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Research Article

Elite Actors: Understanding Representation of Culturally and Linguistically Diverse Communities in the Australian Health System Through an Intersectional Lens

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Abstract Culturally and linguistically diverse (CaLD) communities are disproportionately affected by health disparities in Australia. An important political strategy to address these disparities is to increase CaLD representation in leadership roles within Australian health system. In this paper, we examine how certain members of CaLD communities occupy these representative roles. Using the lens of intersectionality, we dissect the privileged yet simultaneously marginalised positions they occupy as 'CaLD elite actors' representing their diverse communities. We describe Australia's assimilationist political environment as an important context that influences the formation of three categories of CaLD representation within the health system: ethnic councils, health consumers and multicultural health workforce. Then we draw on our positionalities as CaLD elite actors in relation to Asian-born gay men in Australian HIV sector to highlight the significant limitations with the narrow focus on representation as a political strategy. Instead of situating representation as an objective, we propose that representation should be considered a continuous process of power-sharing and reflexivity for CaLD elite actors and wider Australian health system.

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1 Introduction

People in Australia who were born in non-English speaking countries or do not speak English at home are classified by the Australian government as 'culturally and linguistically diverse' communities (CaLD) (Pham et al., 2021). These communities have grown significantly over time, with the latest census reporting 29.5% of Australian population born overseas (Australian Bureau of Statistics, 2023). The health outcomes across CaLD communities are equally varied; however, multiple studies have shown that CaLD communities are disproportionately affected by the health disparities linked to non-communicable diseases (Queensland Health, 2023), sexual health (Kirby Institute, 2022) and mental health (Ferdinand et al., 2015). Systemic challenges contribute to these health disparities, such as limited health funding and research (Garrett et al., 2010; A. Renzaho et al., 2016), poor understanding of culturally sensitive and safe services among healthcare professionals (Chauhan et al., 2021), population data

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gaps related to ethnicity[1], religion and length of stay in Australia (Marcus et al., 2022; A. M. N. Renzaho, 2023), and poor uptake of interpreting services (Khatri & Assefa, 2022). To address these challenges and achieve systemic change, a long-standing and widely acknowledged political strategy is to increase CaLD representation in leadership roles within Australian institutions (Australian Multicultural Health Collaborative, 2024; Marcus et al., 2022). There is a need, however, to develop a nuanced understanding of the complexities involved in becoming and operating as CaLD representatives within the Australian health system that continues to marginalise them.

The marginalisation of CaLD communities is rooted in its colonial history, with the White Australia Policy (1901 – 1973) being the first official immigration policy imposing high restrictions for non-white migrants to enter, work, stay and reproduce with the goal of perpetuating a white British national identity (Jupp, 1995; Markus, 1994). After the White Australia Policy was gradually dismantled (Brawley, 2007; Jupp, 1995), multiculturalism was introduced in 1978 to support the provision of a range of 'special services' such as ethnic-based community programs, housing and English training and interpreting services, mostly targeted towards newly arrived refugees (Castles, 1992; Dunn et al., 2001; Gurry & Tavan, 2004). During this time, the term 'Non-English Speaking Backgrounds' was used to support the shift from categorising people based on race to linguistic differences (Marcus et al., 2022). However, in 1996, the term CaLD was adopted nationally by the government following the acknowledgement that Australia's population diversity should not be reduced to a matter of language (Marcus et al., 2022).

Yet the change in terminology does not necessarily translate into improved health outcomes. The health disparities affecting CaLD communities remain to be understood by pathologising ethnic-based cultures and their lack of English linguistic competencies (Marcus et al., 2022). This has been described as a form of ethnic stereotyping that further perpetuates the dominant depiction of CaLD communities as dependent on 'special services' (Jupp, 2011) instead of working towards diversifying mainstream services. Further, ethnic stereotypes also contribute to the marginalisation of CaLD communities (Woodland et al., 2021) while locating the burden of change solely onto people with lived experiences. As a result, one of the main responses against this marginalisation is to demonstrate one's 'Australian' identity by assimilating into the country's white-dominated society (Hage, 2000). CaLD communities, directly discriminated and excluded during the time of the White Australia Policy, now live in a multicultural society with a health system that ambivalently includes them. It is in this politically and persistently assimilationist context that CaLD representatives operate to advocate for their communities.

In this reflective paper, we examine the role of CaLD representatives within the Australian health system. We embed intersectionality into our examination as both a conceptual and a political tool to make sense of the privileged yet marginalised positions that CaLD representatives occupy within this system. First conceptualised by Black American women scholar-activists in the 1980s (Crenshaw, 1991), intersectionality has become a tool for active critical thinking to understand power relations embedded within specific social contexts and across different axes of social stratifications, and subsequently generate collective actions to challenge inequalities (Hill Collins & Bilge, 2016). Feminist and anti-racist researchers from various disciplines have deepened and widened the scope of intersectionality on both theoretical and methodological grounds (Cho et al., 2013; Yuval-Davis, 2006), including among those who use it to analyse inequitable access to health-relevant resources for different groups of migrants (Spitzer, 2016; Viruell-Fuentess et al., 2012).

Applied in this paper, intersectionality is deployed as a tool to investigate resources, development and challenges related to CaLD representation at the systemic levels (politics, health system and, later on, HIV[2] sector), especially as they occur through the interlocking oppressions affecting CaLD communities based on race (disguised via ethnic stereotypes and the dominance of whiteness as an embodied cultural capital (Hage, 2000)), class, gender, sexuality, visa/citizenship status and health status or disability. In doing so, we also reject the binary positions that often render migrants and wider CaLD communities as either the 'vulnerable groups' or a 'threat' to national identities and resources.

