Safe Houses in Contact Zones: Race Politics, Place-making, and Ethno-specific AIDS Service Organizations in Toronto

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Abstract

This paper explores the recent historical geography of the HIV/AIDS sector in the City of Toronto. It pays attention to the role of racialization in shaping the institutionalization of local responses to the AIDS epidemic in the 1980s and focuses in particular on community-based responses by and for people of colour. The overall argument of this paper is that ethno-specific AIDS service organizations (e-ASOs) emerged as responses to and critiques of the then-nascent mainstream AIDS sector, whose approach to service provision, organizing, and activism were based on a one-size-fits-all model that refused the salience of racialization for sexual health. The consequence of this colour-blindness is one of calculated neglect of racialized people. However, the emergence of e-ASOs, I argue, is a direct, community-based response to this colour-blind history, one that relied on various place-making strategies to provide alternatives to — and, in effect, critiques of — mainstream spaces and practices of sexual health.

John Paul (JP) Catungal was born in the Philippines and raised in Vancouver BC. After graduating with a B.A. Honours in Geography and Sociology from Simon Fraser University in 2006, he moved to Toronto to pursue graduate studies, acquiring an M.A. from the Department of Geography at the University of Toronto in 2007 and continuing in the Ph.D. program in the same department.

JP maintains a broad interest in the co-production of space and social differentiation. His dissertation work explores the emergence and continued importance of ethno-specific AIDS organisations as a way to theorise the political-geographic articulations of the race-sexuality-health nexus. He is also affiliated with the Cultural Economy Lab, where he is engaged in an on-going collaboration with Dr. Deborah Leslie to examine the socio-economic implications of ‘creative city’ theories and policies. Finally, JP is also interested in the lived experiences of Filipino immigrants in Canadian cities, particularly relating to violence and care. He is a founding member of the Kritikal Kolektibo, a network of scholars interested in Filipino-Canadian studies, and is on the editorial team for an anthology on Filipino lives in Canada. His publications on these topics have appeared and are forthcoming in geography and urban studies journals and as chapters in edited collection. In what little spare time he has, JP also works as a relief supervisor for a local queer youth organisation and is an active member of the University of Toronto Qu(e)erying Religion group.
INTRODUCTION: RACIAL DIVERSITY, SEXUALITY, AND THE SPACES OF HIV/AIDS IN TORONTO

I think that ... one of the problems with dealing with ... the diversity of the City of is that we think we’ve come so far, that we forget that we really haven’t come that far. Just because we say ... that diversity is our strength... does not mean that we’re not racist or that we don’t have a lot of issues. I was looking at some pictures that one of my friends had taken at ... the EGALE fundraiser ... and those people don’t look like me. There are coloured people [sic] but the vast majority of them, especially the ones that were in control, are middle aged, white people. [volunteer, e-ASO]

Why are e-ASOs necessary in multicultural Toronto? The quote above was a response to this question, posed to an interviewee who has been involved in a volunteer capacity with a local e-ASO. I find it instructive to begin with this quotation because it hints quite powerfully at the intersections of race, sexuality, and health as a decidedly political nexus. I does so in various ways. First, it packs into a relatively small space several critiques of the discourse of diversity in the multicultural city. It points out the persistence of racism in the face of increased urban demographic diversity (“we really haven’t come that far”), and it does so through a specific rhetorical move — an allusion to the City of Toronto’s official motto “Diversity Our Strength.” This is a powerful critique of diversity discourse as window dressing, a selling point for the increasingly entrepreneurial city. It also mirrors, interestingly, how this discourse acts as a euphemistic code word for racialization in the context of’s polite state-supported multiculturalism (Mitchell 1993).

Second, and related to the first point above, the quote points to racism and racialization in the multicultural-cum-global city as intensely lived and material processes that organize people’s lives and life-worlds, including and especially the institutions that they access to navigate space, including sexual health outcomes. Particularly telling here is the interviewee’s unprompted use of EGALE — the organization Equality for Gays and Lesbians Everywhere — as one example of an important and popular institution, a crucial actor in queer politics, that the volunteer claims is very much still mired in the problem of racial inequality, particularly of its leadership. The institutionalization of racialization in organizations such as EGALE represents, to this volunteer, the problem of social inequality and privilege in the institutional spaces of the global multicultural city. EGALE is an important civil society organization, arguably the premier lesbian, gay, bisexual, trans and queer (LGBTQ) rights group in the country, and at least nominally it is supposed to represent “gays and lesbians everywhere.” What the quote reveals is that ethno-racial difference continues to segment LGBTQ institutions. Given the intimate linkage between LGBTQ and HIV/AIDS politics in , that, another interviewee puts it, “the intersectionality of sexual orientation ... and HIV is very significant in our history”, ethno-racial inequalities are also manifest in HIV/AIDS institutions.

