RETURN OF THE FOREIGN DEVIL

THE CONSTRUCTION OF AIDS IN CONTEMPORARY JAPAN

INAUGURAL LECTURE BY PROFESSOR SANDRA BUCKLEY
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RETURN OF THE FOREIGN DEVIL
THE CONSTRUCTION OF AIDS DISCOURSE IN CONTEMPORARY JAPAN

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An Inaugural Lecture

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INTRODUCTION

Late in 1993, the *Asahi shimbun*, Japan’s major daily newspaper, ran a story featuring the exhibition of Japan’s first AIDS Memorial Message Quilt (*Asahi shimbun* 29 Nov 1994). It consisted of just twenty quilts. The patches were prepared by the friends and family of individuals who had already died of AIDS, as well as of persons with AIDS (PWA)\(^1\). A second story was both demarcated and highlighted in a box at the centre-base of the article. The focus of this story in a story was “a certain Japanese hospital,” where some 26 patients had died of AIDS. The staff attempted to convince the families of these patients to support the production and contribution of quilts to the Memorial Message Quilt but found that the families were extremely reluctant to become involved. Hospital officials reported that the main concern appeared to be the public naming of the family member, and the associated risk of the family itself being identified as having been “exposed” to the AIDS virus.

Finally, one of the families contributed two blank white quilts sewn together, and in the top left hand corner of the top quilt were embroidered the initials KW, in the same corner of the bottom quilt were embroidered the initials KH. These were the initials of the names of a husband and wife. The rest of the white surface of the quilts was starkly empty. This is markedly different from AIDS memorial quilts produced in the United States, Europe and Australia where each square of quilt can include anything from personal history to eulogies, portraits, photos and favorite childhood toys sewn into the cloth. This Japanese family’s reluctance to be publicly associated with AIDS was mirrored in the refusal of the hospital itself to be identified. This fear was not limited to one medical institution. Another *Asahi shimbun* article published a few days earlier under the headline “Medical Examination of AIDS Patients Hasn’t Progressed Much...,” included a cartoon image of a very worried doctor and nurse, beads of sweat dripping from their brows, with the caption “AIDS examination...” over their heads (*Asahi shimbun* 24 November 1993) **Plate 1** Less than a year later yet another article detailed the refusal of some hospitals to be listed in government information booklets as either having experience or expertise in AIDS testing or medical care. The title of this 1994 article summarized the perspective of the hospitals succinctly: “Image-down. Other Patients Won’t Come” (*Asahi shimbun* 2 August 1994).

The aim of this chapter is to link the two AIDS memorial quilts, marked only by the initials of an anonymous husband and wife, with the comments of Japanese critics of the 10th International Conference on AIDS and STD, held in
Yokohama in August 1994. A spokesperson for the Tokyo office of the *HIV and Human Rights Communication Centre* expressed his disappointment that the conference had not attracted the broad support or participation of either HIV seropositive Japanese or persons with AIDS. He noted that when one of the keynote speakers asked, in an emotional moment, that all PWAs in the audience stand, he saw almost no Japanese faces among those standing. He related the lack of Japanese faces to a failure to appeal to the interests of PWAs in the host country of the conference. *(Asahi shimbun* 13 August 1994). A Japanese AIDS researcher from Osaka University, Professor Kurimura, also expressed a similar concern that the conference had shown little understanding for the specific conditions of the lives of PWAs in Japan and that the decision to locate the conference in Japan had been a calculated move by the organizers to place pressure on Japan to fund future WHO activities in the area of AIDS research and education in the Asian region. Kurimura asserted that, “Rather than allowing others to determine the distribution of funds we should support international co-operative efforts that have an understanding of the Japanese point of view.” *(Asahi shimbun* 13 August 1994) What might be meant by “the Japanese point of view” and what is at stake in the drawing of this boundary will be the major focus of this paper. Through the re-deployment of specific examples of the contemporary packaging and circulation of AIDS discourses in Japan, I will seek to develop the context of production for both the silence of the white space of the two AIDS memorial quilts and the static of media coverage of criticism of the AIDS conference in Yokohama.

**THE STORY IN THE STATISTICS**

The major centres for the collection, collation and distribution of AIDS and HIV related information in Japan today are the semi-government Japan Foundation for AIDS Prevention and the Ministry of Welfare Committee for AIDS Surveillance. The official statistics for confirmed cases of AIDS/HIV and HIV seropositive individuals published in 1994 were:

<table>
<thead>
<tr>
<th>Transmission Type</th>
<th>AIDS</th>
<th>HIV Seropositive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual Transmission</td>
<td>91</td>
<td>597</td>
</tr>
<tr>
<td>Homosexual Transmission</td>
<td>88</td>
<td>211</td>
</tr>
<tr>
<td>Drug related Transmission</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Foetal Transmission</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Iatrogenic Transmission</td>
<td>418</td>
<td>1771</td>
</tr>
<tr>
<td>Other</td>
<td>96</td>
<td>373</td>
</tr>
<tr>
<td>Total</td>
<td>700</td>
<td>2965</td>
</tr>
</tbody>
</table>

Source: *Japan Foundation for AIDS Prevention* 1994
Official statistics can function both to mask and foreground marked shifts in the “emergence” of new patterns of transmission. By law in Japan individuals who contract the AIDS virus iatrogenically, must always be listed as a distinct category. They qualify for benefits not available to other HIV seropositive individuals. As of 1993 all hemophiliacs were eligible for a monthly compensation payment of 33,000 Yen regardless of HIV sero-status. Spouses of hemophiliacs who had been infected are also eligible for the same amount of individual compensation. The legal separation of hemophiliacs from other persons who are HIV seropositive confirms an official narrative of passive innocence and active guilt. The distinctive status of hemophiliacs in Japan is a direct government response to extensive and effective lobbying through powerful political constituencies and interest groups who support the status of hemophiliacs as innocent victims of a government failure to develop and implement adequate screening procedures for the national blood supply. The effectiveness of the campaign by hemophiliacs was also dramatically enhanced by an emphasis on the fact that the bulk of the infected blood supply was imported into Japan -- a fact which Japanese officials also used as a central strategy in their own attempts to partially deflect responsibility back onto the United States from which over 90% of the contaminated blood was imported. Both the official defence against claims of negligence and the organized campaigns by hemophiliac groups have been firmly grounded in a rhetoric of guilt and culpability. Within this framework, a hemophiliac who unknowingly received infected blood could not avoid contamination. However, all others are judged as having contracted the virus through high risk activity and/or failure to protect themselves "adequately." Even pediatric AIDS is not granted a similar, separate status. Up until February 1995 there had been 13 cases of pediatric AIDS outside the hemophiliac community. (Japan Times 1 February 1995) While there is no question that these infants were passively exposed to the virus they still appear to be categorized as “guilty” by association within an AIDS discourse grounded in a rhetoric of culpability. This would all seem to reinforce as legitimate the concerns of the members of families of Japanese PWAs that in the present climate, the concept of PWA has been extended to a notional category of "FWA," Families With AIDS.

Japanese government sources and the media are always quick to differentiate Japan from other countries, by pointing out that hemophiliacs represent by far the largest group of persons confirmed as either HIV seropositive or living with AIDS in Japan. However, the figures for hemophiliacs living with AIDS have shown no change over 1993 and 1994, and no new HIV seropositive cases
were reported for the same period. This would seem to indicate a stabilization as a result of new procedures for the stringent screening of both domestic and imported blood supplies. If this stabilization is maintained, as predicted, while the rate of non-hemophiliacs testing HIV seropositive continues to increase, then Japan will face a dramatic shift in the national AIDS profile over the next several years. This shift will require a major transformation of official policy and practice, and significant changes in public awareness and attitudes.