Aligning with our understanding of intersectionality, we refer to the roles CaLD representatives play using the sociological notion of 'elite actors', as people who occupy position that provides them with access and control over resources that advantage them (Khan, 2012). Primarily used to examine stratification based on social class (Khan, 2012), we use 'CaLD elite actors' to unpack the different forms and access to resources that allow one to represent their communities. To develop an intersectional understanding of CaLD elite actors, we structure this paper as follow. First, we describe the under-representation

[1] 'Ethnicity' is defined as a shared identity among a group of people based on one or more distinguishing characteristics, which include history, cultural tradition (including religion), geographical origin, language, literature and experiences of oppression (Australian Bureau of Statistics, 2019). However, 'ethnicity' is often deployed inconsistently among policy makers, researchers, and public health practitioners.

[2] HIV = human immunodeficiency virus

of CaLD communities within the Australian political system as a context that influences CaLD representation in the health system. Then, we critically reflect on our positionalities as CaLD elite actors in relation to Asian-born gay men within the Australian HIV sector as an illustrative case study exposing the complexity of CaLD representation.

2 Political representation of CaLD communities

Across Western Europe, Australia, Canada and the United States, ethnic minoritised groups have been underrepresented in democratic political systems (Bloemraad, 2013). Australia is behind other Western countries in terms of political representation of ethnic minoritised groups (Bloemraad, 2013; Pietsch, 2018). This is not to say that improvements have not taken place. For example, the proportion of parliamentarians from Italian (4.8%) and Greek (1.7%) backgrounds have been reflective of the proportions of Australians with Italian (4.4%) and Greek (1.7%) ancestries (Richards, 2023). Yet outside these white minorities groups, political change has been slow, with representation from Chinese (1.3%) and Vietnamese Australians (0.4%) remains significantly lower considering their population size in Australia (5.5% and 1.3% respectively) (Richards, 2023).

Existing scholarship has identified a range of barriers and facilitators impacting political representation of CaLD communities from federal to local levels (Jakimow, 2022; Peucker et al., 2014; Pietsch, 2018; Wyeth, 2021). One of the main barriers relates to the intersecting racial, religious, economic and gender discriminations that often manifest in subtle ways and deter most people from CaLD communities to initiate and maintain political activities (Jakimow, 2022; Peucker et al., 2014; Pietsch, 2018). Another barrier arises from the Australian political system, where people vote for political parties instead of individuals. This makes the political representation of CaLD communities reliant upon the parties' prejudices regarding the value of minority representation (Pietsch, 2018; Wyeth, 2021). Emerging political representatives are constrained in their development, even at the local government level (Jakimow, 2022), as incumbents typically have more resources to maintain their status and power (Pietsch, 2018).

Navigating the above structural constraints, certain members of CaLD communities are able to become elite actors and engage in various political activities from local to federal levels (Jakimow, 2022; Peucker et al., 2014; Pietsch, 2018). People who are more likely to become CaLD elite actors are those who identify as men, have university degrees and higher socioeconomic status, are eager to participate and reconcile their cultural and religious differences with the dominant group (heterosexual white men), and are willing to constantly prove they represent all constituents and not just their ethnic communities (Jakimow, 2022; Peucker et al., 2014; Pietsch, 2018). This evidence is aligned with the studies with ethnic minoritised groups in Western countries whereby people who are classified as 'elite' tend to come from professional backgrounds (Groutsis & Arnold, 2012; Ong & Cabañes, 2011) with Western educational qualifications (Luthra & Platt, 2016; Ong & Cabañes, 2011), are proficient in English (Luthra & Platt, 2016), open to cultural differences (Choi, 2022; Luthra & Platt, 2016), and financially resourceful to be able to choose which countries to migrate and what professions to occupy (Groutsis & Arnold, 2012; Luthra & Platt, 2016). As such, similar to ethnic minoritised groups in other Western countries, university-educated men who come from middle-class backgrounds and above are more able to demonstrate their assimilation into Australian society and become elite actors in its political arena.

This assimilationist context to political representation carries significant costs. As Pietsch (2018) highlights, parliamentarians from CaLD backgrounds often struggle to address issues relevant to specific ethnic, religious, or migrant groups, as their ability to do so depends on their positioning and the issues' alignment with their parties' agenda. Consequently, they may inadvertently reproduce racial and other social hierarchies. For example, recent literature from Australia and Canada (Caluya, 2020; Kwak, 2018) highlight cases where Asian political groups and politicians distance themselves from the plight of Middle Eastern refugees, as if their presence in these countries is disconnected from refugee movements. This assimilationist context also influences how the representation of CaLD communities in the Australian health system takes shape and evolves.

3 CaLD elite actors in the Australian health system

Assimilation shapes the development of CaLD elite actors in the Australian health system in various ways. To explore this development, we focus on three categories of CaLD elite actors: ethnic councils, CaLD health consumers and the multicultural health workforce. These categories suggest some CaLD elite actors operate as individuals while others represent their communities as part of an institution or a profession in health and social care sector. The following sub-sections detail the *roles* and *contributions* of each category of CaLD elite actors for the health of CaLD communities, while also highlighting their *limitations* in accurately and effectively representing

the diversity within these communities.

