This article explores the resilience and coping mechanisms used by urban immigrant women to mediate gender, migration, socioeconomic conditions, locality and health. A purposive sample of eleven women who had recently immigrated to Canada was interviewed. Despite added stress, guilt and frustration of migration the women demonstrated agency and resiliency, enabling them to develop effective coping strategies. Life in the inner city was described as convenient upon first arrival, however, the inner city neighbourhood did not constitute a community for any of the women. Strong network-building skills enabled them to reach beyond the inner city and identify other coping strategies. While services for immigrants tend to be located centrally, in this case the inner city was generally considered a transient place for recent immigrant women and their families.

Immigrants comprise a large and growing proportion of the Canadian population. Although historically immigrants originated predominantly from European countries, this trend has changed. In 2001, 53% of immigrants to Canada were from Asia and the Pacific, 19% from Africa and the Middle East, and only 17% from Europe and the United Kingdom (Citizenship & Immigration Canada, 2002). With changing demographics, language patterns are also changing. In the past few years, almost half the immigrants to Canada do not speak either official language of the country (English or French) upon arrival (Kinnon, 1999).

Admission to Canada as an immigrant requires a high health standard; consequently, the health status of immigrants upon arrival is
generally very good. Upon arrival to Canada, immigrants tend to have lower levels of chronic diseases than Canadian-born individuals, often referred to as the healthy immigrant effect (Chen, Wilkins & Ng, 1996a/b; Dunn & Dyck, 2000; Hyman, 2001). The healthy immigrant effect, however, is short-lived and over time health status regresses towards national averages (Dunn & Dyck, 2000; Kinnon, 1999). A significant difference appears to exist in the health, income and employment opportunities for recent immigrants compared with established immigrants (those who have lived in Canada more than five years) and native-born citizens (Kinnon, 1999). Not only does health status deteriorate, but rates of healthy behaviours also tend to converge towards the national average over time (Kinnon, 1999). The reasons for deteriorating health of immigrants are not clearly understood.

**Social Determinants of Health for Recent Immigrants**

Health should be understood in holistic terms as physical, mental, spiritual, social and as a resource for a full and productive life. Social determinants of health are cultural, social and economic factors associated with health at the individual and population levels (Dunn, 2000). There is a broad range of determinants that affect the health of immigrants and these determinants interact differently as the context and timing change (Evans & Stoddart, 1990). Recent studies provide evidence for an association between income inequalities and health, which has focused attention on understanding various social determinants of health such as social hierarchies, social deprivation and material deprivation (Macinko & Starfield, 2001). These determinants of health may affect recent immigrant women in specific ways. The migration experience itself, modelled as a cycle, has come to be viewed as a determinant of health for immigrants with a link to the time variable so important to understanding determinants and health (Thurston & Vissandjë, in press). This is not to be confused with culture and 'race' concepts that have often been employed to replace explanations of how gender and class factors affect the adaptation of immigrant women to Canada (Liodakis & Satzewich, 1998; Razack, 1998).

The act of migration changes the economic, social and physical environment of the individual. These major changes are themselves stressful, even if conditions improve, for instance, by replacing food insecurity with access to food. On top of the stress of major changes, language difficulties for those not fluent in one of Canada’s official languages and negative public attitudes or discrimination often predominate (Anderson et al., 1993; Dyck 1992; Thurston, McGrath & Sehgal, 1993). Because skills and qualifications from the country of origin are not recognized, isolation and underemployment can contribute to poor mental and physical health of recent immigrants. All immigrants, however, do not experience and overcome migration stresses in the same way (Berry, 1997; Yoshihama, 2002). Resilience and coping are important to mediating between stresses and health (Allen, 1984) and are especially important to women who are undergoing complex and extensive changes in how and where they live.

Immigrants tend to experience periods of unemployment and underemployment once settled in Canada. Despite higher than average levels of education, both male and female immigrants are concentrated in service, processing, manufacturing and assembling occupations (Beaujot, 1996). Women face barriers to employment based on the gender norms in Canadian labour and on policies and discourses that allocate them to low paying jobs, such as service work (Liodakis & Satzewich, 1998). Socio-economic factors have been shown to weigh more heavily in determining health for immigrants in Canada than for non-immigrants (Steele et al., 2002). Even modest gains in income are associated with positive improvements to health (Bhatia & Katz, 2001), particularly at the low end of the economic spectrum. Even if only temporary, socio-economic disadvantage is an important social determinant of health for recent immigrants.