In most Japanese government statistics for HIV seropositivity and confirmed cases of AIDS, the official figure is followed by a second figure in parenthesis. At the bottom of the spreadsheet there is usually an explanation that this second figure represents the number of foreigners included in the total statistics for the listed category. This separate identification of foreigners is officially explained as a reflection of the large numbers of illegal immigrant workers employed in the entertainment and sex industry in Japan. The isolation of foreigners within the statistics will, over the course of this paper, be seen to be more than a question of numbers. Justice Ministry statistics estimate that there are up to 300,000 illegal immigrant workers in Japan today ("Foreigners Overstay Visas Seen Near 300,000" Japan Times 30 August 1993). Feminist labour activists and human rights groups claim that this figure is a gross understatement of the extent of the illegal foreign worker population. Current statistics are however vastly improved over those from the mid-eighties when estimates were based on apprehension statistics. Immigration entry and exit data is now used to establish the number of foreigners entering Japan on all visa types, who outstay the legal period of validation. The makeup of the illegal foreign worker population has changed dramatically over the last decade. In 1986 the Immigration Bureau identified 8,000 foreign workers in Japan (Yamanaka 1993, 83) and two-thirds of these were Fillipina women, the majority of whom were working as prostitutes or hostesses. As explained above this figure of 8,000 is too low but the high percentage of Fillipina women is confirmed by other sources. While the majority of illegal women workers are still employed in the entertainment and sex industry, women now constitute only 36% of the illegal workers in Japan and the largest group among the women are Thais (Japan Times 30 August 1993). Fillipina women are the second largest group but their proportion is falling significantly as arrivals from Korea, Taiwan and China have continued to increase annually since 1992. Thai officials estimated that there were approximately 70,000 Thais working in prostitution in Japan in 1993 ("Arrests Crack Alleged Sex Syndicate" Japan Times 13 August 1993). There are a further 90,000 legal immigrant workers employed in the entertainment and sex industry (Yamanaka 1993, 77) and Thai
women constitute the largest group within this population also. There has been a mistaken tendency in much popular writing outside Japan over the 1990s, in particular in the genre of news magazines, to focus on the Fillipina women working illegally in Japan and to not pay adequate attention to the fact that other nationalities are also present in significant numbers and that the nationality profile of the population of illegal workers (male and female) undergoes major changes regularly.

In 1993 it was widely reported in the Japanese media that the distribution of HIV seropositive cases between Japanese and foreigners was changing and that Japanese were being infected in larger numbers than before. In other words the media was expressing concern that Japanese nationals had become more vulnerable to HIV infection. Some articles did not shy away from suggesting that foreigners were “to blame.” The increase in Japanese infections as a proportion of the total number of confirmed new cases of HIV infection and AIDS is related to an overall decrease of 26% in confirmed HIV seropositive cases: a major shift away from the annual increases of more than 50% in 1990-91 (97-238) and 1991-92 (238-493) (“Eizu Hokoku Sakunen 364 nin” Asahi shimbun 28 January 1994). However, this decrease has to be interpreted in the light of a correspondingly large reduction in the number of foreigners represented in the figures — a fall from 332 in 1992 to 181 in 1993 — despite the continuation of a pattern of annual increase in foreigners working in the sex industry, where the majority of foreigners infected with HIV are employed.4 The media were quick to sensationalize this documented shift as a sign that AIDS was no longer a foreign disease. However, while there are indications that HIV seropositivity has increased among Japanese, the drop in the number of reported confirmed cases among foreigners is most likely to be the result of a decrease in testing of foreign males and females employed in the sex industry. Improved understanding of safe sex methods within the sex industry might partly explain this decrease in official figures. However, there is a far more likely explanation. In the sex industry the processes of documentation and monitoring associated with blood testing have become a mechanism for the extension of the policing of illegal immigrant labour. This “policing" remains largely restricted to HIV positive individuals in the industry, aimed at “protecting” Japanese male clients against “exposure” to HIV positive sex workers. It is commonly reported among sex workers that blood tests are far more actively encouraged, some would argue enforced, among foreign sex workers than among Japanese nationals employed in the same industry. A colleague related to me the story of a young Fillipina woman who was clearly suffering from an infection to a shallow knife wound to her neck which she claimed she got while
cutting vegetables. She refused to go to the doctor for fear of being given a blood test for blood poisoning that would also be automatically screened for HIV/AIDS. She had no symptoms that might indicate she was HIV positive but she was taking no risks for fear of deportation or losing her job. In this context testing functions more as an aggressive process of screening than as a co-operative process of education, prevention and treatment. It is impossible to document the anecdotal evidence of a targeted screening campaign among foreign sex workers due to the unwillingness of officials and doctors to offer information in this area. An immigration crackdown has however been widely reported since 1993 with regular media coverage of co-ordinated nationwide raids leading to groups of up to 3,000 being deported at a time. (“Thousands Deported in Recent Clampdown” Japan Times 4 October 1993. “July Raids Send 2,700 Illegals Home” Japan Times October 9 1994) The wide publicity of these crackdowns can be interpreted at one level as an official attempt to reassure the public that the government is acting to “protect” against any further incursion by the “foreign disease.” The strong perception of the existence of a targeted campaign has led both illegal immigrant workers and their employers to adopt a less co-operative stance towards self-identification of possible symptoms of HIV seropositivity and voluntary testing.

The Japanese figures for new confirmed cases of HIV seropositivity for January and February of 1994 continue the pattern of new confirmations for 1993-94 with the highest total number of new cases occurring among "heterosexuals" (30 including 11 foreigners) (Japan Foundation for AIDS Prevention Statistics 1994). However, the rate of increase among "homosexuals" is far greater as a percentage of the total male homosexual population (16 - including 1 foreigner). There were no new cases confirmed among injecting drug users, hemophiliacs and no new cases of pediatric AIDS. There is, however, a further category of “Other/Uncertain,” which lists 20 new cases (including 16 foreigners) for the same period. This category designates individuals who may fall into more than one of the other categories and therefore a single condition/practice cannot be identified as the site of exposure or the individual offers no information that can facilitate the identification of the conditions of transmission. The insistence on categories based on the identification of originary sites or contexts of exposure is linked to structures of identification used by the two major international bodies involved in the collection and collation of AIDS data and the formation of international AIDS policy: World Health Organization (WHO) and the affiliated but distinctive WHO Global Programme in AIDS (GPA). There will be some further discussion of these categories later.
While the rate of newly confirmed cases is higher as a percentage of the total population of homosexual men than is true for the heterosexual community, the overall rate of increase is also higher. An increase of 26 from 1993 (571) to 1994 (597) in the category of heterosexual transmissions and 12 from 1993 (199) to 1994 (211) in the category of homosexual transmissions translates into a 1994 increase over 1993 of 4.5% in heterosexual and 16.5% increase for homosexual transmissions. (Japan Foundation for AIDS Prevention Statistics 1994). While it is important to remember that the figures for heterosexual cases appear to have been distorted since 1993 due to the downturn in testing and reporting among illegal immigrant sex workers, this does not change the fact that the level of increase in homosexual transmissions is high and that this must have serious on-going implications for the national AIDS profile. Moreover, the decline in testing among illegal immigrants is also assumed to extend to male homosexual and bisexual foreign sex workers, and that this would in turn lead to under-reporting and a downward distortion of figures under both the homosexual transmission and “Others/Uncertain” categories. This latter category includes all individuals who for whatever reasons cannot be simply located in any of the other categories. Men who engage in both heterosexual and homosexual sexual practices and for whom no clear source of infection can be established will be listed under "Others/Uncertain." Even at the present levels of reporting the representation of foreigners in this category is extremely high with 295 of the 373 cases confirmed in 1994 listed as foreigners. (Japan Foundation for AIDS Prevention Statistics 1994).