3.1 Ethnic councils

Among the diverse spaces CaLD elite actors occupy, ethnic councils remain the peak organisations that advocate for the needs of CaLD communities at the federal, state and territory levels, a position most of them have retained since the 1970s (see Table 1). However, not all ethnic councils were established purely through 'bottom-up' political and social mobilisation of CaLD communities. With the emergence of multiculturalism in the 1970s, the Federal government funded ethnic councils as a substitute for the previous organisations they established called Good Neighbour Councils, which was deemed a failure in assimilating people from 'Non-English Speaking Backgrounds' (Multicultural Communities Council of South Australia, 2020). Since then, ethnic councils have been receiving a mixture of funding from federal, state and territory governments to deliver health programmes, primarily focusing on aged care and disability alongside other community development agenda (Ethnic Communities Council of Victoria, 2024) (refer to Table 1). These programmes' primary approach is to use bilingual health workers to translate health information and educate their ethnic communities on specific medical conditions or disabilities.

The limitations in how ethnic councils represent CaLD communities in the Australian health system stem from their predominant focus on ethnicity as the basis for understanding what 'cultures' are. The Federation of Ethnic Communities' Council of Australia (Federation of Ethnic Communities' Council of Australia, 2024), the national body for all ethnic councils, acknowledges the importance of intersectionality, or *"diversity within diversity"*, yet a narrow focus on ethnicity continues to perpetuate ethnic stereotypes (Federation of Ethnic Communities' Council of Australia, 2024). This is exemplified by the ethnic councils' stance on what is widely known in Australia as Harmony Day, observed annually on the 21st of March (see Table 1). Originally intended to mark the International Day for the Elimination of Racial Discrimination (IDERD) in remembrance of the Sharpeville massacre, the day was rebranded by the conservative liberal Prime Minister John Howard in 1996 (Butler, 2023). Howard sought to deny the existence of racism in Australia, dismissing national survey findings of prevalent racist attitudes to promote an image of the country as an inclusive, multicultural society through Harmony Day (Butler, 2023).

As shown in Table 1, ethnic councils engage with Harmony Day and IDERD in various manners, with two of them celebrating Harmony Day but not commemorating IDERD on their social media posts dated 21st March 2024. On the contrary, two others took a clear stand to move away from Harmony Day, including the Federation of Ethnic Communities' Council of Australia[3]. This finding suggests that CaLD representation remains limited to celebrating non-Western ethnic food and arts.

This form of 'positive' ethnic representation that Harmony Day champions is one of the most preferred methods to tackle anti-racism in Australia without explicitly mentioning racism (Australian Human Rights Commission, 2024; Nelson, 2015). Subsequently, some ethnic councils may avoid taking visible and intersectional approaches that may destabilise ethnic stereotypes when it comes to tackling the health impacts of racism. For instance, supporting the health of LGBTIQA+[4] people from CaLD backgrounds may create discomfort for some members of CaLD communities who reproduce ethnic stereotypes portraying LGBTIQA+ identities as Western propaganda (see Chandra and Wilkinson (2022) as an example of this). Recently, in addition to engaging with ethnic councils and their organisational agenda, the Australian health system has increasingly engaged with independent elite actors that is the CaLD health consumers.

3.2 CaLD health consumers

In Australia, the term 'health consumer' broadly encompasses patients, families, carers, friends and other people who use or are potential users of health services (Australian Commission on Safety and Quality in Health Care, 2014). They are recognised as partners in decision-making processes that influence the design, delivery and improvement of health services at multiple levels: individual (doctor-patient), care programmes, institutions and the wider health system (Australian Commission on Safety and Quality in Health Care, 2014). However, the degree to which this partnership is equal depends on the purpose, task and roles assigned to the health consumers within the funded projects (Chauhan et al., 2021).

Existing health consumer engagement frameworks have identified language barriers and cultural sensitivity as the most common challenges in engaging with CaLD health consumers (Chauhan et al., 2021). Both are used to describe the barriers between (Australian) English language and 'cultures' and those from non-Western ethnic groups. As noted in the Introduction, addressing ethnic-based barriers requires a careful approach as it can become a fertile ground for reproducing stereotypes of CaLD communities. In the context of overcoming 'language barriers', a recent study on co-designing sexual health resources shows that

[3] In this review of social media posts, we do not suggest that ethnic councils are not engaging in anti-racism. Instead, we suggest their anti-racism is constrained and mediated by the political environment in which they operate.

[4] LGBTIQA+ stands for lesbian, gay, bisexual, transgender, intersex, queer, asexual, and other gender and sexually diverse identities.

Table 1: Overview of ethnic councils at the state, territory, and national levels