Finally, I point to a more subtle portion of the quote, which is that the interviewee bemoans that “those people don’t look like me.” I interpret this as a reading of the racialized self in relation to a scene captured in a photograph and relayed through memory. It reveals two persistent ideas about race: first, that race continues to be understood as a largely visual or, more accurately, visualized, phenomenon; and second, that the production of social and institutional space still happens along colour lines, to use W.E.B. DuBois’ memorable phrase. The quote also draws attention to the practice of actively reading space for similar people: a means of gauging whether one is in a space of belonging. Belonging, of course, has material benefits, among them access to community, institutions, and other social spaces. In other words, the quote draws out the material importance of feeling affinity through commonality, in this case, an ethno-racial affinity. During this particular interview, the clause “those people don’t look like me” was uttered with frustration, and I believe that this is because looking like people in an organization is another way of claiming representation and access in a space that does not reflect the multicultural demographic more broadly.

In this paper, I examine the ways that, in its early history, Toronto’s mainstream HIV/AIDS sector explicitly used a colour-blind approach, one that eschewed the importance of race and racialization for people of colour’s access to sexual health information and services, and instead privileged particular sexual bodies — gay white men — as subjects of sexual health. I argue that this approach led to lived experiences of alienation and exclusion of people of colour, queer and straight, from then-nascent mainstream HIV/AIDS organizations and ultimately contributed to the rise of alternative approaches to sexual health social service provision, particularly in the form of e-ASOs. I further argue that these alternative approaches were, by
necessity, place-making practices that produced, and continue to produce, e-ASO spaces *in contradistinction* to the colour-blind mainstream, i.e., as sites of ethno-racial belonging and culturally appropriate sexual health services.

The paper proceeds as follows. After a brief section describing the methodological design of the dissertation project from which this paper is drawn, I outline a theoretical framework to analyze the rise of e-ASOs in the City of. I draw on the work of Mary Louise Pratt, particularly her concept of the “contact zone,” as a way to emphasize the importance of racialization in the shaping of sexual health institutions in the city. In this section, I also outline a longer genealogy of the relationship between racialization and health in the multicultural city. In the next section, I detail both the construction of a colour-blind approach to sexual health by a young local HIV/AIDS sector in the 1980s and the “birth” of e-ASOs as a critique of this colour-blindness. In the penultimate section, I make a case for the role of place-making practices in the production of e-ASOs as “safe houses” in contact zones. I give three examples of strategies — alternative languages, self-representations, and social events — that differentiate e-ASOs from the mainstream. I close by returning the Pratt's idea of the “safe house” and conclude, drawing on examples from e-ASOs, with a call for sustained analysis of its constant negotiation.

This paper makes use of various forms of data collected primarily through three methods: interviews, archival analysis, and media analysis. Interviews involve current and former participants, mostly staff members, volunteers, and board members, of ethno-specific and mainstream ASOs in Toronto. These interviews were semi-structured and largely conversational in nature, and they dealt largely with the participants’ histories of involvement with e-ASOs and their perspectives on the importance of e-ASOs in their personal and community life and in the broader sexual health sector. As this paper was written in the middle of the data collection stage of my dissertation, I draw on the transcripts of the first 22 interviews that I have conducted. In total, I have now conducted 38 interviews.

The archival research used in this paper draws on the collections of the Canadian Lesbian and Gay Archives (CLGA). The archives have extensive and diverse holdings related to e-ASOs, including collections of health promotional material (e.g., brochures, posters), newsletters, annual reports, and meeting minutes. These documents were useful in elucidating the histories of e-ASOs, particularly in terms of the shifting political and sectoral landscapes within which they are located. I use them in this paper largely to illustrate both the sectoral histories and the strategies of e-ASOs in their work to create alternative spaces.

Finally, with the research assistance of Thomas Perry, I also looked into media coverage of e-ASOs, which was collected through online archives of news article, both from the websites of periodicals themselves (e.g., national and local papers like the *Globe and Mail* and the *Toronto Star*, and smaller, community publications like *Xtra* and *F A B Magazine*) and through library periodical databases. DVDs and online copies of documentaries related to e-ASOs where collected, viewed and analyzed, where available. The media components of the research are employed to make sense of *publicly circulated* narratives around e-ASOs.

**THEORIZING RACE AND SEXUAL HEALTH 1: THE MULTICULTURAL CITY AS CONTACT ZONE**

In simple terms, my research site is the City of Toronto, as it is the location of the three e-ASOs that form the basis of my dissertation and where many of the major players of the HIV/AIDS sector in Ontario are based. Given Toronto's historical and recent multicultural demographic composition and its importance, historically and at present, as a gateway for new immigrants (Hieber 2000), it is not surprising that the city is a space of ethno-racial difference and a hub for the formation of transnational linkages all over the world. Toronto is also an important economic engine, the site of the national headquarters of many Canadian firms and an important player in national and international trade. Roger Keil and Harris Ali (2006), among others, have cited both the demographic and economic geographies of Toronto as evidence that it is a “global city.”