Another distinctive listing is offered in the annual AIDS statistics in Japan. It is published immediately after the separate category-based figures for newly confirmed cases and accumulative totals per annum. This is a statistical breakdown into three site-of-transmission categories -- domestic, foreign, uncertain -- for the accumulative totals according to gender and age groupings. This data is potentially unreliable, since it assumes that HIV seropositive individuals are able to accurately identify the specific situation in which they contracted the HIV virus or that this information can be tracked effectively. If, for example -- as is common in Japan -- an individual tests HIV positive and has engaged in unprotected sexual intercourse in both foreign and domestic contexts (heterosexual and/or homosexual), it could prove extremely difficult to ascertain the carrier, even with effective official tracking mechanisms. Within the existing statistical data base, while there is a breakdown of those who contracted HIV outside Japan and of those who contracted it domestically, there is no attempt to breakdown the domestic transmissions to indicate who contracted HIV from foreigners and who contracted it from Japanese nationals.
The absence of these distinct categories of foreign and Japanese nationals for cases of transmission within Japan could be interpreted as carrying the implication that domestic exposure to AIDS is assumed to be almost exclusively linked to foreign sex workers. This in turn would assume that the high percentage of foreigners represented in both the homosexual and heterosexual transmission categories reflects the reality and not a failure of the system to accurately identify the real levels of transmission between Japanese nationals. Some Japanese feminists have insisted that the present focus on AIDS education for highschool and tertiary age students and the concentration of screening on foreign sex workers, effectively bypasses adult heterosexuals and homosexuals who are not sex workers and are unknowingly exposed to the risk of contracting the HIV virus through unprotected sex with Japanese spouses and lovers who are themselves involved in unprotected high risk activities. AIDS-related educational and medical materials in Japan consistently list three activities as the main conditions of “high risk”: unprotected sex with a person whose sexual history is unknown or who has multiple sexual partners, shared use of hypodermic needles and vertical transmission (mother/child). (Japan Stop AIDS Fund 1994, 5).

It is widely suspected, but difficult to confirm, that high levels of corruption in the Japanese medical profession may be contributing to a potentially serious problem of non-reporting of HIV seropositivity among Japanese nationals, creating a further distortion in the proportion of foreigners to Japanese represented in the official statistical picture. In addition to extensive exposure of unnecessary surgical procedures and overprescription of drugs, the practice of non-reporting and disguising of certain medical conditions (e.g. STDs) and procedures (e.g. abortion and gender screening of pregnancies) have long been the subject of media scrutiny in Japan. In this medical environment there is considerable potential for doctors, patients and families to take action to conceal sero status, and to disguise AIDS related deaths, purportedly in the interest of protecting the reputation of the family from any association with "risky" sexual practice -- heterosexual or homosexual -- or its categorization within an emerging unofficial identity of Family With Aids. Even more disturbing than the issue of deliberate non-reporting is the closely related issue of non-disclosure of HIV seropositive status to the infected individual. The practice of non-disclosure of terminal illness to a patient, and possibly also the patient's family, is common in Japan. The practice has gained most attention in medical journals, patients rights group publications and the media in relation to non-disclosure of terminal conditions to cancer patients. It is widely argued by doctors that non-disclosure is in the best interests of the patient who is more
likely to respond positively to treatment if unaware of the terminal nature of the condition. Critics of the medical profession however interpret non-disclosure as an example of the tremendous discretionary power of Japanese doctors. Moreover, the practice is also often linked to issues of unnecessary procedures and overbilling in situations where a patient is unaware of the terminal nature of their illness. In a Ministry of Health and Welfare survey of medical institutions dealing with AIDS patients only 43% stated that they always inform patients who are seropositive. (“Jissai wa hokoku no 8.7 bai: Eizu urusu no kansenshasu” Asahi shimbun 28 July 1993) 28% responded that they sometimes inform the patient. (“AIDS Spread Outlined in Poll” Japan Times 10 November 1994) Institutions that admitted to not informing offered two dominant explanations: the patient was a minor and the parents chose for the information to be withheld or the patient him/herself did not want to know. There is no information offered as to how this latter preference is ascertained or if it is assumed on the part of the physician/institution. It is estimated that among the people who have been infected by a spouse who is an HIV positive hemophiliac, in 39% of cases the spouse had not been informed that they themselves were infected and the virus was transmitted unknowingly. (“Spouses Were Not Told About HIV” Japan Times 17 July 1993).

Whether through the corrupt disguising of sero status or doctor-based non-disclosure to patients there is good reason to consider the official AIDS statistics for Japanese nationals unreliable. The Japanese government continues to focus on identifying potential HIV carriers and within Japanese official statistics that category is always implicitly marked as “foreign” whether the site of transmission is assumed to be domestic or overseas. Even as recently as December 1994, a government funded educational publication entitled rather inappropriately Laughing AIDS (AIDS wa warau) described Thailand as the “major AIDS power in the world”.9 This particular publication was withdrawn from circulation after extensive campaigning by the gay community. There would appear to have been little movement in the official framing of AIDS since the 1992 controversy over a Japan Foundation for AIDS Prevention poster that showed a Japanese with a passport shielding his face above the caption “Have a nice trip but be careful of AIDS.” Once the source of “contagion” is marked as non-Japanese (whether internal or external) then the goal becomes the protection of innocent Japanese through a process of the identification and expulsion of “carriers”. The “othering” of contagion represented by this deeply entrenched stereotyping of the HIV carrier as foreign, inhibits the accurate profiling of new transmission trends among both foreigners and Japanese across the range of current official categories of
classification. As Simon Watney, Cindy Patton and others have demonstrated the very categories themselves require extensive interrogation and can be seen to be similarly acting to mask intensely differentiated community and individual experiences of living with AIDS. I will return to this larger issue further on in the paper.

The Ministry of Welfare predicts that the number of Japanese who are HIV seropositive will reach 27,000 by the end of 1997. (Asahi shimbun 28 July 1993). Yet the official figures for 1993 and 1994 are not consistent with this level of increase. The Ministry itself has suggested that the discrepancy may reflect a fall in official reporting and self-identification of symptomatic individuals as well as shortcomings in the screening and educational processes across the fullrange of potential “risk groups”. As early as July 1993 the Ministry had stated publicly its concern that actual levels of HIV infection in Japan could be as much as 8.7 times higher than reporting suggests (Asahi shimbun 28 July 1993). The implications of such high levels of underreporting are obviously significant for the successful development and implementation of policies and programs for both the prevention and treatment of AIDS.