For recent immigrants, discrimination is an important component of the migration experience in Canada. Discrimination begins with entrance criteria, is manifested through difficulty finding employment and exists in uncomfortable social situations for recent immigrants from non-Western countries (Meadows, Thurston & Melton, 2001). Hierarchies are created through formal and non-formal definitions of who is and is not Canadian. These hierarchies are reinforced through social policies leading to unequal access to services (such as health services), limited employment opportunities and increased exposure to dangerous substances (Kreiger, 2000). This negatively affects both mental and physical health status of recent immigrants. While discrimination is important, immigrant women are often framed as victims, with a research focus on the disadvantages they face without mention of their coping mechanisms, resilience or survival skills. Coping is often connected to networks and communities.

The term community is used to describe a range of concepts, from geographic neighbourhood to social support network. Bassett and Short (1980) define community as “a territorially based system of human interaction” (p.15) and this is the initial understanding of the concept in this article. Neighbourhood, in contrast, is a discrete geographic location delineated within a municipality. The characteristics of a neighbourhood
and community can affect health in several ways. Both physical and social features of places or residence may affect health and health behaviour (Diez Roux et al., 2001). Macintyre, Macivor and Sooman (1993) suggest that among other aspects of the local environment, socio-cultural factors such as community norms and values, level of community integration and networks of community support may damage or promote health. By virtue of a move immigrants instantly become members of a neighbourhood, but it takes effort to become part of a social network.

Social support is a particularly important aspect of community that affects the health of an individual. For immigrant women, isolation is common, leading to several different health problems including stress and depression (Franks & Faux, 1990). A review of quasi-experimental and experimental research on social support and health revealed that individuals who are more isolated are more likely to suffer a higher burden of disease and have an increased relative risk of mortality (Berkman & Syme, 1979; House, Landis & Umberson, 1988). In some cases, socio-political constraints and economic opportunities define the experiences of immigrant women more than their cultural background or country of origin (Dyck, 1992).

A review of the literature has revealed a lack of information on the effects of the determinants of health of immigrant sub-populations. Sent et al. (1998) suggest that there is little documented evidence of the barriers specifically encountered by sub-populations of immigrant women. Kinnon (1999) concluded that there is a lack of information describing the health impact of employment, income, family structures and living conditions of immigrant sub-populations. This article presents the results of a study exploring the coping and resiliency exhibited by immigrant women living in Calgary, Alberta.

**METHODS**

*Data Collection*

A sample of eleven was drawn from a population of women who had recently immigrated to Canada and who were living in the inner city of Calgary. Recruitment was done through immigrant service agencies, English-as-a-second-language courses and health clinics in the inner city. Although the sample was relatively homogenous (i.e., all women, all recently immigrated to Canada, all living in the inner city), purposive sampling was used to identify women from different countries of origin with a variety of social status characteristics (children/no children or employed/not employed) important to the study questions. Recent immigrants were selected to explore that phase of the immigration cycle (Thurston & Vissandje, in press) and inner city was selected to explore the role of community. The sample size was limited but previous experience has shown that this will provide sufficient data for exploratory purposes (Kuzel, 1999).

Data was collected during one-on-one ethnographic style interviews using an interview guide (Creswell, 1998). The purpose of the in-depth interviews was to explore the complex nature and meaning (Rice & Ezzy, 1999) of migration. A guide provided a framework of open-ended questions and probes were used for ease of comprehension and to seek clarity. The guide was originally piloted with peers for ease of comprehension. Demographic information was collected at the beginning of each interview using questions developed for use with recent immigrants (Vissandje, Thurston & Amaratunga, 2000). Interviews lasted between 90 minutes to two-and-a-half hours. Each interview was audio-recorded and transcribed verbatim.

Other sources of data included a journal kept by one researcher (Maltreud, 2001), field notes and memos recording the processes and ideas involved in the data analysis (Morse & Field, 1995). These were used to assist in the analysis by providing a record of all interim conclusions and questions that arose during data collection and initial analysis. Prior to beginning data collection, the research proposal received approval from the University of Calgary Conjoint Medical Research Ethics Board.

