiology and Community Health*, 50, 245-251.

Kawachi I, Kennedy BP, Lochner K, Prothrow-Stith D (1997). Social capital, income inequality, and mortality. *American Journal of Public Health*, 87, 1491-1498.

Kawachi I, Kennedy BP, Wilkinson RG (1999). Crime: Social disorganisation and relative deprivation. *Social Science and Medicine*, 48, 719-731.

Kawachi I, Kennedy BP, Glass R (1999). Social capital self-rated health: A contextual analysis. *American Journal of Public Health*, 89(8), 1187-1193.

Kennedy BP, Kawachi I, Prothrow-Stith D, Lochner K, Gupta V (1998). Social capital, income inequality, and firearm violent crime. *Social Science and Medicine*, 47, 7-17.

Labonte R (1997). *Power, participation and partnerships for health promotion*. Melbourne: VicHealth.

Light I (1972). *Ethnic enterprise in America*. Berkeley: University of California Press.

Lindström M (2000). *Social participation, social capital and socioeconomic differences in health-related behaviours. An epidemiological study*. Lund: Lund University. (Thesis)

Lindström M, Hanson BS, Östergren P-O (2001). Socioeconomic differences in leisure-time physical activity: The role of social participation and social capital in shaping health-related behaviour. *Social Science and Medicine*, 52, 441-451.

Lindström M, Isacsson S-O, The Malmö Shoulder Neck Study Group (2002). Smoking cessation among daily smokers, aged 45-69 years: A longitudinal study in Malmö, Sweden. *Addiction*, 97; 205-215.

Lindström M, Isacsson S-O (2002). Long term and transitional intermittent smokers: A longitudinal study. *Tobacco control*, 11(1): 61-67.

Lindström M, Isacsson S-O, Elmståhl S (2003). Impact of different aspects of social participation and social capital on smoking cessation among daily smokers: A longitudinal study. *Tobacco Control* 12(3): 274-281.

Lindström M, Merlo J, Östergren P-O (2002). Individual and neighbourhood determinants of social participation and social capital: A multilevel analysis of the city of Malmö, Sweden. *Social Science and Medicine*, 54, 1779-1791.

Lindström M, Sundquist J (2001). Immigration and leisure-time physical inactivity. *Ethnicity and Health*, 6(2): 77-85.

Lindström M, Sundquist J (2002). Ethnic differences in daily smoking in Malmö, Sweden. Varying influence of psychosocial and economic factors. *European Journal of Public Health* 12(4): 287-294.

Lindström M, Sundquist J, Östergren PO. Ethnic differences in self reported health in Malmö in southern Sweden. *J Epidemiol Community Health* 2001; 55(2): 97-103.

Lipsky M, Lounds M (1976). Citizen participation and health care: problems of government and induced participation. *J Health Polit Policy Law* 1: 85-111.

Loury GC (1992). The economics of discrimination: Getting to the core of the problem. *Harvard Journal of African American Public Policy* 1:1.

Lundh C, Ohlsson R (1999). *Från arbetskraftsimport till flyktinginvandring (From import of manpower to refugee immigration)*. Stockholm: SNS Förlag.

Macinko J, Starfield B (2001). The utility of social capital in research on health determinants. *The Milbank Quarterly* 79 (3): 387-427.

Malmö Statistical Yearbook (1994). Malmö: The City of Malmö.

Malmö Statistical Yearbook, Administrative Areas, Supplement (1994). Malmö: The City of Malmö.

Malmö Statistical Yearbook, Administrative Areas, Supplement (1998). Malmö: The City of Malmö.

McKnight JL (1985). Health and empowerment. *Canadian Journal of Public Health* 76: 37-8.

Norusis MJ (1999). *SPSS for Windows. Advanced statistics*. Release 10.0. Chicago; SPSS Inc.

Park DK, Vargas-Ramos C (2002). Paradigms of minority and immigrant political participation in the United States. In: *Political Decision-Making, Deliberation and Participation*, (Eds:) Delli-Carpini MX, Huddie L, Shapiro RY. London, New York: An Imprint of Elsevier Science.

Podolny JM, Baron JN (1997). Resources and relationships in the workplace: Social networks and mobility in the workplace. *American Sociological Review* 62: 673-693.

Portes A, Sensenbrenner J (1993). Embeddedness and immigration. *American Journal of Sociology* 98: 1320-1350.

Pudaric S (2002). *Elderly immigrants, socio-economic status and health. An epidemiological study of cardiovascular risk factors, impaired mobility and self-reported health status*. Lund: Lund University. (Thesis)

Putnam RD (1993). *Making Democracy Work. Civic Traditions in Modern Italy*. Princeton: Princeton University Press.

Putnam RD (2000). *Bowling Alone. The Collapse and Revival of American Community*. New York, London: Simon Schuster.

Putnam RD (2001). Social capital. Measurement and consequences. *Canadian Journal of Policy Research (Isima)*, 2(1), 41-51.

Rappaport J (1987). Terms of empowerment/exemplars or prevention: towards a theory for community psychology. *American Journal of Community Psychology* 15: 121-148.