Ethnic council	Year and background of establishment	Key health-related programs	Celebrating Harmony Day or commemorating International Day for the Elimination of Racial Discrimination (IDERD)
Ethnic Communities Council of Victoria	1974, formed through various meetings involving different community organisations	Support to navigate aged care Speak My Language (disability) Bilingual health education Domestic violence Multicultural mental health reform	Moving away from Harmony Day towards IDERD
Ethnic Communities Council of New South Wales	1975, mass rally of ethnic communities	Support to navigate aged care Speak My Language (disability) Bilingual health education Domestic violence	Acknowledging IDERD while celebrating Harmony Day
Ethnic Communities Council of Western Australia	1975, no further information available on their website	Speak My Language (disability) Domestic violence	Celebrate Harmony Day, but not commemorating IDERD
Ethnic Communities Council of Queensland	1976, Federal Minister for Community Welfare Services invited 14 people from Queensland to establish the council	Own and manage an aged care facility Bilingual health education (blood borne viruses, sexually transmitted infections, and chronic diseases)	Using Harmony Day as a strategy to eliminate racism
Multicultural Communities of Northern Territory	1977, no further information available on their website	Speak My Language (disability)	Celebrate Harmony Day, but not commemorating IDERD
Multicultural Communities of Tasmania	Information is unavailable on their website	Speak My Language (disability)	Information is unavailable on their social media
Australian Capital Territory Multicultural Council	Official website is unavailable		
Multicultural Communities of South Australia	1995, established by merging two ethnic councils with divergent views on advocacy for CaLD communities	Support to navigate aged care Speak My Language (disability) Multicultural mental health support	Using Harmony Day as a strategy to eliminate racism
Federation of Ethnic Communities Council of Australia	1979, no further information available on their website	Advocate for nationally consistent collection and reporting of data on culture and language Support social, health, and medical research Address under-representation Hold biannual National Multicultural Health & Wellbeing Conference	Moving away from Harmony Day towards IDERD

relying only on translation and over-simplified English language can infantilise CaLD health consumers (Gray et al., 2024). The sole focus on ethnicity can further hide other systemic challenges such as how medical researchers often do not reach out to CaLD communities to ensure their participation (Brijnath et al., 2024) and the lack of resources to engage with specific members of their ethnic communities, particularly women, young people, LGBTIQA+ and disabled people. As such, CaLD health consumers must navigate systemic challenges that arguably should be addressed by increasing and strengthening the multicultural health workforce within the Australian health system.

3.3 Multicultural health workforce

The Australian Multicultural Health Collaborative (Australian Multicultural Health Collaborative, 2024), the national advisory body consisting of ethnic councils, CaLD healthcare professionals and CaLD health consumers, has identified multicultural health workforce as an integral part to improve the health of CaLD communities. Although bilingual health workers, interpreters and translators have long been acknowledged for their pivotal roles in improving the communication between healthcare professionals and CaLD patients (Khatri & Assefa, 2022), their role in health decision-making is limited to translating, interpreting and/or relaying clinical information from the healthcare professionals. Thus, the Australian Multicultural Health Collaborative (Australian Multicultural Health Collaborative, 2022) argues that CaLD healthcare professionals are crucial to improve CaLD representation at the organisation and systemic levels:

> *This [multicultural health] workforce is pivotal in fostering stronger connections with the communities they represent, build sector capacity, and ensure diversity is present in decision-making.* (Australian Multicultural Health Collaborative, 2022, p. 9)

With an ageing population, one of the strategies through which Australia attempts to increase the number of CaLD healthcare professionals involves the recruitment of overseas-qualified nurses and aged care workers (Chun Tie et al., 2018; Wilkinson et al., 2023). However, the existing studies highlight how overseas-qualified nurses and aged care workers (mostly from Southeast Asian countries, particularly The Philippines) face difficulties to settle post arrival, racial discrimination and organisational budgetary constraints that create an environment where they are afraid to speak up (Chen et al., 2020; Chun Tie et al., 2018; Wilkinson et al., 2023). With the power imbalance between employers and overseas-qualified workers who are often recruited through third-party agencies, the working conditions of these workers are highly vulnerable to modern slavery practices (Brodie & Jelenic, 2021), further creating systemic constraints that prevent the development of CaLD elite actors among them.

In addition to CaLD healthcare professionals, the roles of CaLD health promotion practitioners, community development workers and social care professionals based in community organisations, such as LGBTIQA+ and women's health organisations, are crucial within the health system (see ACON (n.d.) and Multicultural Centre for Women's Health (2024)). These roles are created to address the lack of intersectional approaches to support women, young people, LGBTQIA+ and disabled individuals from CaLD backgrounds. However, the capacity of these individuals to adequately represent the complex needs of their diverse community members is influenced by their organisational resources, the CaLD employees' agency and interests, and the racial hierarchies within their organisations. For instance, in the history of HIV prevention in Australia, LGBTIQA+ organisations had perpetuated ethnic stereotypes through their use of images and health promotional messages targeting Asian-born gay men (Yue, 2008). Nevertheless, the presence of CaLD employees in community organisations with health programs remains essential, given the inconsistent health funding for CaLD communities since the introduction of multiculturalism (Jupp, 2011; Moran, 2017; World Wellness Group, 2024).

To summarise, this section has identified diverse forms of CaLD representation in the Australian health system. They emerge from the tensions between political mobilisation from CaLD communities themselves, and the systemic challenges that create an assimilationist context where 'diversity' is understood through the narrow lens of ethnicity. This is a conundrum for the Australian health system as the ongoing use of CaLD as a category will perpetuate the reduction of complex intersecting cultures into ethnic differences. Despite such complex challenges, some CaLD community members have emerged as CaLD elite actors within ethnic councils, health consumer movements, multicultural health workforce and other roles not reviewed in this section, such as researchers and activists. In what comes next, we examine the emergence of these actors through an illustrative case study focusing on Asian-born gay men in the Australian HIV sector.

4 CaLD elite actors among Asian-born gay men: An illustrative case study

Gay men from Southeast and Northeast Asia have been disproportionately affected by HIV in Australia since the early 2010s (Gunaratnam et al., 2019), with a 59% increase of new HIV diagnoses from 2013 to 2019 (Kirby Institute, 2023). In contrast, Australian-born gay men experienced a significant decline in new HIV diagnoses within the same period (36%) (Kirby Institute, 2023). Across Australia, HIV prevention programmes specifically targeting Asian-born gay men only exist in LGBTIQA+ organisations located in New South Wales and Victoria (see ACON (n.d.) for example). This pattern partially reflects the unequitable level of health funding for CaLD communities across the country, reinforcing the relevance of using Asian-born gay men as an illustrative case study to examine CaLD elite actors.