*Data Analysis*

The factors of interest to this study (gender, socio-economic conditions, community, migration and health) formed the basic outline of a coding template. This template was subsequently modified by the analysis as categories and sub-categories were identified in the data (Miles & Huberman, 1994). A preliminary read-through of the transcripts allowed the researchers to obtain a sense of the overall data (Creswell, 1998). Each transcript was summarized by one researcher, using an adaptation of Miles and Huberman’s (1994) template of case summaries. This facilitated reduction of data and identification of themes. The data were entered into QSR N6 to assist with data management (Creswell, 1998; Weitzman & Miles, 1995). Basic statistics were computed to describe the sample.

Inductive analysis was used to identify links and connections between and among areas of interest, using an iterative collection and analysis process. The most important aspects were crystallized out of the data (Maltreud, 2001). Analysis involved decontextualization and recontextualization, allowing excerpts of the text to be examined for meaning both on their own and in the context of the whole text (Maltreud, 2001).
Multiple researchers coded the initial transcripts and were able to discuss data analysis as it progressed. The different perspectives on the data helped ensure that connections were not overlooked, thereby increasing the credibility of the data collection, analysis and presentation (Guba & Lincoln, 1989).

RESULTS

A description of the demographic characteristics of the study participants is presented in Table I. Results concerning coping strategies and resilience are discussed under socio-economic conditions, identity and conceptualizing community. These four themes captured the key aspects of migration that women were managing and each is clearly gendered.

Table I: Characteristics of the Participants

- 9 countries of origin with representation from South Asia, Southeast Asia, Africa, South-America, North America, Eastern Europe, and the Middle East
- 3 women spoke English at home, only 1 spoke English as a first language
- Ages ranged from 29-48, with a mean age of 37 years old
- Amount of time lived in Canada ranged (at time of interview) from 4 weeks to 4 years; 6 women migrated within the last year
- 9 women had landed immigrant status, 1 came as a refugee, 1 was on a work permit
- Primary reasons to coming to Canada were economic (5 women), to give a better future to their children (2 women), and other reasons included to be with their spouse, for adventure, and political problems in their country of origin
- None of the women had less than a few years of post-secondary education, 6 had a bachelor degree, 3 had a masters degree
- The women migrated primarily from urban areas: 6 from a big city, 4 from a city, 1 from a town
- 2 women reported not having a religion, 1 was Muslim, 2 were Hindu, 1 was Roman Catholic, 5 were other Christian denominations
- 1 woman was single, 10 were married
- 3 women had no children, 6 women had 1 child, 2 women had 2 children (children ranged in age from 3.5 to 20 years old)
- Only 1 woman had not worked for a salary prior to migrating to Canada, however 5 women had not worked for a salary since being in Canada
- 4 women reported not knowing their total annual household income, 1 woman reported no income (and was living off savings), 2 women had incomes between $10000 and $59999, 1 woman had an income between $20000 and $29999, 3 women had an income of more than $60000

Socio-economic Conditions

For the women in the study, employment was closely tied to socio-economic status. The expense of setting up a home, compounded with the loss of net worth due to poor currency exchange rates, meant that the migration experience was a financial strain. As one woman described it, the experience can be “very very scary, too much pressure you know when we just came we very scared…and uh spending a lot of money” (Informant 03) to find and furnish a house, among other things. With jobs not readily available and savings dwindling, socio-economics featured prominently in the day-to-day experiences and coping of many of the women.

Underemployment was a common situation. While prior to migration the women held jobs such as accountants, engineers, computer programmers and chemists, after migrating, they were limited, at least initially, to jobs in the service sector (e.g., convenience store clerk, hotel room cleaner, fast-food restaurant staff). These jobs were called ‘survival jobs’ by several women. While survival jobs were not an end goal, they did provide temporary employment, minimal income and a chance to practice English language skills. One woman conceded her change in socio-economic status resulting from migration and described how survival jobs are necessary:

...a lot of um, eh survivor job opportunities there. Yeah, it’s very important because at the beginning when usually we had to, we had to make some money…. Because in China you will have 500 hundred, 500 hundred Chinese everyday but ah, in Calgary only, less than hundred…Canadian dollars, so yeah. In China maybe you are rich but here, you are poor. (Informant 05)

Survival jobs also allowed spouses to study English full-time while the women earned a small income to support the family.

Finding survival jobs was not usually difficult for the women interviewed; however, the first few experiences of looking for professional work were not usually what recent immigrants expected. The women described frustration at and difficulty understanding the systems or processes involved with finding work in Canada. Generally the women had tried a number of different strategies to obtain professional employment in their field and were aware of many job opportunities through newspaper advertisements, however their efforts had been unsuccessful.