Rifkin SB (1986). Lessons from community participation in health programmes. *Health Policy and Planning* 1(3): 240-9.

Rissel C (1994). Empowerment: the holy grail of health promotion. *Health Promotion* 9: 39-47.

Rosenfeld ER (1997). *Social support and health status: a literature review*. Adelaide, South Australia: South Australian Community Health Research Unit.

Schoenbach VJ, Kaplan BH, Fredman L, Kleinbaum DG (1986). Social ties and mortality in Evans county, Georgia. *American Journal of Epidemiology*, 123(4), 577-591.

Sundquist J, Johansson SE (editors) (2002). *Födelselandets betydelse. En rapport om hälsan hos olika invandrargrupper i Sverige (The importance of country of birth. A Report concerning the health of different immigrant groups in Sweden)*. Stockholm: Statens Folkhälsoinstitut (National Institute of Health).

Turner JH, Beeghly L, Powers CH (1989). *The Emergence of Sociological Theory*. Chicago, IL: The Dorsey Press.

Verba S, Nie NH (1972). *Participation in America*. Chicago: University of Chicago Press.

Verba S, Schlozman KL, Brady HE, Nie NH (1993). Race, ethnicity and political resources: Participation in the United States. *British Journal of Political Sciences* 24(4): 453-497.

Verba S, Lehman Schlozman K, Brady H (1995). *Voice and Equality. Civic Voluntarism in American Politics*. Cambridge, Mass: Harvard University Press.

Wilkinson RG (1996). *Unhealthy societies. The afflictions of inequality*. London: Routledge.

Williams R (1993). Health and length of residence among South Asians in Glasgow: a study controlling for age. *Journal of Public Health Medicine*, 15, 52-60.

Woolcock M (1998). Social capital and economic development: Toward a theoretical synthesis and policy framework. *Theory and Society*, 27, 151-208.

Woolcock M (2001). The place of social capital in understanding social and economic outcomes. *Canadian Journal of Policy Research (Isima)*, 2(1), 11-17.

World Health Organisation (1981). *Global Strategy for Health for All by the Year 2000*. Geneva: World Health Organisation.

World Health Organisation (1986). Ottawa Charter for Health Promotion. *Health Promotion* 1: i-v.

World health organisation (1997). *The Jakarta Declaration on leading health promotion into the 21st century*. Geneva: World Health Organisation.

Ziguras SA (1992). Passport to health and participation. *Community Quarterly* 24: 15-20.

Table 1. Prevalences (%) of the social participation variables by country of origin. Men. N=1872. The public health survey in Malmö 1994.

Country of origin N (Total)	Sweden 1367	Denmark/ Norway 67	Other Western 88	Yugoslavia 70	Poland 53	Arabic speaking 57	Other countries 170
Study circle/ work (Missing)	15.4 (0)	14.9 (0)	22.7 (0)	20.0 (0)	13.2 (0)	8.8 (0)	22.9* (0)
Study circle/ other (Missing)	16.2 (0)	13.4 (0)	23.9 (0)	10.0 (0)	18.9 (0)	19.3 (0)	19.4 (0)
Meeting/ union (Missing)	12.4 (0)	22.4* (0)	17.0 (0)	10.0 (0)	11.3 (0)	5.3 (0)	14.7 (0)
Meeting/ other (Missing)	28.8 (0)	40.3* (0)	35.3 (0)	22.9 (0)	17.0 (0)	21.1 (0)	16.5* (0)
Theatre/ cinema (Missing)	55.2 (0)	46.3 (0)	55.7 (0)	41.4* (0)	64.2 (0)	14.0* (0)	52.9 (0)
Arts exhibition (Missing)	39.3 (0)	40.3 (0)	38.6 (0)	21.4* (0)	52.8 (0)	14.0* (0)	37.1 (0)
Church (Missing)	33.9 (0)	31.3 (0)	47.1 (0)	45.7* (0)	49.0* (0)	10.5* (0)	27.6 (0)
Sports event (Missing)	42.1 (0)	35.8 (0)	37.5 (0)	34.3 (0)	30.2 (0)	17.5* (0)	36.5 (0)
Newspaper / journal (Missing)	7.3 (0)	6.0 (0)	14.8* (0)	4.3 (0)	3.8 (0)	3.5 (0)	7.6 (0)
Demon- stration (Missing)	4.7 (0)	4.5 (0)	11.4* (0)	12.9* (0)	13.2* (0)	10.5 (0)	11.8* (0)
Night club/ entertainment (Missing)	49.2 (0)	47.8 (0)	48.9 (0)	42.9 (0)	49.1 (0)	14.0* (0)	38.8* (0)
Big gathering of relatives (Missing)	44.0 (0)	58.2* (0)	34.1 (0)	40.0 (0)	50.9 (0)	24.6* (0)	36.5 (0)
Private party (Missing)	76.4 (0)	77.6 (0)	69.3 (0)	67.1 (0)	83.0 (0)	47.4* (0)	59.4* (0)
No activity (Missing)	5.9 (0)	4.5 (0)	5.7 (0)	8.6 (0)	1.9 (0)	8.8 (0)	14.1* (0)

*= significant difference at 5% significance level compared to the group born in Sweden.