THE STORY IN BLACK AND WHITE

In the months leading up to the 10th International Conference on AIDS in Yokohama, the Asahi shimbun ran two serialized human interest columns related to AIDS issues. The first column, ran daily from 13 - 20 March, and was entitled, “The Battle Against AIDS.” (Asahi shimbun 1994) The opening article of the series ended with the lines:

The AIDS virus was discovered in the United States in the early 1980s and since then has spread across the entire world. This summer, the first international conference on AIDS to be hosted in Asia will take place in Yokohama. The number of HIV seropositive individuals in the U.S. now exceeds 1,000,000; and the number of persons with AIDS is estimated at 340,000. We will be reporting from the U.S. on the battle between individual people and this deadly illness. (13 March 1994)

Each of the eight days coverage featured a particular individual or group either afflicted with AIDS or involved in AIDS related work: toddlers at the New York Hillhouse Centre suffering from pediatric AIDS, New York female sex workers, a New York based Japanese epidemiologist and a Japanese gay10 male living in San Fransisco (these two featured in the same column), a female doctor and her husband whom she met as a patient with AIDS, a heterosexual 21 year-old
New York woman with advanced AIDS who was exposed to the virus as a result of unprotected sex, two gay men in San Fransisco who tested HIV seropositive over ten years ago but who are described as “AIDS-free”, a San Fransisco gay man who died from AIDS related complications before publication of the column and who had established a Zen AIDS hospice, and a middle-aged Dominican woman who emigrated to New York not knowing she had been infected by her male lover.

Each of the articles depicts the AIDS epidemic in the United States in stark terms with a strong emphasis on the vulnerability of all groups of the population but there is little or no information on the specific conditions under which any one of the individuals contracted the virus. The individuals documented are differentiated at the level of biographical detail but beyond this the only information offered is a distinction between homosexual, heterosexual and vertical transmission (mother to child). The absence of detail beyond this denies the diversity and complexity of conditions of transmission and obscures the potential to develop and practice alternative strategies for safe sex. No detail is offered regarding the individual from whom the virus was contracted i.e. was the Dominican woman’s lover a bisexual male, a hypodermic drug user, a hemophiliac who received tainted blood etc. These details are not necessary within a framework of culpability. With the exception of the Hillhouse toddlers, sexually “promiscuous” behaviour - non-heterosexual, extra-marital, premarital and homosexual sex - were represented as the “cause” of infection. AIDS was generally presented as a product of “lifestyle”. That is to say, an infected individual is assumed to have engaged in “high risk” activities and the burden of responsibility is laid, unproblematically, at the door of the individual. The hope for the children at the Hillhouse Centre is identified as the protected life of that environment and access to alternative “lifestyle” opportunities through institutional intervention in their futures. Although the portrayals were sympathetic at the level of the suffering and courage of each of the individuals depicted, there was a definite tendency to allocate responsibility to the HIV seropositive individual and there was no attempt to explore notions of “risk,” safe practices or the socio-economic factors surrounding what are presented as “lifestyle choices”. While in the mid-1990s we are now aware of the risks and pitfalls associated with the resort to categories of risk, the strategy of levelling or disappearing differences in patterns of exposure and transmission in much AIDS-related material in Japan frequently has the effect of blurring or obscuring the specificities of different communities and the permeability of community/identity boundaries. In the “Battle Against AIDS” series everyone is identified as “at risk” and it is individual action - “choice” -- that activates (or
not) that risk. In these articles notions such as risk, choice, responsibility and lifestyle are mobilized within an intensely moralizing framework.

The implicit underlying notions of “lifestyle” and “choice” were most problematic in the context of descriptions of the lives of gay homosexual men and sex workers. Any possible politicization of the discussion of sexual practices or gay identity was avoided, except in the case of AIDS activism which was presented in the same light as any other community-based action e.g. for multiple sclerosis, cancer, alcohol and drug addiction etc. The term “coming out” occurs in various contexts but always in reference to self-identification as HIV seropositive, and is used for non-gays as well. In this manner AIDS is displaced from a radical politics of sexuality to become just one more deadly disease and source of tragic, human interest stories. However the author is careful to distinguish AIDS from other terminal conditions by constantly, if only implicitly, insisting that AIDS can be “avoided” through “appropriate” behaviour (except in the case of hemophiliacs). With this implicit assertion, despite itself, the series “Battle Against AIDS” repeatedly collapses back into a politics of sexuality - but it is a distinctly conservative politics.

In each of the eight stories in the “Battle Against AIDS” series the individuals were named and clear portrait photographs accompanied the articles. At some level, all but one of the articles also described highly developed levels of community support for PWAs and widespread and well organized activism on AIDS-related issues in North America. The exception was the column that featured the story of a young gay Japanese PWA living in San Fransisco and a Japanese epidemiologist who migrates between Japan and Columbia University. This article provides the link between the U.S. based “Battle Against AIDS” series and the later Japan-based series “The Age of AIDS.” (12-17 July 1994) The Japanese epidemiologist, Dr. Inada, explains that one of his primary goals in undertaking research in the United States is to create opportunities for other Japanese doctors to come to that country to gain a better understanding of AIDS, and to encourage a less prejudiced and more informed approach to the treatment of people with HIV/AIDS in Japan. The concerns he expresses regarding the present level of available care in Japan and attitudes within the Japanese medical profession are quite consistent with media coverage of high levels of reticence and anxiety among doctors and hospital administrators and earlier references here to the practice of non-disclosure. Inada’s experience of treatment facilities and procedures in the United States has convinced him that while there is still evidence of some level of resistance and fear among medical workers in U.S. facilities that this is minimal when compared to the Japanese
environment of AIDS care. The only explanation Inada offers for the extent of 
this difference in attitude is the better educational and information programs in 
the United States. He does not make reference to the central role of gay 
activists in the creation of a more open and supportive institutional and 
community base for AIDS care. Inada has developed a project to host the visits 
of Japanese doctors to American AIDS-related facilities in the belief that they 
may learn enough from the contrasts they see to encourage reform within the 
Japanese medical profession.

Inada’s story is strategically framed by a brief introductory description of a 
young unidentified Japanese man living in the San Francisico gay community. 
The man is HIV seropositive but while publicly active in AIDS support groups in 
San Fransisco he states that his saddest moments are when he remembers 
that he will never be able to return to Japan. His family does not know of his gay 
identity and he believes that he will never be able to tell them even though he 
assumes that this will mean dying in the U.S. without seeing them again. At the 
end of the column there is a brief description of a young third-generation 
Japanese-American gay man, Suki Terada-Potts, who has developed a support 
network for Japanese gay men in just this situation because, “The majority of 
Japanese AIDS sufferers in the U.S. die a solitary death without ever letting 
their families know of their illness, and asking that their families not even be 
notified of their dying.” (14 March 1994) The significance of this last comment is 
far greater when placed in the context of Japanese society where the majority 
of families still maintain a small shrine in the home for the family dead and give 
offerings and perform or commission prayers for the dead for important religious 
and secular ceremonies. The practice of returning the ashes of overseas 
Japanese to Japan for family interment is still strong in some communities, at 
least for first generation immigrants. The final lines of the article assume a self-
consciously poetic tone as they describe how thoughts of condemnation of their 
homeland must well up in the final emotions of the Japanese AIDS sufferers as 
they lie on their deathbed in this foreign place. The Inada column points an 
accusatory finger at a Japan which is believed by its own expatriate PWAs to be 
so unsympathetic and nonreceptive that they choose to die alone in a foreign 
land where they can at least anticipate the comfort and care of community, and 
informed medical support. There is a further jibe in the fact that it is a third-
generation Japanese who is depicted as showing compassion for the young 
Japanese gay in San Fransisco. The article implies that if someone separated 
from his Japanese heritage by three generations can feel so much compassion 
for these young men then why not their own immediate kin in Japan.
The second series of Japan-based articles published four months later reflect exactly these same sentiments, in a strange mix of self-reflexivity and critical oblivion. Two of the pieces identify by name the individual being profiled - the first piece constitutes a self-introduction by the author of the series, a Japanese gay AIDS activist in his twenties, and the fifth piece which profiles a gay American who is a long term resident of Japan. The other profiles are all anonymous: a male hemophiliac who is a businessman and contracted AIDS through blood transfusion, a heterosexual male who had unprotected sex during a one night stand, and a hemophiliac heterosexual whose wife gave birth, after an unplanned pregnancy, two years after he was confirmed as HIV seropositive.