After using several different strategies to find employment in a
As people migrate to Canada, they are faced with living in a different society with different norms and mores, some vastly different and others slightly different from their own depending on where they came from and the stops on the way to Canada. Women who migrated seemed to be increasingly aware of the cultural construction of their identities. Roles and redefining roles within the family and within society were salient aspects of identity. Migration was not only a process of change but also a process of increasing self-awareness on many levels.

This is something that happens when you live in, in a, in a foreign country, is it helps you identify who you are... Where when you're in your own country, you don't have those boundaries that establish who you are but you... Go to another country and all of a sudden those things identify themselves. (Informant 11)

The process of migrating allowed women to examine differences between cultures as manifest in their own behaviour and attitudes, which was one form of self-exploration.

The interplay of gender and identity recurred throughout the data. Women’s roles often changed significantly through migrating to Canada, but some major roles (e.g., homemaker) did not necessarily change. Negotiating and adapting to new roles and expectations was part of the adaptation process for both spouses. Not only did these roles need to be reformed, but different aspects of the roles became more or less important to their day-to-day survival and also to their social identity. All women, for instance, migrated with a set of expectations of what a wife should be, and those who were married aspired to fulfill that role although only some had the aspiration of being a ‘perfect wife.’ The notion of being the perfect housekeeper and cook was reinforced in Canada and resulted in some of the women putting higher expectations on themselves than they had when entering Canada and carrying a double burden of home and employment labour. Adding English language classes for some increased this to a triple burden of studying, employment and housework. One woman laughed when asked whether she had enough help around the house and replied that it was a woman’s job to take care of all the household work; however, four others lamented the loss of help that they had had from maids, family or spouses in their country of origin. The changes in their partners’ expectations were also noteworthy, for instance:

I would get a little bit worried, but insecurity at times, yeah, when his contract is going to be over. He keeps on saying that that’s a good thing because he can go on EI and we can support ourselves. But then we still
I don't know, before I think uh, I career goal woman in my country. But uh, now I think uh, not a bad sit at home or ah, have a simple work and ah help my husband and grow my children. I think it's not bad, it's good. It's for a woman. It's woman's work. (Informant 08)

Taking on more responsibility for the home was also seen as positive because it made it possible to be a couple or a family.

So, we don't, we didn't have time to shopping together, to do something. But here every weekend we got to sit down and even in Safeway we talk, we, with shopping. I like it [laughs]. (Informant 05)

But here, without them [husband’s extended family], quite like, sort of, we can look up to our future because we know that we are a family now. Back home we would be, we would be like a family… But now we have, we are a family and now, we can plan for, for the future, for the future here. You know, having kids and settling down here. (Informant 01)

Conceptualizing Community

Throughout interviews, as in the literature, women did not use the term community uniformly. Each woman who used the term had a slightly different understanding and meaning, and the word was occasionally used several times in one interview with different meanings attached. Several women did not use the term community, choosing instead to use the name of their neighbourhood (e.g., downtown) or group of friends.

Inner city was never part of the women's community but rather a convenient place to live during the settlement period: "I r eally would advise somebody come to Canada new to live in, to stay in downtown at beginning. But then I think, to move away" (Informant 01). While women acknowledged that being close to free transportation within the downtown core, immigrant services, survival job opportunities, and English language classes was useful, the inner city was exclusively viewed as a temporary home for the women and their families.

There was a strong element of self-sacrifice in some of the women's actions following migration, trying to keep their husband and family happy. One informant stated, “And when I have time I like to cook something, do everything for them... Because I want, I want them um, be happy” (Informant 05). Taking over the housework, however, could also lead to feelings of inequity for those women who had experienced more sharing of the work in their country of origin. For example, one woman said, “Maybe uh here we are more stress and sometimes we feel... the other one [spouse] work more” (Informant 03); housework and child care were not considered on the same plain as other 'work,' a common experience in Canadian society (McDaniel, 1998).

One coping strategy and part of developing a positive self-image in Canada was a re-framing of life goals by the women. Two of the women had re-framed the extra housework required of them positively as a reorientation of their goals to raise a family rather than succeed at a career. One woman described how career had been a priority for her, but now she realized that raising their children was satisfying and this had become her goal:
internet and telephone, which meant that even without a car women were able to maintain a network of friends that were not necessarily linked geographically.