In this section, we introduce a conversation that took place between both authors, who recognise the 'elite'-ness of their social and political positions among Asian-born gay men within Australian HIV sector. Originally from Indonesia, the first author (SNI) worked for eight years in various capacities, including for an organisation supporting people living with HIV in Queensland (mainly working with migrants and refugees, including Asian-born gay men), and is also a CaLD health consumer, an activist for LGBTIQA+ people with lived experience of seeking asylum, and a public health researcher. They used to identify as an 'Asian gay man' and have now identified as an 'Asian queer person' since 2021.

The second author (BS) is nonbinary, queer and a Muslim of Asian background. They were also born in Indonesia but have been living in Melbourne since 1998. They previously worked in HIV and sexually transmitted infections (STIs) health promotion and was involved in running a social support group specific to gay, bi and other men who have sex with men of Asian backgrounds. They have worked alongside multicultural communities in sexual health and, at the time writing this article, was a co-chair of a professional network focusing on international students and sexual health. They have been heavily involved with LGBTIQA+ inclusion, intersectionality multiculturalism and interculturalism for over two decades.

Our positionalities as 'CaLD elite actors' in relation to Asian-born gay men is defined by a complex interplay of individual, social and political factors: being assigned male at birth and benefitting from patriarchal structures; holding Australian educational qualifications; confident and proficient in communicating in English; past history of being permanent residents and then citizens in Australia which provide access to the health and welfare systems; and extensive professional experiences in the Australian HIV sector and related fields. This combination of factors has allowed us to engage with, and sometimes lead, projects related to sexual health promotion, education and services. We have worked alongside healthcare professionals, researchers and community leaders representing those most affected by HIV, therefore enriching our understanding and impact in this sector.

Building on our positionalities, we chose conversation as a method to leverage our lived, professional and research experiences. This approach seeks to increase transparency in our co-production of knowledge and to create a reflexive and safe space for dissent. This conversation was guided by a series of open-ended questions surrounding our roles as CaLD elite actors within the Australian HIV sector, specifically in relation to Asian-born gay men. We exchanged responses through a series of emails from 17 April to 1 August 2024. The key points from our conversation are summarised and explored in the discussion section.

4.1 Q1: How did you get involved in the HIV sector?

BS: *I came to Australia in 1998 as an undergraduate student, and I was searching for a support system where I could feel a sense of belonging. A friend of mine told me about Gay Asian Proud, a workshop for Asian-born gay men offered by the AIDS Council. In the late 90s, there was an attempt to inform and educate gay and bisexual men from migrant communities about HIV and STI as part of the national response to reduce the rate of HIV transmission. The workshop was designed by and for the community, and it talked about socio-cultural issues that affected sexual health, including race and ethnicity, relationships and community belonging. The workshop morphed itself into a social support group, and expanded its reach to include other gay, bisexual and men who have sex with men. I had a full circle moment because I was employed as a health promotion officer at the local AIDS council, and one of my roles was to coordinate this social support group. I was a participant, then a member, then a co-ordinator. During that time, I saw some progress as well as setbacks in relation to HIV response specific to Asian-born gay men.*

SNI: *I arrived in Brisbane, Australia, from Jakarta, Indonesia, in February 2016. Like most migrants from Asia, I was an international student and was enrolled in a postgraduate program in health management. Back in Indonesia, I just finished my education in medical school, but I did not want to continue to work as a medical doctor. In March 2016, I acquired HIV in Brisbane and was dia-*

gnosed here. By June 2016, I began working for Queensland Positive People as a peer educator based on my lived experience as a migrant living with HIV, and my educational background. Like you, I also got promoted into a coordinator position – a team leader was the official title – for the peer education program. In this role, I noticed the absence of sexual health programs for Asian-born gay men in Queensland. With the current increase of new HIV diagnoses in this group, I decided to do my PhD in public health about this topic. It's interesting to know that two queer people from Indonesia who arrived in Australia at different times and lived in different cities had similar early career trajectories.

4.2 Q2: What are the factors that have shaped your roles in the Australian HIV sector over the years?

BS: *When I first 'entered' the Australian gay scene in the late '90s, a lot of the focus was on educating people about HIV and STIs, with HIV prevention strategy (back then, condom use). I think this has shaped my roles in HIV response, because HIV and STI education has been at the forefront of my involvement with the gay scene and community. Being involved at events distributing condoms and lube, and partaking in social and educational groups for young gay men and Asian-born gay men gave a sense of belonging and community, an important part of my survival in Australia. When I was working at the AIDS Council, creating a sense of community and belonging became an important part of my role, because we knew that HIV responses couldn't be successful without addressing the fundamental human needs: connections and belonging. I think this is an area that we still need to improve because HIV prevention messages cannot simply rely on the technical sides of prevention strategies, such as where to get PrEP, how to take PrEP, how to negotiate condom use, etc. It also needs to incorporate the human elements and touch on the basic human need of belonging.*

