Stigma and discrimination affect the lives of people who are perceived as different from the norm in some important way—the physically or mentally disabled, those who are overweight or obese, those who suffer from infectious diseases ranging from leprosy to HIV/AIDS, as well as members of certain cultural and minority groups. While the exact mechanisms are unknown, the stigmatization process most certainly includes a complex array of personal, interpersonal, and structural components. Link and Phelan (2001) refer to this as a *labyrinth of details* that creates substantial social inequalities in life circumstances even when it is difficult for an individual to specify any single causal event. Multiple, mutually reinforcing mechanisms are used by dominant groups to maintain their pre-eminence. When one mechanism is weakened, another is strengthened. Over time the process becomes increasingly complex, subtle, and covert.

When mechanisms are not fully understood—either because they are complex, mutually reinforcing, or difficult to discern—effective intervention becomes more difficult; though not impossible. The famous public health example of John Snow—who took the handle off the Broad Street water pump in London, to stave off the cholera epidemic of 1854—shows how the causal chain of events can be disrupted even without knowing the specific causal agent. Snow’s intervention predated germ theory by about 10 years (Friis & Sellers, 1996). Yet, as already pointed out, what makes stigma different is that there is no single causal pathway, but many different mutually reinforcing parts all of which interact like cogs to create cycles of disadvantage. There is no single agent to disrupt; no simple fix; no handle to remove from the pump.

Although the pervasiveness and complexity of stigma may be daunting, Sartorius has argued that the cyclical complexity gives us multiple entry points and wide room for action (Sartorius & Schulze, 2005). Thus, in his view, there is no one who could not contribute to fighting stigma and its consequences, and no perspective that could not (or, perhaps should not) be accommodated. Indeed, scientific interest in stigma has come from a variety of disciplines—everything from law to humanities and from policy to practice. This has resulted in a rich but scattered literature with little opportunity for inter-disciplinary syntheses. Methodological innovations and findings have not easily found their way across the various substantive areas of investigation and there has been little theoretical or methodological discussion about benchmarks for success for anti-stigma work. Much of the theoretical research has been grounded in scientific world views that have excluded the lived experiences of people who bear the brunt of stigma and discrimination. New person-centred approaches to measurement are emerging, but they remain in their infancy pending future psychometric validation. At the same time, policy and public health interest in reducing stigma is on the rise and new programs are emerging at international, national, and regional levels. Yet, scientific attempts to bridge the knowledge-to-action gap have been meagre. As a result, many programs have not been evaluated or remain uninformed about best principles or practices.

The time is ripe for an inter-disciplinary platform to foster scholarly discussion and debate; and to consolidate and expand best practice knowledge in stigma reduction. It is with these goals in mind that scholars from a variety of disciplines have come together to create *Stigma Research and Action*. Our Editorial Board and organizational partners are committed to providing an international forum for research and practice pertaining to social prejudice and discrimination, whatever their manifestations: health conditions, disabilities, or socio-cultural standing.

This, our inaugural issue of *Stigma Research and Action*, illustrates our commitment to maintaining the broadest possible perspective. We have included original research pertaining to HIV and homosexuality stigma (Cianelli et al.; Liu et al.), obesity bias (Li & Rukavina), mental illness stigma (Chanean et al.;
West et al.; Shrivastava et al.), and substance abuse stigma (Scott & Wahl). Our commitment to providing an international forum is highlighted by papers from Santiago, Chile (Cianelli et al.), Tehran, Iran (Chanean et al.), Shenzhen, China (Liu et al.) and Mumbai, India (Shrivastava et al.). Finally, our goal of expanding best practice knowledge is illustrated by contributions that examine the impact of anti-stigma programming (Quinn et al.; Wahl et al.).

In order to ensure that people with lived experiences of stigma also have a voice, the journal will publish papers reflecting a range of different qualitative perspectives including opinion pieces, qualitative research, and commentaries. In an effort to help build research capacity in this field, the journal will also feature work conducted by students. In future issues we will include scholarly commentaries designed to provoke debate about important and emerging issues (see the call for papers in this issue on our website on Retiring the Term Stigma), guest editorials with accompanying theme papers, book reviews, and first person accounts. Each issue will also highlight a different piece of cover art submitted to us by our readers, authors, organizational partners, or members of the Board. We hope that this will provide a creative outlet for members of our community, and would encourage submissions from people who face stigma and discrimination on a daily basis. We hope that these images will be eye catching, thought-provoking, and provide a dimension of understanding that will go far beyond our words.

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References