A further use of the term community was to describe a neighbourhood within which social ties were strong. This use of the term was only used as an ideal or a future goal, never to describe the women’s present situation. This use was the only place-bound definition: “Like what we think is if you move to a house, you belong to a community and you have a social life with it” (Informant 01). When neighbourhood and community were used synonymously, they referred to an ideal rather than the present situation for these women.

By far the most effective and widely used coping strategy was the development of social support networks. All the women, with the exception of the woman who migrated very recently from the United States, were able to describe Calgary-based social support networks that they had developed since migrating. Individual personality traits and coping strategies post migration enabled the women to build social support networks quickly with diverse groups of people.

Network building skills of the women enabled them to increase their power to access services and information. Immigrants could act in a role of relative power by becoming a social bridge between different social groups, providing a link, for example, between an ethno-cultural group and Canadian group of co-workers. Social support network building was a powerful tool used by the women to facilitate acculturation and settlement post migration.

The types of social support networks described by the women included a broad range of sources with both weak and strong ties. The women described forming close friendships with a small number of people, usually in a similar situation (i.e., recently migrated and working a survival job); however, the social support networks developed by the women tended to be heterogeneous and included close and loose ties with other network members. Women described church groups, immigrant service organizations, ethno-cultural groups, and friends who lived nearby. Not all neighbours were identified as sources of social support, but almost all women had people who they referred to as friends who lived in the same building or neighbourhood. When asked if neighbours looked out for each other, one woman replied:

Ah, I haven’t noticed it yet but my neighbour, she always, she always see when I coming home and very strange. Even if I walk at the back, yesterday I saw, I was walking at the back. And then her son called up, uh ‘My mother’s calling’… I said, ‘How, how did she know I’m home?’ [laughs]… No I don’t know, with at, it felt good! You know there’s someone who know that you’re here. (Informant 06)

Although the women might have been members of a homogenous network (such as an ethno-cultural society), this was never the full extent of their social support.

**DISCUSSION**

The results of this study support the heterogeneity of immigrant women’s experiences based on their migration experiences, including countries of origin, reasons for migrating and other personal characteristics. The results also reveal the many structural barriers that women face when trying to maintain physical, mental, social, and spiritual health. Several studies point to the potential for female immigrants in particular to be very isolated (e.g., Meadows, Thurston & Melton, 2001). Contradictory to those findings, the results of this study indicate that the women had excellent skills for developing social support networks. Social support networks are made up of ties between and among individuals which cut across traditional kinship, residential and class groups (Berkman et al., 2000). The association between social support networks and health has been well researched and documented in the literature (Berkman & Syme, 1979; Berkman et al., 2000; Cattell, 2001; House, Landis & Umberson, 1988). Health Canada (2002) lists social support networks as one of the social determinants of health, by which they mean emotional support of friends and family as important for buffering stress and other health problems. Social support networks are not necessarily tied to a geographic location such as a neighbourhood (Berkman et al., 2000). Not only the type of network but also the ability of individuals to become members of several different networks can confer advantage for health and well-being (Burt, 2000). The women were able to maximize the benefits of a variety of social support networks with loose and close ties, as described by Cattell (2001).

The bulk of literature on immigrants and health focuses on the health disparities between immigrants and Canadian-born individuals (e.g., Beach & Worswick, 1993; Bollini & Siem, 1995). While important contributions regarding the inequalities in health among certain populations have been made, it is also important to focus on the coping, resilience and resistance strategies developed by these populations so that they are not viewed as helpless victims. Seeing recent immigrants as victims results in their being viewed as passive rather than active, which can contribute to stereotypes reinforcing certain societal structures that discriminate against immigrants. As Bacchi (1999) points out, how groups...
are described “continues to create those who are poor and oppressed as the problem” (p. 109). Solutions then become individualized rather than addressing structural issues, such as employment practices for foreign trained health providers. Coping strategies have been discussed here with an eye towards increasing the positive dialogue for solutions to the challenges for recent immigrants that include immigrants themselves in that dialogue, not only in identifying problems but in devising feasible, realistic solutions across the determinants of a population’s health, one of which is health services. Recent immigrant women can, we have seen, contribute to an analysis of policy problems and solutions.