SNI: *I agree with what you said, that focusing only on "the technical sides of prevention strategies" is often too narrow. This approach also risks stereotyping migrants, asylum seekers and refugees as sexually uneducated people. To challenge this infantilisation of migrants, I've recently incorporated storytelling as an HIV health promotion approach to bring into the spotlight the sexual and social lives of migrants, including Asian-born gay men, which is an important context for HIV prevention. But I've faced challenges from some public health researchers and practitioners who seem to prefer a narrow, top-down, biomedical focus on HIV prevention. Although they support storytelling as an approach, they want the stories to avoid portraying the sexual agency of Asian-born gay men (and other migrants) and to limit the focus on racism as a threat to their sense of belonging to gay communities and Australian society. I wonder what barriers you've encountered and observed in your role within Australian HIV sector for almost two decades.*

BS: *I think it's a result of the lingering sexual stereotypes around Asian-born gay men, whereby we are either seen as asexual or for our sexuality to exist only in relation to White[5] gay men's sexual fantasy and desire. The idea of providing agency to Asian-born gay men may be seen as a threat towards these cultural and sexual stereotypes, and by association, their own knowledge around Asian-born gay men and HIV prevention, which only further reinforced the idea of Whiteness in the HIV sector. This means that the sector still sees prevention strategies and services that work for Anglo-European or White Australian as the default, in which ethnic minorities are expected to follow without considering our unique cultural identities and construct of sex and intimacy. As such, we are seen as an addition instead of being allowed to define our sexuality and intimacy as we understand it, not in the way that White people view it.*

Indeed, we rarely pay attention to Asian-born gay men who are only attracted to other Asian-born gay men, or those who are not attracted to White gay men, and how they communicate and navigate safer sex. The lingering stereotype of young, Asian-born gay men with little agency, or as you said, the infantilisation of our sexuality and identity, influences the messaging that we give to members of the community. In doing so, we are not doing justice and lacking both compassion and nuances to Asian-born gay men and how they navigate their sexual desire in the Australian gay sexual culture.

I wish I could say that things have greatly improved, but the stereotypes are still there, and to make it worst, the use of selective data further perpetuate these stereotypes, instead of presenting Asian-born gay communities as diverse, full of agency, and able to make informed decisions through HIV prevention strategies that are culturally safe and relevant to their lived experiences, including the emotional aspects of sex and intimacy that are unique to our circumstances.

[5] We have different views regarding whether the letter 'w' in 'white' should be capitalised or not. According to the Associated Press, white should be lowercased because white people do not necessarily organise themselves based on shared historical and cultural commonalities the ways Black people in United States do (Daniszewski, 2020). However, SA argues that 'w' in white should be capitalised because it denotes a socio-political identity.

4.3 Q3: How has the Australian HIV sector engaged with the diversity of Asian-born gay men over the years?

BS: *There has been some progress. We now have support groups specific to Asian-born gay men living with HIV, as well as resources on HIV prevention strategies in multiple languages. In saying that, the HIV sector seems to be 'stuck' in relation to creating culturally appropriate and safe resources that do not follow the White cultural norms. As such, there is still a view that HIV response for Asian-born gay men are to duplicate the Anglo Australians HIV response. We are yet to see HIV response that addresses our cultural identities and norms, and to link sexual health with the way we understand sexuality, sex and intimacy. As such, there is still a disconnect between how some Asian-born gay men may see themselves and understand their sexuality and intimacy with messages on HIV prevention strategies. We are also not good at understanding the intersections between race, ethnicity, sexuality, migration status and more, and how these affect Asian-born gay men. As such, we tend to take the easy way out, homogenising the entire community and construct them as having little agency or sexual health literacy because it would make the program design easier than if we are to work with the diversity and intersections that exist within Asian-born gay men communities. For example, HIV prevention strategies often assume that all Asian-born gay men are international students. We forget about those who are on temporary visas, such as visitors, working holiday visa holders and those who are seeking asylum or on a bridging visa. Each of this cohort requires HIV response that are specific to their needs. We are not there yet.*

SNI: *I agree. Intersectionality continues to be a challenge for Australian HIV sector and the health system at large. Our contributions to the LGBTIQA+ scene in Australia are often rendered invisible, especially our activism to tackle anti-racism in these diverse communities, which has been integral to the history and sustainability of our communities. I was very happy when I saw a recent publication challenge this narrative (Chandra et al., 2024). At the same time, we also need to acknowledge our activism within CaLD communities. For instance, Third Queer Culture, a social and advocacy group for LGBTIQA+ asylum seekers and refugees, recently held an event in Brisbane to help their members connect with allies within local ethnic and religious communities. These examples highlight that those who celebrate their intersectional identities must stretch their acts of representation across different sectors, which contribute to unique and innovative forms of representation while also creating risks of burnouts due to lack of support. The complexity and potential burnouts in doing representation intersectionally may also hinder the political participation of Asian-born gay men and other LGBTIQA+ migrants.*

4.4 Q4: What have been some of the feedback from Asian-born gay men towards your representative roles in the HIV sector?

BS: *I think it's not just my role, but a collective role to increase awareness and literacy around HIV prevention strategies and support for people living with HIV. I honestly don't know how they respond to my views, but I've often encountered Asian-born gay men who agree with me that, for HIV responses to be successful, we need to put Asian identity at the centre instead of as an addition. When we put our 'Asianness' at the centre, it creates a space for us to decide what could work and how we would communicate it to our peers. With our intersectionality, it could also enable us to identify the various intersections that exist within our communities, and we could be able to tailor the messaging accordingly. It could also create a space for us to explore the idea of sex and intimacy as per our own cultural norms and backgrounds, and how these may be in contrast with the dominant and default White construction of sex and intimacy. The goal is to find a middle ground, because we are members of Australian society and we are proud of our Asian backgrounds. I think this is the next step in HIV responses for Asian-born gay men: how do we construct messages that speak to our identities, cultures, norms and practices, and offer various ways to navigate our intersectional identities in the White-dominated gay sexual culture as an integral part of HIV prevention strategies.*

Of course, I've also experienced resistance from Asian-born gay men whose mode of survival in Australia is by assimilating to the dominant White gay culture, and from those who see White Australia as liberating in contrast to the situations in their countries of origin. For me, it only shows the diverse views that exist within the Asian-born gay communities, and how we need to move away from a one-size-fits-all mentality in HIV responses to give options and offer thoughts and narratives that do not follow the convention of Whiteness.