The City of Toronto's motto, “Diversity our strength,” represents the glitz and glamourization of the global city as a contact zone of racial difference. As mentioned, the discourse of urban diversity is often used as a branding mechanism that elevates demographic diversity as a tool for economic competitiveness. However, such a view is incomplete: the romantic idea of diversity-as-strength relies on the liberal idea of a level playing field among participants in the urban social body. Many scholars have noted that the City of Toronto
is far from an egalitarian space and that the social geographies of the city are characterized by the persistence of power, hierarchy, and social differentiation, particularly in the form of increased socio-spatial polarization and inequality (e.g., Walks 2001; Hulchanski 2007). What is necessary in this context of a radically uneven city is another vocabulary to contest the liberal idealization of diversity in much public multicultural discourse — one that pays close attention to the production of socio-spatial inequality. I draw on one idea offered by Mary Louise Pratt some years ago: the ‘contact zone’.

Pratt’s contact zone “invokes the space and time where subjects previously separated by geography and history are co-present, the point at which their trajectories now intersect” (Pratt 2008, 8). In her formulation of this co-presence, Pratt refuses a liberal politics of multicultural “encounter.” Hers is a theorization of contact that foregrounds uneven power relations; for her, the term “refer[s] to social spaces where cultures meet, clash, and grapple with each other, often in contexts of highly asymmetrical relations of power” (Pratt 1991, 34). In the contact zone, groups come together and “establish ongoing relations, usually involving conditions of coercion, radical inequality and intractable conflict” (Pratt 2008, 8). Viewed from this vantage point, then, the global city as a contact zone is a stratified space, one experienced unequally by different groups based on uneven access to institutions, social capital, human rights, the law, public space, and other social resources.

I am, by no means, the first to point out that the romantic discourse of urban diversity has problems (e.g., Mitchell 1993; Goonewardena and Kipfer 2005). My focus is on these problems in the context of the governance of sexual health. Historically, in many cities in North America, the governance of racial diversity was accomplished in part through the governance of sexual intimacy, couched in the language and practice of health. Renisa Mawani’s Colonial Proximities (2009) makes this point eloquently. What, politically speaking, can we learn from the histories of racialization via the governance of sexuality and health?

The relationship between sexual, racial, and health politics in the Canadian multicultural city has a long genealogy, as Mawani’s study of racial relations in British Columbia (1871–1921) shows. Similarly, Kay Anderson’s (1991) seminal work on the historical geography of Vancouver’s Chinatown provides another example of race, sexuality, and health coming together to create spaces of exclusion. It makes clear that the production of the racialized space of Chinatown was accomplished in huge part through the political use of the figure of the unhealthy immigrant by local health institutions. The study reveals in stark detail the collusion of local public health institutions and municipal by-law enforcement in the production of Chinatown as effectively the literal quarantining of Chinese immigrants in the City of Vancouver in the late 1800s. At this historical-geographical moment, Chinese immigrants were rendered abject beings through their construction as a threat to the emergent colonial city. This was accomplished in part through the public circulation of the idea that Chinese “lifestyle” practices were unhealthy, that Chinese people were culturally habituated to filthy living conditions and predisposed to opium addiction by their racial and cultural background. There was a particular sexual and moral health component to this, as Chinese men were further constructed in public discourse — particularly by the media — as degenerate stock and therefore to be restricted from interracial heterosexual coupling.

This process, while locally embedded in Vancouver, was paralleled by similar practices in other North American cities. The health scholar Susan Craddock has done similar research on historical San Francisco. City of Plagues (Craddock 2000) highlights the work of the San Francisco Board of Health in literally pathologizing that city’s Chinatown district as a source of all manner of ill health and vector-borne disease, from smallpox and syphilis to rats and fleas. These two examples reveal the spatial articulations between racial and health politics, and I argue that they serve as important genealogical points for studying the present relationship between health and racialization.

I highlight these examples not just because they are interesting, but also because they prefigure some of the same processes that I am describe below, particularly the ways that racial and sexual identities become at stake in the field of health promotion. In geographical terms, these examples reveal how the space of the global-city-as-contact-zone has a long history where the politics of identity on the one hand and the politics of health on the other hand collide in the creation of exclusionary geographies. At the heart of this problem of governance of difference and health is biopolitics.
Michel Foucault’s theory of biopolitics emphasizes the ways that life (bios) has become the preoccupation of government and governance, and this is at the scale of the “population” or social body as opposed to the discipline of the individual body (anatamo-politics) (Lemke 2001; Brown and Knopp 2010). In biopolitical terms, the “population” becomes central to the exercise of power, and the notion of “life” the very stake of power struggles. Regulations meant to safeguard, prolong, and maintain the life of populations become embedded into state and increasingly non-state practices. In this vein, it is not surprising that many scholars (e.g., Brown and Knopp 2010) have argued that work of public health is an obvious biopolitical practice of the state. Other state practices — including population-level surveillance such as the census and regulations on public safety in the name of the “population” — also belong in this category.

I want to make one other point about biopolitics, which is that crucial to its exercise is the practice of framing. Framing is, put simply, a political process of definition of what counts as the objects and subjects of power. In the context of public health, framing enables the creation of boundaries around what counts as crucial issues for sexual health promotion and who counts as a legitimate “sexual health subject.” These boundaries matter in shaping local institutional responses to HIV/AIDS, as they help consolidate what issues and which bodies are in place or out of place in the political field of sexual health organizing and promotion. In other words, framing has material consequences for the conduct of sexual health work in the city.