The last three are all Japanese nationals. Each of the stories is disturbing for its silences, none more so than the last story of the birth of the baby. While the story exudes optimism and hope focused on the new life of the infant there is no reference to whether or not the baby or its mother were also HIV seropositive. There is only one brief comment to the effect that some people may think that they were involved in risky activity. The implication is that the wife was not infected at the time they had unprotected intercourse. The question remains unanswered as to whether or not he or his doctor had informed his wife that he was HIV positive at the time they were having unprotected sex. The article on the single male hemophiliac ends a long account of his struggle to come to terms with his HIV seropositivity and to finally tell his family. Again in this series, "coming out" is used to describe public self-identification as HIV seropositive regardless of sexual orientation. The last lines of the article describe how all he wants to do now is to marry and hold his own child in his arms. While with the current reproductive technologies available in Japan this is not an impossible goal, with minimum risk of transmission to the infant and mother (usual rates of vertical transmission are about 30% elsewhere), there is no discussion of the complex and expensive procedures this entails despite the fact that much of the article has described the serious lack of understanding of HIV/AIDS and related medical treatments and procedures within Japanese society. In Japan where hemophiliacs constituted the major activist group during the first years after AIDS was identified in the country medical researchers focused much of their initial energy and resources on the development of hi-tech procedures to deal with the concerns of this specific community, including the desire to reduce the risk of vertical HIV transmission. Ironically, at the same time that researchers were experimenting with alternative fertilization and foetal screening methods for use in this community a
considerable number of medical practitioners simply failed to inform HIV positive hemophiliacs and/or their spouses of their sero status.

The three articles in the "Age of AIDS" series do not name the individual(s) profiled and are careful not to offer enough biographical or medical case history to disclose identity. Each of these articles features a photograph but none of the shots are a close-up of the individual: a photo of an adult hand holding the fingers of a newborn, a back profile of a young man looking out across a pond, a close-up frame of an office desktop. The stories of the young gay author of the series and the American gay man, in contrast, feature a close-up portrait shot. Each of these stories follows the pattern of the earlier "Battle Against AIDS" series, with a strong focus on the importance of the development of a shared community. However, they differ in emphasis with the earlier series in their identification of the family as a central element in the development of a network of support. The American interviewed, never clearly identified as gay, describes the Japanese situation in the following terms:

Compared with ten years ago when I first arrived in Japan, information about AIDS is now more readily available. However, the general reception is still largely unchanged. Just last Autumn I was shocked to read an article about a Japanese hotel that refused lodgings to a group of PWAs. People are afraid of an illness that has no "face." In February of this year a young woman who lost her husband to AIDS came to me for advice. She was also HIV seropositive, "I want to return home to my family but if I do there will be gossip and my family will have to sell their house and move. What should I do?" I told her that she should go home and that everything would be okay. I assured her that her family would help her. She didn't believe me and replied, "You can say that because you are a foreigner." (17 July 1994)

The American goes on to state that it would be foolish for Japan to wait until the incidence of HIV reaches the same levels as the U.S. before taking action to create change in the social conscience. The interview makes a smooth transition from family conscience to social conscience.

The self-portrait of the author of the series opens with the description of his sister's sympathetic response to the news of his diagnosis and his older brother's far less generous response,

"You brought this on yourself so you should deal with it yourself. Don't cause difficulties for the family." (12 July 1994)
Towards the end of the article he relates his relief that even his brother wished
him well at their last family gathering. He concludes with the prefacing of the
other profiles he will present in the series:

"We should speak our own experience as PWAs whether to family or
friends or through the media. It is called "Coming Out" and it is a new
movement to remove the discrimination and prejudice associated with
AIDS." (12 July 1994)

The author had been an active member of gay activist and AIDS support groups
even before his own diagnosis but it is the family that is the focus of the opening
and ending of this self portrait rather than the community that had been so
central to his life as a gay man and a PWA in contemporary Japan. Each of the
articles in this Asahi shimbun series emphasises the need for reconciliation with
family and the importance of family support for PWAs. In some cases the focus
shifts to the desire of PWAs to create a family of their own. The family
described as the source of comfort and support is always the heterosexual
normative household. The "Age of AIDS" series appeals to its Japanese
readership to reject the fear of being associated with AIDS and calls on families
to embrace the role of Family With AIDS not as a marginalizing or negative
category of exclusion but as a positive identity. The fundamental underpinning
of the "Age of AIDS" series is a strategy of "Coming Home" rather than "Coming
Out."

THE STORY IN EDUCATION

In 1993 the Japan Education Foundation produced a video in their Home Room
Series entitled, AIDS: What Is Really So Frightening?, (Japan Education Centre
and TAO Communications, Tokyo, 1993) for classroom use in high schools.
The project focused on AIDS awareness activities at the International Christian
University High School. As the video voice-over states, this school was selected
because of its reputation for an internationally diverse student body. The
classroom AIDS workshop, in which most of the footage is filmed, is structured
around brief information sessions presented by teachers and AIDS researchers,
followed by open question periods. Both the high proportion of female to male
students and the diverse racial and ethnic backgrounds of the student body
combine to make this a quite atypical classroom environment in the Japanese
context. While generational difference may also account for some of the marked
difference between attitudes towards AIDS expressed in larger public surveys
and the views of these students, the internationally mixed environment among
students and faculty at I.C.U. and its affiliate high school may also explain a more open climate of nondiscrimination. None of the students in the workshop considered any need to adjust daily interaction and practices should a fellow student be diagnosed as HIV seropositive. Exposure to blood in case of an accident was the only contact issue discussed as a potential area for modification of past behaviour. These responses are significantly different from those found in an Asahi shimbun survey of 21 October 1993 which indicated that 70% of those questioned would not change their daily interaction, 20% would modify their interaction and 10% would cease all contact with a fellow worker who was identified as HIV seropositive. A broader Ministry of Welfare survey of public opinion, also in 1993, suggests that the level of behavioural modification may be even higher, given the lack of basic AIDS-related knowledge demonstrated by respondents. Forty-one percent believed that entering the same bath or using the same toilet could lead to infection; 45% identified drinking from the same cup as a risk behaviour; 62% believed that they could contract AIDS from a mosquito bite. (What is AIDS, Ministry of Welfare Japan Foundation for AIDS Prevention, Tokyo, 1993, 1) If nothing else, the Ministry survey underlined the need for enhanced public education programs. It was in the same year as these surveys that the government allocated a total of 10.3 billion Yen (Far Eastern Economic Review 7 January 1993) to the three areas of AIDS education, surveillance and treatment. The Japanese Education Foundation video and classroom teaching kits for high school use are consistent with the designation of high school students as a key target group of AIDS education resources.