SNI: *I've also been doing some reflections on this concept of 'Asian' and the evolution and diversity behind this term in Australian context. Some scholars argued that many people in the Asian diaspora are more likely to associate ethnicity with nationality, such as Vietnamese, Thai, Indonesian, Australian, etc*[6]*. They also posited that 'Asian' by itself is used as a racial category, which is further affirmed by the examples where people refer to*

[6] See Liu et al. (2024).

'Asian' as their race[7]*, suggesting the tendency to internalise the use of racial category as a form of identity. So, it seems to me that a part of doing representation intersectionally is to dismantle the racial discourse attached to categories that are intended to suggest diversity instead of generalisation.*

I've also been reflecting on how Asian-born gay men have been reacting to what you called "a collective role" that we are part of. What I think is important is that many of us are aware of how much anti-racism work is needed to challenge this. Yet anti-racism rarely gets acknowledged within Australian HIV response for CaLD communities, resulting in the absence of interventions to improve racial literacy or even using anti-racist as a framework to implement HIV prevention and treatment interventions. There is an assumption that it is all just about increasing the diversity of people in decision-making roles. But that, for me, is just one aspect and without a strong and explicit anti-racist lens that also intersects with other forms of oppressions, what we have is simply a tokenistic and assimilationist form of representation.

BS: *I think that's the danger of being fixated with the idea of 'representation' instead of reflecting on and questioning the dominant culture that exists within the HIV sector. As I said earlier, the Australian context is still dominated by cis, White, gay men from middle class backgrounds. When there has not been genuine willingness to reflect on the system that has continued to privilege cis, White, gay men, then we will forever be stuck with the idea of 'representation' instead of turning the system upside down and ask ourselves: "How can we put intersectional marginalised communities at the centre? How can we share power? How can we give agency? And, how can we be an accomplice?" Sadly, we are not there yet. I often encounter resistance because the thinking is, "We are already marginalised, we know what it's all about." There has not been any appetite for reflexivity and humility, let alone anti-racism. This could only harm Asian-born gay men in terms of strategies and support that are available to our communities, or the lack of it.*

4.5 Q5: As elite actors, how do you see your positionalities in relation to Asian-born gay men and Australian HIV sector?

BS: *The first thing to do is to acknowledge the privileges that we, elite actors, bring to the conversation. Both of us are tertiary educated, obtained our degrees from a Western education system, able to communicate in English, middle-class, with previous work experiences in HIV education and health promotion. This means that we have a very high literacy when it comes to HIV prevention strategies. We have the knowledge and the skills to communicate using the dominant language, English. I think we have the responsibility to advocate for those who do not have the same privileges or have not been given access to conversation and decision-making process. In my experience, we rarely hear from Asian-born gay men with limited English language proficiency, hence most of our messaging has been tailored to those who speak English. Indeed, even in a roundtable discussion involving Asian-born gay men, we used English instead of making accommodation to use interpreters. This means that we probably missed culturally-specific nuances.*

As elite actors, we need to get together and constantly challenge the status quo within the HIV sector and among ourselves. I think we have the responsibility to do so, make way for non-elite actors, work with them to increase their capacity to communicate and advocate, then step back. I see it as our ethical responsibility in our collective effort to question and dismantle Whiteness in the HIV sector. We can only be successful if we work collaboratively to support one another. Yet, Whiteness tends to put us against one another, a deliberate strategy to divide and conquer us to maintain the status quo. We need to realise this, and we need to work as a collective. Then, we can start thinking about meaningful and purposeful engagement when it comes to policy, intervention and support.

SNI: *I agree that elite actors need to engage in reflexivity to consider the ways in which our privileges may exclude others. However, I also want to point out that institutions who engage with CaLD elite actors often do not offer support, time and space for this reflexivity to occur. When reflexivity does occur among a group of CaLD elite actors, there are often limited financial resources to support whatever solutions identified from this collective process of reflexivity. Also, there is a danger in thinking that those who occupy elite position does not experience challenges in navigating the health system due to the resources they have. In my experience, despite having the ability to communicate in English, my English is valued and treated differently compared to others who speak English the ways Australians do. As such, becoming and being elite actors in relation to other Asian-born gay men is not just about having resources and privileges. It is also about challenging the status quo, which is the assimilationist context in which CaLD elite actors operate.*

4.6 Q6: How can Australian HIV sector improve the representation of Asian-born gay men at the policy and intervention levels?