In this spirit, the definition of target populations in organized responses to HIV/AIDS is necessarily a biopolitical question, as it entails setting the parameters of what is and what isn’t to be governed. In the contact zone of the global multicultural city, where ethno-racial differentiation is produced by historical and contemporary patterns of immigration and state-sanctioned and everyday racialization, it seems surprising that the history of organizing around HIV/AIDS started out as a colour-blind one. I acknowledge that there were moments in the early history of the sector when responses to ethno-racial issues did exist, as for example when the AIDS Committee of Toronto (ACT) worked in concert with Haitian diaspora populations living in Toronto in the early 1980s to contest media constructions of Haitians as vectors of disease. However, I argue that early HIV/AIDS organizing in Toronto revolved primarily around sexuality and its politics, to the exclusion of other salient axes of difference.

THEORIZING RACE AND SEXUAL HEALTH 2: E-ASOS AS SAFE HOUSES

In the late 1980s, as organized responses to HIV/AIDS consolidated in the form of ACT and other members of the sector, organizations emerged to contest the colour-blindness of much of social service provision in the 1980s. The omission of ethno-racial concerns about culturally and linguistically appropriate services was accomplished not by accident but by active design. As an interviewee who was instrumental in the founding of one local e-ASO notes: “I recall very explicitly the discussion [in the 1980s] that ‘we are here to talk about HIV. We are not here to talk about race. We are not here to talk about other stuff because it will diffuse that attention.’” He goes on to note, with clear frustration, the inattention to racialization as a crucial factor in HIV/AIDS work: “We really had to go out of our way to ... educate people to understand that at the same time that you are queer or get HIV and you have to deal with homophobia and AID$-phobia, people of colour have to deal with racial discrimination.” This colour-blindness had the effect of producing a one-size-fits-all approach that severely neglected, if not denied, the role of power, inequality, and hierarchy, defined along ethno-racial lines, in the contact zones of the global city.

It was in this political context of utter refusal to see race as something that matters in HIV service provision that e-ASOs emerged, and they did so to contest what was, by default, their exclusion from the HIV sector. In the face of this refusal, organizations such as the Asian Community AIDS Services (ACAS), the Alliance for South Asian AIDS Prevention (ASAAP), and the Black Coalition for AIDS Prevention (Black CAP) emerged out of community-based struggles to respond in culturally and linguistically appropriate ways to the mounting crisis of HIV in 1980s and early 1990s Toronto. It is worth recounting the histories of these e-ASOs here because they hint, to a great extent, at the severity of gaps in sexual health services for people of colour and how, for these organizations and the people they serve, these gaps were literally matters of life and death.

ACAS’ official founding was in December 1994, but its genealogy stems from the 1980s through the Gay Asian AIDS Project (GAAP) of Gay Asians Toronto. GAAP — so named to identify that there was a gap in
AIDS services for racialized people, particularly those of Asian descent — was founded in 1989 because, according to one of its founders, Dr. Alan Li, “in 1989, an Asian with HIV/AIDS had no place to go ...” (Li, 5th anniversary publication). In 1994, ACAS was formed out of the amalgamation of GAAP and two relatively unsuccessful projects — the Vietnamese AIDS Project of the Southeast Asian Services Center and the AIDS Alert Project of the Toronto Chinese Health Education Committee.

ASAAP was founded in 1989 by members of Khush, a group of South Asian gays and lesbians. In the 10th anniversary publication for ASAAP, Sharmini Fernando writes that the organization “started with a phone call.”

Doug Stewart from ACT [future first executive director of Black CAP] calls to talk about one of the clients who is HIV+. Like myself, the client is from Sri Lanka ... He speaks very little English and wants to tell his story to someone who can understand his language and his situation. I arrange a meeting of some South Asian queer activists ... [and] the group decides that there is a need to support not only Doug Stewart’s efforts to assist his client, but any other South Asian infected with or affected by AIDS. And so the South Asian AIDS Coalition is born.

From interviews, I learned that this originary client was in a straight relationship and that his wife also contracted HIV. Here, it becomes clear that sexualities outside of “out” gayness, particularly those inflected with ethno-racial understandings, were often excluded from early AIDS services. This might be explained, as one interviewee put it, but the intimate linkage between the early HIV/AIDS sector and gay liberation movements in 1980s Toronto.

Black CAP was formed in 1987 out of the efforts of various members of Toronto’s Black community with the goal of generating awareness and education on HIV transmission and prevention. Doug Stewart, who worked at ACT prior to becoming the first executive director of Black CAP, notes of the early stages of Black CAP: “[The organizers] were concerned about the numbers of people who were trying to access services and were not getting competent care and services in the health care system.” The organization was officially incorporated in 1991.

These e-ASOs are part of a broader social ecology of the HIV/AIDS sector. These three organizations are not the only ones that serve racialized communities. Others exist as independent ASOs, such as the Africans in Partnership Against AIDS (APAA), or as programs of broader social service organizations, such as the HIV/AIDS Prevention Program of the Centre for Spanish Speaking People. Taken together, their emergence and the necessary hailing of racialized communities as nascent “target populations” in the 1980s and 1990s signalled the inability and failure of mainstream ways of responding to sexual health issues and the need to address the nexus of racial, sexual, and health politics beyond a colour-blind framework. As a result, the presence of these organizations in the HIV/AIDS sector can be theorized as the formation of a racialised division of labour. The continued presence of ethno-specific ASOs signals the continuation of the need for these organizations, despite recent efforts within mainstream ASOs to at least attempt more culturally appropriate and to some extent anti-racist forms of social service provision.