The video is 30 minutes long. In that time the Japanese word homo (male homosexual) is heard only once when a student is asked what he would feel personally if he was diagnosed as HIV seropositive: “There wouldn’t be much I could do about it if I’d ended up becoming a homosexual.” The implication is that in the mind of this young student AIDS is a homosexual disease. It is also worth noting his assumption that one “becomes” a homosexual. The only other reference to homosexuality is a brief sighting of the term doosei, a more traditional term meaning literally “same sex love,” 13 written on a blackboard, but the camera focuses on the blackboard as the characters are being erased. This video is almost exclusively about heterosexually transmitted AIDS in Japan. The fact that the student comment was left in the video raises concern that its inclusion might be intended to reinforce a notion that AIDS among gay men is uncontrollable (“there wouldn’t be much I could do about it”) while heterosexual AIDS is avoidable. Anti-homosexual content in official AIDS
publications is not without precedent. The controversial brochure *Laughing AIDS*, outraged Japanese gays with its statement that Japanese should avoid travelling to Germany because it has been infested with homosexuals since ancient times. (*Far Eastern Economic Review* 7 January 1993) The fact that *doosei* was clearly a topic of discussion within the workshop but edited out of the material for school distribution raises worrying issues of discriminatory censorship and the misrepresentation of the changing national AIDS profile. The target audience of the Home Room Video is not the atypical I.C.U. classroom of students but classrooms across rural and urban Japan where the understanding and willingness to discuss homosexuality and/or AIDS is likely to be far lower and levels of ignorance or prejudice potentially far higher.

In an early scene in the video, a teacher asks if it is possible to contract AIDS from one act of unprotected sexual intercourse. The students respond correctly that it is not 100% certain. The teacher agrees but then turns to one of the foreign students and asks her to recount a story she had heard of a young foreigner who contracted AIDS in this way. Both Hong Kong and the U.S. are mentioned in the scenario that follows. The students are also asked if they have ever seen a condom. The teacher does not give any demonstration of condom fitting but goes on to assert that a condom should be worn “from the very beginning”. This part of the video resonates with a passage in the “Battle Against AIDS” article dealing with the 21 year-old woman who was infected during unprotected sex as a teenager. She stated succinctly that she had been taught how to get condoms and even fit them but no-one had taught her how to ask a guy to wear one or get him to agree. This is an important distinction and one I will return to in the discussion of marriage, contraception and HIV transmission. The Home Room video fails to offer advice in this area. In the absence of any discussion of sexual practices (homosexual or heterosexual) that might not focus on vaginal penetration alone (“from the very beginning” -- penetration -- to the end -- ejaculation) there is little scope to expand notions of safe sex beyond condom use. It is also interesting to observe that the teacher’s non-verbal gestures and eye contact direct these remarks on condom use specifically to the female, rather than the male, students in the classroom. The weight of responsibility falls on women to protect themselves.

The final segment of the video records a meeting at a neighbourhood youth information centre between young teenage students and Hirata Yutaka. In October of 1992 Hirata became the first Japanese to publicly identify as having been infected through sexual intercourse rather than contaminated blood. Even
as late as mid-1993 he was one of only three non-hemophiliacs in all of Japan to speak openly in public forums about their personal experience of AIDS. Hirata’s 1992 public statement was followed by his nationwide campaign for AIDS education and the establishment of regional AIDS hospices. In his on-video exchange with the students Hirata emphasized the importance of reducing ignorance and fear. He asked a student what she would do if her lover was diagnosed with AIDS. “If we were really in love and still wanted to have sex...?” she asks. “Yes, and that person you love is diagnosed as HIV seropositive... what would you do?” She couldn’t respond. Hirata stepped into the silence his question had created and explained that it was ignorance and uncertainty that led to fear and it was fear that left so many PWAs battling their illness alone. Despite the strong impact on the students of Hirata’s words the video does not include any details of safe sex methods or alternative sexual practices to intercourse. In his exchanges with the students he actively avoids gendering the words lover and person through gender specific pronouns or inflections. His tactic is intentionally to keep open the possibility of both homosexual and heterosexual love and sexual relations in his discussions with the students. Nowhere in the video, nor in the newspaper eulogies that followed his death in January 1994, is it clearly stated whether or not Hirata himself was gay. The strategy in the video is to consistently retrieve any ambiguity within a normative heterosexual model. There is a genuine effort in the video to present a realistic picture that recognizes that an increasing majority of young Japanese engage in heterosexual relationships prior to marriage. However, the video in no way addresses the issue of unprotected sex (either marital or extra-marital) after marriage or the possibility that some of the young students who will watch this video are gay or may engage in both homosexual and heterosexual sexual practice during their lives. One student makes a comment back in the classroom situation that performs a smooth appropriation of the empowering strategy of the identity of the community of PWAs. The student speaking as a non-PWA comments that the real issue is not how “we” live with AIDS (tomo ni ikite iku) but how we give life (ikite ageru) to PWAs for the remainder of the time they have to live. In this slippage from the history of PWA as a designation for those who have AIDS to this use of the term to describe those who live with those who have AIDS, the video AIDS: What Is Really So Frightening? seems to begin to answer its own question. The video goes to great lengths to silence or erase any evidence of sexual identity or practice that falls outside very limited parameters of “appropriate” heterosexual behaviour for young Japanese.
LAUGHING AIDS?

The Japan Foundation for AIDS Prevention and the Ministry of Welfare prepare a range of adult educational materials for wide public distribution. The brochures are mailed out in response to a phone or mail request for information and they are also distributed through various clinics, hospitals and counselling services offering AIDS-related services. The very name “Japan Foundation for AIDS Prevention” resonates with the emphasis of the Home Room video. Protection and prevention seem to be used synonymously in these adult educational materials. The question “What is really so frightening?” begs the question “Who is frightened of what?” and in turn “What or who specifically is protected through the strategies of prevention?” The adult education materials leave no doubt that at the heart of the matter is the healthy-heterosexual-family. Three of the more widely distributed brochures for adult AIDS education are entitled: What You Need To Know About AIDS: Basic Knowledge for Protection and Co-Existence (Legal Foundation for AIDS Prevention, Tokyo, 1994), What Is AIDS: Correct Knowledge and Practice Will Protect You (Ministry for Welfare and the Japan Foundation for AIDS Prevention, Tokyo, 1993) and The AIDS Reader (Ministry of Welfare and Japan Foundation for AIDS Prevention, Tokyo, 1993). The front covers of the first and the last of these sport an image of a happy and loving heterosexual couple holding hands. What is AIDS features a more science oriented cover with a “through the microscope view” rendering visible the invisible. All three cover images show the design influence of the extremely popular graphic style of Japanese comic books (manga). The aim of the style of presentation is clearly to capture as broad a readership as possible by utilizing the familiar design and graphics of the most widely read printed medium of popular culture, the manga. The only non-manga images in the three brochures are occasional maps of the global distribution of AIDS, photographs of healthy and unhealthy cells, statistical graphs, and lists of AIDS information contact numbers.