BS: *Again, the language should move beyond 'representation', and the question should be, "How can we put Asian-*

[7] See Wong (2023) as example.

born gay men at the centre, how can we embed intersectionality, how can we give them the agency to decide what would work best for them, and how can we create an enabling environment and share our resources?". When we adopt this thinking, we realise that, at times, the ones who have been creating barriers are ourselves, because we are not willing to let go of our power and privilege to make and give space to intersectional marginalised communities. When we put intersectionality at the centre, we can start to make the necessary changes to ensure that members of the communities are given the agency, dignity, and opportunity to be involved in policy, intervention, and support services. As I said earlier, we are not there yet, so hopefully this article will be a catalyst for change.

5 Discussion

Using intersectionality as a lens, this article has sought to examine CaLD elite actors within the Australian health system. We first discussed the political landscape in which CaLD representation operates before focusing on the different types of CaLD elite actors within the system. We then engaged in a critical conversation to provide a more nuanced understanding about the role of CaLD elite actors, addressing our positionalities in relation to Asian-born gay men within the Australian HIV sector. While our conversation is context-specific, it also functions as a starting point to highlight three key points regarding the potentials and limitations of the current political focus on increasing CaLD representation in the Australian health system.

First, social, cultural and economic capital are not the only factors that contribute to the emergence and development of CaLD elite actors as suggested by existing literature on CaLD political representation (Jakimow, 2022; Peucker et al., 2014; Pietsch, 2018). As people who occupy this position in relation to Asian-born gay men, we also recognise that our sense of belonging, both within Australia and our communities based on our intersectional identities, constitutes a key factor driving our representation. In this sense, our understanding of the notion of being 'Asian' moves beyond the narrow focus on ethnicity and intersects with complex gender, sexuality and anti-racist activisms. Despite these factors, we still face racialisation through ethnic stereotypes imposed on Asian-born gay men and communities grouped as 'Asian' within the health system. Actively and continuously contesting these stereotypes within the health system's fragmented sectors is essential yet may create risk of burnout among CaLD elite actors.

Second, the Australian health system, as revealed by its HIV response, continues to use whiteness as the benchmark to define what it means to be 'Australian', 'healthy' and 'LGBTIQA+'. These practices, ingrained within Australian health system (Mayes, 2020), hinder the development of meaningful and diverse CaLD representation. At the same time, CaLD communities who accumulate whiteness, for example via obtaining Australian educational qualification and developing English proficiency, can still find themselves at a disadvantage when navigating the health system.

Third, CaLD elite actors can become gatekeepers. As gatekeepers, they may exclude certain community perspectives to maintain their own power and privilege. From an intersectionality perspective, this point affirms the importance of paying attention to how power relations can change over time (Hill Collins & Bilge, 2016). Thus, simply increasing the number of CaLD elite actors in leadership roles should not be mistaken for a genuine improvement in the quality and effectiveness of CaLD representation.

5.1 Implications for practice

Based on the three key points above, our recommendation for representational model is to provide adequate funding to support CaLD elite actors to engage in two key practices. The most important one is to implement power-sharing strategies that extend within and beyond CaLD communities. For instance, it would be beneficial to support CaLD elite actors to engage more deeply with community members who are typically overlooked by the health system and the elite actors themselves. This approach requires deliberation and adequate funding, which is increasingly recognised as essential to reduce the reproduction of power imbalances in co-producing health research and services (Smith et al., 2023). Funding is also key to enable the second key practice that CaLD elite actors must engage with, and that is: ongoing reflexivity (Smith et al., 2023). We argue that reflexivity can counteract assimilationist tendencies in the representation of CaLD communities by encouraging an openness to diverse perspectives and lived experiences.

5.2 Limitations

Regarding our conversation as two CaLD elite actors itself, we are aware that our understanding of representation, intersectionality and whiteness may be limited to our perspectives as people who come from similar ethnocultural and geographical contexts. As we previously mentioned in the beginning of this section, our conversation merely functions as a starting point for wider, more diverse perspectives and debates on the utility and limitations of CaLD representation within the Australian health system. At the same time, our conversation, produced through people from different age group and year of migration into Australia, illuminates the changes and persistent challenges in CaLD representation for Asian-born

gay men since the late 1990s until present.

6 Conclusions

Increasing CaLD representation holds promise but is not without its challenges. Our dialogue suggests caution against using representation solely as an indicator of improved responses in the health system for CaLD communities. Representation should be understood as open and multi-directional processes rather than an outcome to enable ongoing, reflective collaboration to improve health outcomes for CaLD communities.

AI statement:

During the preparation of this work, the authors did not use any generative AI software or AI-based services and technologies.

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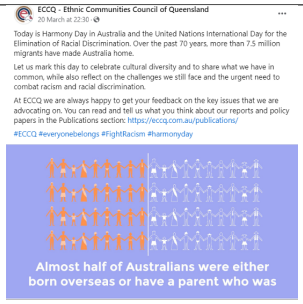
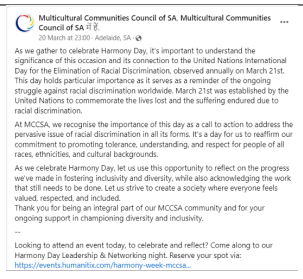
Appendix 1: Social media posts of ethnic councils on Harmony Day and IDERD

No.	Ethnic Council	Social Media Post (dated 21st March 2024)
1	Ethnic Communities Council of Victoria	
2	Ethnic Communities Council of New South Wales	
3	Ethnic Communities Council of Queensland	
4	Multicultural Communities of Northern Territory	
5	Multicultural Communities of Tasmania	Not available
6	Australian Capital Territory Multicultural Council	Not available
7	Multicultural Communities of South Australia	
8	Federation of Ethnic Communities Council of Australia