The founding of these organizations formed one avenue — at least in the realm of sexual health — to confront the challenges posed by the contact zone as a radically uneven space by creating a sort of “safe house,” a space of belonging and inclusion that exists in contradistinction to spaces of exclusion within mainstream HIV organizations. Mary Louise Pratt defines safe houses as:

spaces where groups can constitute themselves as horizontal, homogenous, sovereign communities with high degrees of trust, shared understandings, temporary protection from legacies of oppression ... where there are legacies of subordination, groups need [such] places for healing and mutual recognition, safe houses in which to construct shared understandings, knowledges, claims on the world that they can then bring into the contact zone. (Pratt 1991, 40)

In his seminal The Production of Space, Henri Lefebvre (1991) noted that spaces are products of human labour, that they are neither natural nor frozen and that they are constantly created, reproduced, and contested. Similarly, I argue that e-ASO spaces undergo this sort of socio-spatial production process, doing so in direct relation to particular fields of possibility, including — quite importantly — the ways that the
broader HIV/AIDS sector has been organized historically through colour-blind approaches and practices. That is, e-ASOs are not safe houses by default. They are safe houses because of the active work that go into their production as such spaces. In other words, e-ASOs as safe houses are not naturally safe houses simply by virtue of their difference from the mainstream. They are so because their differentiation from the mainstream is accomplished in part through the active adoption of alternative discourses, images, and practices.

**MAKING SAFE HOUSES: THREE EXAMPLES OF E-ASO CULTURAL PRACTICES OF PLACE-MAKING**

In this section, I elucidate the emergence of e-ASOs as safe houses through three examples of practices of health promotion, place-making, and community-building. These practices are innovative insofar as they reconfigure the ways that the spaces of HIV/AIDS social service provision are created, and they do so with a particularly political goal in mind: the creation of sexual health spaces for people of colour by people of colour. This active creation requires strategies, including the use of language, the mobilization of images, and camaraderie-building practices.

Lost in Translation? Use of Languages and Culturally Specific Discourses

Language is a powerful medium through which messages about sexual health are disseminated to a broader public. However, the universality of discourse is not guaranteed, particularly in the context of the contact zone, where the presence of different ethno-cultural groups in a single site means there is a need for sexual health messages to be translated into multilingual and multicultural forms. At its simplest, the translation work of e-ASOs comes in the form of pamphlets, brochures, and websites that are accessible in different languages. It also means being able to provide services in multiple languages. As one interviewee notes in relation to the AIDS Committee of Toronto (ACT), a mainstream organization: “Language barriers is [sic] certainly one of the most important issue [sic] when it comes to ACT.” He goes on: “Like say, if you don’t speak English, ACT doesn’t have anyone specifically for that language-speaking group on site. They might have appointments, but definitely not on site.” This was true historically as well, as another interviewee notes in his reflection on the history of his e-ASO: “There were other AIDS organizations in Toronto [at the time], but they do not have the language and also the cultural, linguistic services [that] catered to the East and Southeast Asian community.”

It is clear from these quotes that one major practice that differentiates e-ASOs from mainstream organizations is the ability to provide services and materials in different languages (see Figure 1 for an example). One interviewee describes ASAAP, for example, as a space where “you can get a plethora of information in Hindi, Punjabi, Gujarati and so forth.” Similarly, a former volunteer with ACAS notes: “I know our materials are translated into Cantonese, Mandarin, Tagalog, Thai, Korean, Japanese ... that makes a huge difference especially if you’re new immigrants.” This is also accomplished in part through strategic staffing: the hiring of workers and volunteers that are able to provide services in multiple languages.

The availability of health information and services in multiple languages enables fuller sexual health service access, since, according to another interviewee, in e-ASOs, “your inability to speak English as fluently ... is not used against you.” Here, it is important to clarify that English as a requirement for full access to sexual health services is not one explicitly encoded in the work of mainstream ASOs. What this quote suggests is that exclusion as a result of language is achieved more through the mundane linguistic mores of social interaction, that is, that one’s ability to speak English might have a bearing on whether one is thought to be or feels in place or out of place in a particular program. In other words, the policing of language is deemed by several interviewees as the policing of belonging in mainstream ASO spaces. As an alternative to this, some e-ASOs have adopted explicit policies around language that serve as alternatives to implicit mainstream practices. An interviewee gives this example: “One of my friends has... this thing called creative speaking ... which is a way of respecting that people say things differently, and that you can tell what they’re saying, [that] they don’t have to say it perfectly in order for you to understand what they’re saying. It’s something we’ve kind of adopted [in the program].”
Beyond this relatively simple strategy of service provision in many languages, I argue that language translation should be understood as more complex than the provision of health promotion by people who speak different languages or the passive switching of printed sexual health messages from one language to another. This point is especially important to note given that sexual health messages are located within the socio-spatial contexts within which they are situated. In other words, these messages are culturally specific. Translation requires navigating the terrain of difference between cultures, and the role of language in this navigation is important given that sexual health discourses often come from Western contexts.