It is worth a closer look at the manga-esque images that illustrate every page of these brochures. The choice of the manga style is easily open to misunderstanding outside Japan. In a country where the most popular bi-weekly and monthly manga sell two to three million copies per edition and where leading manga artists have the status of media stars, the decision to use the graphic style of the comic books in AIDS related materials is not at all unlike the logic behind U.S. and European AIDS awareness and education campaigns that employ high profile figures from the world of entertainment and sport as spokespersons. In Japan, the prevailing reluctance to be publicly associated
with AIDS has reduced the viability of this as a serious option. The use of one of the most popular forms of contemporary consumer culture as a medium for communicating AIDS-related information amounts to the same basic strategy. Although today the *manga* are at the centre of an on-going public debate over censorship and pornography laws the fact remains that since the mid-sixties *manga* have been the key cultural site for the testing and stretching of strong taboos and legal restrictions that have limited the open discussion or imaging of sexual practices. The body, sexuality and desire are not easily spoken into public discourses in Japan. The cultural territory of the *manga* offers a rare space for the uncomplicated and unapologetic presentation of images and content that might be distorted or diffused by the more familiar forms of official communications.

To anyone unfamiliar with the *manga* market the comic book graphics may seem an inappropriate form for the circulation of AIDS materials. However, this is far from true. The gay community called for the withdrawal of the controversial *manga*-esque *Laughing AIDS* brochure not because of any objection to the format but because of the offensive title, and anti-gay and racist content. Gays, lesbians, feminists, A-bomb survivors, environmentalists, conservative politicians, right-wing promilitarist groups, the Ministry of Education and new religious sects are just a few of the bodies that have selected *manga* as a medium for communicating their messages to the public in a popular and accessible form. The *manga* themselves are often far too serious in content to fit the implications of humour implied by the English translation of “comic book.” For example, one of the best selling *manga* following the death of Emperor Showa in 1989 was a singularly unhumorous rewriting of the life of the emperor as a peace loving man more interested in the natural sciences than in the issues of government, an innocent man caught up in the tide of history. Nakasone Yasuhiro, published a similarly chilling retelling of history in a *manga* version of his political career published after his term as Prime Minister in an apparent attempt to regain popular support. Conservative Diet members resorted to the *manga* form when attempting to explain their proposal for constitutional reforms to allow for increased military spending and the dispatch of Japanese S.D.F. troops under the U.N. banner. There are many *manga* on the market that are extremely comical, however, it would be a mistake to think that the use of *manga* graphics implies a lack of seriousness or undermines the legitimacy of the information conveyed. In the context of AIDS-related publications it is more accurate to identify the *manga* style as familiar, accessible and non-alienating.
Another potential misunderstanding relates to the highly stylized and apparently western appearance of so many *manga* characters. Since the first boom in teenage *manga* in the sixties the imaging of characters, male and female, has involved a complex and highly inflected movement across a range of physical and racial characteristics or marks of identity that have emerged into a virtual repertoire of personality codings. Readers of the *manga* are extremely fluent in interpreting these codes as an extra level of textual depth. Shape of eyes, skin tone, hairstyle, type of shoes, fit and style of clothes, shape of hands, type of moustache, length of eye lashes, shape of smile combine as in a police identikit to disclose character and personality as the reader’s eye scans the narrative off the visual mix of text, image and white space on the page. Between three and five seconds is the average “read” per page.\(^\text{16}\)

What is always commented on by non-Japanese readers is the very western -- or more accurately non-Japanese -- appearance of so many of the faces that populate the pages of the *manga*. Japanese readers will generally state that they do not react to these large round eyes, high cheekbones, and other “western” facial features as anything but Japanese. One Japanese cultural critic once asked me why Americans were so perplexed by what they saw as western style features of the *manga* characters. She commented that any Japanese who questioned why Batman and Phantom comic book characters aren’t a realistic representation of Americans would be considered very naive.\(^\text{17}\) The presence of a large number of advertisements for plastic surgery, slimming techniques, body building etc in the pages of so many of the adult genres of *manga* for men and women suggests that the notion of beauty and the role of racial and other differentiating characteristics in the construction of identity in the *manga* do warrant closer attention.\(^\text{18}\) I discuss the tension of the meanings read in and out of this “non-Japanese” Japanese body of the *manga* in more detail elsewhere, but it is important to emphasize here that the interpretation of this representational practice as no more than the substitution of western figures for Japanese is too simple and misreads the multiple layerings of interpretation and displacement through which a Japanese reader articulates an identification with these images as Self and not Other.

A typical example of the potential for misinterpretation occurs in one critic’s description of the content of a Japanese AIDS education poster: “the dress and coiffure are clearly western, reinforced by the coffee bar and french bread.” (P. Hill, 1994:16) **Plate 2** The inevitable question is what would this commentator consider “Japanese?” if not smart stylish dress and modern and sophisticated consumer habits? The designation of french bread and coffee as
western and reinforcing the foreign influences associated with AIDS makes as much sense as suggesting that a French AIDS education poster showing a youth in their jeans indicates the foreignness of AIDS in that country. Notions of ownership or origin of the objects of everyday life cannot be applied so unproblematically in the global cultural economy in which Japan is a high end user and producer. It is crucial to interpret images of Japanese contemporary AIDS education materials in the context of their production and circulation and not to read these images through the lens of a lingering othering of Japanese identity. The style of dress in the poster is consistent with specific codes of dress popular in the romantic and "soft pom" genres of manga for older teenage girls and young married women. In combination with this very particular graphic style the grammatical inflection of the caption identifies the primary target group for this poster as female, heterosexual and falling somewhere between senior highschool and pre- to early motherhood. What is interpreted as alien by a critic apparently unfamiliar with the stylistics of the popular genre of Reedeexu Komikku (Ladies Comics) has been selected specifically for its non-alienating potential to trigger familiar mechanisms of identification.

Certain patterns are repeated across all three of the manga based AIDS education publications listed above. For instance, the person represented as worried about possible symptoms, anxious after unprotected sex, undergoing a blood test or receiving medical treatment is always a male homosexual. Plate 3 The notable exception is the image of a pregnant woman. Two of the brochures include such an image, together with some description of the risks of vertical transmission. One of the images leaves no doubt as to the general attitude towards in-vitro transmission promoted in much adult AIDS education. An HIV-seropositive infant points accusingly at the mother and the bubble-caption over the infant's head reads simply "You." Plate 4 Sweat forms into exclamation marks over the mother's head. This uncomplicated attribution of full responsibility and guilt to the mother is consistent with the tone of Japanese media coverage of stories relating to "AIDS babies" in the United States over the 1993-94 period. Within the three brochures there is not one image of a male that offers any indication of a gay identity. The heterogeneously heterosexual context of the imaging and packaging of this AIDS information is so complete that it would be essential to offer some "mark" of difference if any of the male figures were intended to be identified as gay. Visual codification of gay identity in the manga style is well established and easily recognized. The specular coding of sexual identity of the male characters that inhabit the pages of these brochures is unambiguously heterosexual. While there is discussion and imaging of the various activities that are described as constituting a "high risk"
of transmission such as unprotected sex with someone whose sexual history is not known, sharing of syringes, pregnancy when HIV seropositive, direct contact with blood of an HIV seropositive individual etc, any overt reference to gay male sexual practices is avoided. Each of the brochures mentions body fluids as a potential source of contamination and the *What is AIDS?* brochure lists anal sex together with intercourse without a condom and shared use of sex aids (vibrators etc.) as high risk activities. However, only one of the brochures, uses the word homosexual, and that is in the context of a brief response to the question "Isn't AIDS a homosexual disease?":