A caution is warranted, however, in that switching from an individualized victim discourse to an individualized coping discourse will continue to mask structural inequalities caused by gender and race discrimination. A review of the relevant literature on health of immigrants, for instance, suggested that under-utilization and barriers to accessing health services was a serious problem for recent immigrants, particularly women (Ballem, 1998; Despard 1998; Kinnon 1999). The women in this study did not have trouble accessing services, in part because social support networks increased access as did local immigrant service organizations, and in part because of psychological responses to their situation. Access was also increased by the availability of special services in the inner city that had developed cultural competence, used a language line frequently and could be reached easily by public transportation. Women who had the money to settle immediately in suburbs and who did not participate in immigrant settlement programs may actually have faced more problems accessing primary care than the poorer women in this study.

Despite not necessarily arriving in Canada with useful schemas (Thurston & Vissandjée, in press), with support women quickly developed ways to process, group and analyze new information within the new context. The temporal nature of their solutions must be highlighted, however, as the long-term consequences of some choices (for instance, sacrificing their careers for family) may be catastrophic at later stages (for instance, increased dependency on spouses, poverty in old age and loss of identity as a productive member of society) and loss of access to sources of social support may result (Doyal, 1995; Greenglass, 1993; McDaniel, 1998; McDowell, 1999).

The public health literature that focuses on neighbourhood-based social relations as they relate to health did not fit the situation of the women in the study. Inhabitants of modern urban spaces often create non-spatial communities (Sampson, 1999). This does not mean that local relations are unimportant, but they are not controlling factors for many areas of social life (Sampson, 1999). Germain (2000) also suggests that social networks in contemporary urban areas are less dependent on physical proximity than those of the past. Specific geographic location within urban environments was salient to the health of the study participants in terms of their access to services, but they felt this living arrangement was temporary. With this sub-population, using geographic neighbourhoods as the unit from which to measure social relations is not appropriate.

Analysis reveals that the variation between different sub-populations of recent immigrants may be more enlightening for local policy initiatives than broad national surveys using aggregate data and problematic definitions of the term immigrant (e.g., not born in Canada). For the women living in inner city Calgary, accessing health care services was not a problem, however, underemployment and the frustration of hiring policies were very salient issues creating stress with both emotional and physical consequences but, more fundamentally, challenging identity at a time all coping mechanisms might be called into action. Following these women over time might show that their hope for success in employment and better socio-economic conditions, for gender equality and for a happy family life diminishes. Research in gendered violence against women, for instance, has long indicated that some women will have this as a new threat to their health in Canada, while for some women it will be a continuation of a pattern they had hoped would change in the new country (MacLeod & Shin, 1990).

We agree with Mauthner and Doucet (1998) when they stated, [T]here can be no ‘pure’, ‘real’ or ‘authentic’ experiences or voices of respondents because of the complex set of relationships between the respondents’ experiences, voices and narratives, and the researcher’s interpretation and representation of these experiences / voices / narratives… We cannot be sure that we have faithfully reported our respondents’ concerns. (p. 140-141)

As population health researchers we were struck by strength of the women we interviewed in the face of many social and structural barriers. We believe that acknowledging this strength is an important component of understanding how immigrant women stay healthy and why their health might deteriorate over time. We encourage others to continue our exploration.
REFERENCES


We are in the process of preparing the eighth issue of Women's Health & Urban Life Journal. The journal is located at the Department of Sociology, University of Toronto. The journal addresses a plethora of topics relating to women's and girls' health from an international and interdisciplinary perspective and link health to globalization and urbanization issues. General topics include but are not limited to: Women's health in general; Health related to reproduction; Health related to sexuality; Health related to paid or unpaid labour; Health related to parenthood; Health and the environment; Health and social policy and Health related to urbanization and globalization issues. The orientation of the journal is critical, feminist and social scientific. Both qualitative and quantitative manuscripts, and theoretical or empirical works are welcome. Papers should not exceed 30 pages, and four copies of the paper should be submitted. All submissions will be peer reviewed by anonymous reviewers. For more details about the goals, substantive basis and submission guidelines of the new journal, please contact:

Professor Aysan Sev’er, General Editor
Department of Sociology
University of Toronto at Scarborough
1265 Military Trail, Scarborough
Ontario, Canada M1C 1A4
Fax: 416-287-7296; e-mail: sever@utsc.utoronto.ca
or visit: http://utsc.utoronto.ca/~socsci/sever