From a Foucaultian perspective, dominant and publicly circulated sexual health discourses reflect hierarchies of power, as particular meanings and constructions of sexuality, health, and sexual health get encoded into campaigns and others are excluded. As these discourses attempt to travel from one context to another, from place to place or culture to culture, socio-spatial differences in understandings of sexual health come to matter. As Manalansan notes in the context of the globalization of “gay” as an identity term, the friction of cultural geographic differences means that the term often collides with other formulations and understandings — indeed, vernacular constructions — of sexual identities and politics, since the hegemonic use of the Western term “gay” has the tendency to elide the culturally specific “social dynamics” of vernacular terms for othered sexualities (2003, 24). Similarly, I argue that concepts encoded in sexual health
promotion messages also need to negotiate these cultural dynamics, as they often do not translate easily across ethno-racial boundaries.

Some e-ASOs articulate the complexity of translation as more than simply linguistic, by pointing out the salience of vernacular knowledges for doing sexual health promotion. One worker uses the example of identity markers for social and sexual relationships that are specific to particular groups:

In North America, our lingo when we're talking about “top” and “bottom,” we are referring to anal sex, aren't we? In Hong Kong, Taiwan, they might be referring to ... if they want to be taken care of ... That [the term] “one” would take care of the “zero.” When you talk to them, they're “oh no no, I don't like anal at all” ... When you're providing services, in a nutshell, this kind of cultural knowledge can make or break what you're doing.

This quote captures the fact that translation, as a practice that produces e-ASOs as spaces for ethno-racialized people, is more than just about the language in its skeletal sense of words and syntaxes; it is also about the specific cultural knowledges and meanings that can or cannot be transmitted through them. Sensitivity to these culturally grounded understandings of sexuality and health is necessary if sexual health promotion and services are to be effective and appropriate.

Practices of Self-representation: Creating Spaces in and through One's Own Image

Writing almost two decades ago, Robert Crawford examined how the cultural politics of AIDS reconfigured the relationship between the self and the unhealthy other. He argued that cultural theorists of AIDS have noted that the crisis “has been ‘an epidemic of signification’, which means in part that it lays bare questions of identity” (1994, 1347) and that the cultural politics of AIDS “is a politics about identity and difference ... and the meanings upon which identities are constructed, managed and reworked. (ibid)” As I argued above, colour-blind racialization has shaped the landscape of sexual health promotion and social service provision in the City of Toronto. One of the ways this has been done is through strategic definitions of target populations, or the bodies and groups of people who are marked as legitimate objects of sexual health. In the context of Toronto's HIV/AIDS sector, historically, white gay men were hailed as the figures for which the sexual health sector existed. As an interviewee who was involved with Black CAP in the 1990s notes, “It was clear to me even then ... that what you refer to as mainstream [AIDS] organizations did not have the same involvement with black people’s health and well-being as an organization as Black CAP. There's always been a lack of understanding. There's always been an unwillingness to engage.”

The tactics of definition were instrumental in shaping the spaces and strategies in and through which sexual health institutions did their prevention, education, and support work. The use of images in this work was and continues to be particularly salient in defining who is in place and out of place within these sexual health spaces, with images of mostly white gay men dominating much of the material cultures of sexual health promotion in the 1980s and 1990s, and arguably, still today. Many of my interviewees articulate this view not only in terms of actual bodies occupying spaces, as in the quote about EGALIE that begins this paper, but also in terms of the use of images to define spaces as for particular people. For example, one volunteer notes that “when you walk around the (Gay) Village, you see all the posters have white, really built, perfect, idealized men ... You very rarely, if ever, will see an Asian person on them, and if you do, that poster is probably ACASs.” He adds, as an alternative example: “If you go around the ACAS office, you'll see all sorts of pictures for bathhouse nights, for clubs nights ... for events that have Asian themes, Asian people on them” (see Figure 2 for another example). The presence of these cultural signifiers of belonging is crucial for feeling in place is significant, and when e-ASOs have had to resort to other spaces (e.g., community centres) to do their programming, perhaps as a result of small offices, the lack of affirming images of the racialized self has been met with disappointment. As an interviewee notes in relation to the use of the 519 Community Centre in Toronto’s Church/Wellesley Gay Village, “It’s a sterile space. It’s not like where we used to have posters everywhere, and you could see posters of ... like, people who look like you.” These quotes signal an important practice among e-ASOs, which is to use images of the racialized self as both a political critique of the overall whiteness — historically and even at present — of images and discourses in sexual health promotion in Toronto and a cultural marking of space as one's own.
The use of images is strategic, and they often required forethought. In the context of small budgets and therefore limited ability to produce posters and other material cultures of sexual health promotion, early e-ASO organizers and workers needed to be careful about which images to use. For example, one early founder of ACAS noted, “I remember the first poster we made. We went through a lot of debate about whether the person should be on his back or his stomach, you know, because we’re dealing with this whole baggage of [sexual] relations, of being top or bottom.” Historically, the trope of the submissive gay Asian man has been used to represent racialized sexualities in and through queer-oriented forms of cultural production (e.g., pornographic videos, community publications) as passive sexual subjects (Fung 1991). This quote suggests that these images can be used as a counterclaim and self-representation, a form of cultural contestation of dominant racialized images. He goes on to note: “It represents certain values ... but also a mindful construct of what we’re really battling at that particular time.”

Han (2007) notes that this racist representation of Asian male sexualities is not a thing of the past: people continue to battle the pervasive trope of racialized passivity and general exclusion from mainstream sexual fields. E-ASOs therefore continue to use images as markers of identity and belonging. These images of sexual health promotion, of course, transcend the boundaries of e-ASO offices and social spaces themselves, and are often placed strategically in public spaces to capture a general public, particularly racialized people who
might not visit e-ASO spaces. The Alliance for South Asian AIDS Prevention’s much praised “Wrap It Right” sexual health promotion campaign does exactly this. Funded by the Public Health Agency of Canada and consisting of public transit posters as well as television commercials, this campaign strategically employs racialized bodies and cultural signifiers (e.g., South Asian men and women in traditional dress) to publicize sexual health message, with the overall tagline being “We wrap it right. Do you? Being Desi will not protect you, condoms will” (Taylor 2009; Gulliver 2006). The campaign has been lauded as significant and innovative not only because it features bodies and symbols that have traditionally been excluded from mainstream material cultures of health promotion, but also because it boldly does so in the many public spaces of the local transit system and the mediated spaces of television.

As practices of self-representation, ad campaigns, posters, and other material cultures of HIV/AIDS social service provision work to critique the pervasive colour-blindness of mainstream images of sexual health promotion. Placed as they are in the spaces of e-ASO offices and meeting rooms, these images mark space for people of colour by people of colour. Sometimes, as in the case of more general campaigns like “Wrap It Right,” these images also spill over the boundaries of e-ASO spaces to occupy mainstream places — streets, public transit.

Engaging in Community-building Practices: The Role of Social Events and Food

E-ASOs treat sexual health through a more-than-individual approach, recognizing that ethno-racial categorizations, inherited from state institutions like legislated multiculturalism or census knowledges, interpellate individuals as belonging into social groupings based on particular markers of difference (Razack 2002). These conditions have shaped the ways that racialized people’s lives and life-worlds have been organized. As mentioned above, these conditions have also contributed to the shaping of the HIV/AIDS sector as the realm of those with societal privilege.

It is therefore not surprising that, apart from following not-so-recent trends in health promotion practice to treat health as necessarily social and spatial (Kearns 1993), e-ASOs generally approach their work in collective terms. Indeed, the history of e-ASOs is generally histories of collective action, as evidenced by the presence of the terms “coalition,” “alliance,” and “community” in the names of Black CAP, ASAAP, and ACAS, respectively. This collective approach is, of course, grounded in the context of an unwaveringly colour-blind mainstream HIV/AIDS sector in the 1980s.

One of the ways that the importance of the “collective” has manifested itself in the work of e-ASOs is through the decidedly social form of much of their programming. As one volunteer notes, groups within ASOs such as Queer Asian Youth (QAY), for example, organize their programming around “social events, which are cleverly disguised ways of dealing with sexual health.” He elaborates: “Those social events ... were really useful because those were really the key to getting community members together. And it was building a community that was based on sexuality that had a really big sexual health component to it, which was really important.” Social events and the spaces within which they occur are therefore key to bringing together individuals who share both ethno-cultural knowledges about sexuality and health and experiences of racialized exclusion from the mainstream.

One important and successful tactic for community-building used by e-ASOs is programming centred on food. Like the practice of visual self-representations described above, food can be an important marker of space for racialized groups. Whether through imagery or the actual making and sharing of it, food figures prominently in the work of e-ASOs to create supportive safe spaces. Food is community-building in that its preparation and consumption is often social in nature, particularly in the context of ethno-specific cuisines. It is therefore not surprising that food-centred social events are often embedded in the sexual health work of e-ASOs.

Two programmatic examples help illustrate this point. First, the monthly Community Kitchen program, hosted jointly by Africans in Partnership Against AIDS, ACT, Black CAP, and Voices of Positive Women, uses the collective sharing of food as a form of community-building and the creation of safe, if temporary, space for engaging in conversations about women’s reproductive sexual and reproductive health.
A second example is the bubble tea socials hosted by QAY, a group within ACAS. Bubble tea socials are centred not just on the shared consumption of bubble tea, a sweet flavoured drink, usually cold, with tapioca balls, but also on the collective occupation of a particular space: a local bubble tea cafe, which is similar to a coffee house in terms of its social atmosphere (see Figure 3). One interviewee, a former volunteer, relays his first encounter with ACAS as having occurred in a bubble tea lounge: “They had a bubble tea night ... It was the first time I experienced [being] with other LGBTQ, queer Asian youth, in this social space, and it was pretty neat.” When pressed as to why this is important, he responded: “I felt like I still wasn't really myself. I couldn't be Asian and gay at the same time, at this time ... ACAS was really — it was really being able to put my identities together ... You didn't have to choose. You could be you.” Similarly, the documentary *F3: A Queer Asian Youth Conference*, which chronicles the Facts for Friction conference hosted by ACAS, describes the inclusion of bubble tea in the conference program in this way: “The bubble tea lounge event was a large scale version of an event that ACAS has been running for three years ... This event reinforced our belief that social support is an essential part of improving the social determinants of health” (Chan et al. 2005)

The quotidian presence of food in e-ASOs also contributes to making them everyday spaces of belonging for e-ASO participants. For example, food plays a prominent role in the way that e-ASO participants occupy and
use space. In a piece published in the Black CAP Links newsletter, Camille Griffith writes in celebration of the organization's former space on Parliament Street, titling her poem “‘Sweet 103’” after the office's marked number (Suite 103). Written after Black CAP moved to another location on Bay Street, this poem begins by describing the space as “like home to all ah we.” On the fourth stanza, food is alluded to as a marker of space and shared belonging:

There was always plenty, plenty food
From fry saltfish to Jerk pork
The usual “What are we having for lunch today guys”
Sent us scurrying for our knife and fork.

The poem ends with laudatory praise for this former space:

After all is said and done
Why are some of us still so sad to leave?
Well what can I say?
Suite #103
Was de place to be.

CONCLUSION: THE “SAFE HOUSE” AS NEGOTIATED SPACE

As explicit alternatives for people of colour to mainstream spaces of sexual health, e-ASOs are necessarily political spaces. In this paper, I have mapped, if briefly, their emergence as important players in Toronto’s HIV/AIDS sector. I have argued that the context of the multicultural city as contact zone is important for understanding the racialized contours of the field of sexual health in 1980s Toronto, and so is the hegemony of a one-size-fits-all, colour-blind approach in sexual health organizing, activism, and service provision. The entry of e-ASOs in this field is, I argue, an important radical critique of this colour-blind approach. As spaces created for and by people of colour, e-ASOs represent material spaces for belonging and sexual health access for marginalized people.

By way of concluding, I would like to revisit the relationship between contact zones and safe houses. I want to do this to emphasize the centrality of social differentiation in the production of both these social geographies: in both spaces, social difference — particularly in terms of racialization — animates social interaction, organization, and institutions. As I have argued, in the contact zone of the global city, the physical intimacy and sharing of space necessitated by the coming together of multicultural strangers does not always translate into supportive social spaces in sectors and institutions that are part of the social system of care, including and especially health institutions. I have indicated that the history of institutionalized responses to HIV/AIDS in Toronto is a history of racialization, largely because of the mobilization of colour-blind ways of doing sexual health work in mainstream organizations. The emergence of ethno-specific forms of sexual health work as safe houses created for and by people of colour contests this racialization, in huge part by naming the materiality of race in everyday life-worlds, sexually and otherwise.

This is not to suggest that e-ASOs are immune from issues of power and inequality. Indeed, I would suggest that e-ASOs are heterotopias as opposed to utopias. Like safe houses, heterotopias are material locations that are produced as safe spaces for excluded others, but they are material and continually produced rather than frozen and permanently perfect, as in the idea of utopias (Foucault 1986). In other words, e-ASOs are under constant negotiation, not only because the practices and institutions that contribute to racialization do shift (e.g., generally speaking, mainstream ASOs have become more sensitive to issues of race, ethnicity, and culture over time), but also because participants in e-ASOs are themselves assemblages or intersections of multiple identifications and subjectifications. One cannot and should not expect, for example, that there is always already an immutable basis of unity between racialized men and racialized women, since the politics of gender still matters tremendously, particularly in terms of sexual health. Furthermore, the identity terms “Black,” “Asian,” and “South Asian” are themselves not truths with binding ontological status, but political
categories that are always under constant negotiation. Indeed, to return to an earlier theme, these categories are biopolitical insofar as they have the ability to define who gets subsumed under which population and organization. But, as scholars of race have told us long ago, these ethno-racial categorizations are complex. For example, what might it mean for someone who identifies as “mixed race” or as Singaporean of Sri Lankan descent to access sexual health organizations that are defined by ethno-racial or regional affiliations? How would one negotiate the boundaries between these categories when one is located at these very boundaries?

These questions, beyond the scope of this paper, require further exploration and will animate other parts of my dissertation and future research work on sexual health organizations (and hopefully others as well). By mentioning them, my goal is not to invalidate the work of e-ASOs. After all, it is equally important to note that the use of these categorizations is strategic and political, rather than an essentialization of identity. E-ASOs make use of and indeed appropriate already available categories, which, while laden with complex histories of racialized knowledges (e.g., as anthropological groupings of “culture”), state governmentalities (e.g., as census groupings), or geopolitical imaginations (e.g., as colonial or military constructions of the world), are nevertheless useful in the material context of the global multicultural city as a contact zone. These categories should therefore be regarded as tactics of negotiation and, similarly, e-ASOs should be treated as spaces of negotiation in the face of a hostile history and geography of racialization, which continues — to a great extent — to this day.
Bibliography