Of course this is wrong. Anyone can contract AIDS. Because it was initially limited to male homosexuals a misconception spread across the world that this was "a disease that only certain people can contract" and this led to discrimination and prejudice towards individuals with AIDS. *What You Need to Know About AIDS* (12)

The question and answer reinforce the fact that in this brochure AIDS is being treated as a heterosexual issue. In the process of clarifying that AIDS is not a homosexual disease the statement also appears to reinforce a negative and deviant marking of male gay identity by uncritically linking discrimination towards PWAs with an association of the disease with gay men. It criticizes the negative marking of AIDS while apparently accepting and participating in the negative marking of gay men. While it is true that other focused materials are prepared and circulated within gay communities (much of this material is produced not by government agencies but AIDS action groups), it remains worrying that gay men who have AIDS or are HIV seropositive are disappeared out of key educational instruments of the two major AIDS education and prevention organizations in Japan. This is particularly disturbing given that statistical indications of significant increases in the cases of HIV-seropositivity and AIDS among gay men were already evident in 1993 and 1994 when these brochures were in production. Even if the brochures have been designed specifically for a heterosexual target readership, the absence of any reference to AIDS in the context of male homosexuality suggests that the boundaries between homosexual and heterosexual identities are clearly drawn and not crossed. This would imply, for example, that there is no sexual contact between female heterosexuals and men (who may or may not self-identify as gay) who have sexual relations with male homosexuals, an assumption that is not supported even by the official statistics. I return to this towards the end of the paper.
Another obvious absence in the brochures is a lack of any reference to hemophiliacs or the transmission of AIDS through infected blood products. This is consistent with the Japanese government agreement with lobby groups representing hemophiliacs afflicted with AIDS that they will be treated under a separate legal status to all other PWAs in Japan. The problem this separate status creates in the context of educational materials is the risk that, in the interests of recognizing the specificity of the history of transmission in the hemophiliac community and protecting the rights of HIV-seropositive hemophiliacs, there is a restriction placed on the open flow of information to the general public about what was, until recently, the largest group of HIV-seropositive individuals in Japan. There is an implicit message in this absence of references to hemophiliacs in general AIDS prevention educational materials that goes beyond the separate legal status of these individuals. Put simply, it is that the "risk of contagion" is identified as located elsewhere, without. When the brochures attempt to identify high risk sites of transmission these usually fall into one of two clear categories: (i) exposure of Japanese to non-Japanese "carriers" (ii) transmission through objects and practices of everyday life e.g. sharing towels, toothbrushes, razor blades, and syringes, and unprotected intercourse. The images in the brochures position these two categories as what is best described as primary and secondary sites of exposure. Within this framework the point of "origin" of AIDS -- what is represented as the primary level of exposure that must be protected against --is always located "outside" or on/in bodies that cross from "outside" to "inside" Japan. Hemophiliacs could be located within this construction of a narrative of Japanese AIDS on the basis that the contaminated blood supply was predominantly imported from the United States however activists within the community have resisted this framing of their history in order to avoid a disclaimer of responsibility by the Japanese government.

Japanese who are represented in the educational materials as having been "infected" are most frequently shown as having participated in "high risk" activity in association with a non-Japanese "carrier." That person is then themselves represented as a potential site of secondary exposure for other Japanese with whom they come into contact in daily life and share the use of everyday objects. In one illustration a Japanese man and woman sit under a palm tree on an island surrounded by the mounting statistics for confirmed cases of HIV seropositivity in Japan. Plate 5 The image can be interpreted as either island-Japan at risk or the risks of venturing abroad to tropical paradises only to bring AIDS back to Japan. Either way the message of "inside" and "outside" is explicit. In the brochure The AIDS Reader, the first page is a full-
page manga image of a medical laboratory with a man looking into a microscope and taking notes. The reader turns to the next double-page to find a second full page-image of an airport scene with four young Japanese, two men and two women, sitting on their suitcases (marked with U.S. tourist stickers) reading a guidebook for Hawaii while they wait for their flight. The caption reads, "Recently AIDS has been spreading in Asia." Plate 6 The image appears on the left hand page. On the right hand page are two graphs based on WHO statistics: the rate of increase of HIV infection and AIDS in Japan from 1989 - 1992, together with a prefectural breakdown of the distribution of HIV, below these figures is a map of the world showing selected regional statistics. The lower image/graph shows a statistic of 1,500 confirmed AIDS cases on the Chinese mainland and 25 on the Korean peninsula, but there is no indication which regions these two figures represent in total or whether Japan is included at all. In combination, the map of global AIDS statistics and the cartoon image of Japanese tourists visually reinforce the message that the "problem" lies elsewhere, and that the Japanese statistics represent the arrival of something foreign that is carried in from the outside.

Articles that appeared in the Asahi shimbun in July and early August of 1994, during the lead-up to the International Conference on AIDS reinforce a similar notion of AIDS arriving in an innocent or passive Japan that exists outside a newly emerging Asian AIDS epidemic. This particular Japanese conceptualization of AIDS replicates WHO/GPA models for the patterning of the AIDS epidemic. The earlier WHO model was based on a geographic clustering of countries into six regions: Pan-America, Europe & U.K., Western Pacific, Southeast Asia, Sub-saharan Africa and Eastern Mediterranea). In response to widespread criticism of the original WHO model the WHO Global Programme in AIDS developed a different clustering based on the notion of the temporal "emergence" of densities of AIDS of differing "origins" - where origins are defined not only by geographic space but also specific forms of transmission and a notion of an epidemiological timeline. Again this model has met with extensive criticism but it continues to have a significant impact on the conceptualization of AIDS in much public discourse, both official and popular. It is this model which offers a legitimization of the dominant narrativization of AIDS in Japan. The WHO/GPA model describes three "patterns." Pattern One is called simply AIDS and this describes the transmission category of male homosexual intercourse and is most closely associated with North America. Pattern Two is African AIDS and describes heterosexual transmission. Pattern Three describes Asia "where AIDS arrived late." The criteria in the case of Asia is not a dominant transmission pattern but a temporal categorization grounded
in an initial state of absence. As the predictions for the rate of increase of HIV seropositivity rates across Asia continue to rise, the significance of the historical lateness of the "arrival" of AIDS is rapidly being displaced by the magnitude of the problem facing the governments of Asia.

Critics of the WHO/GPA Patterns argue that the notion of the "lateness" of the Asian AIDS "pattern" conveniently fed into both international and local strategies of inaction. Instead of being treated as a major opportunity for the development of preventive pre-emptive strategies, official non-action effectively promoted the conditions for the rapid spread of infection through specific communities, in particular injecting drug users, prostitutes and gay men. Japan's own self-representation in relation to regional and international discourses of "Asian AIDS" has remained firmly grounded in the same assumptions of epidemiological progression as the WHO/GPA model -- even as the enormity of the AIDS epidemic in Asia has rendered that model historically redundant. Japan continues to insist on framing itself out of the picture, a last frontier on the margin of Asia. An 7 August 1994 Asahi shimbun article entitled "How AIDS is Transmitted" shows a map tracking the global transmission of AIDS. Plate 7 It depicts three distinctive strains of the AIDS virus "arriving" in Japan - two strains from Thailand and one from North America and Australia. In this map AIDS is always represented as moving unilaterally. Simple black lines with an arrow at the end mark a progression into Japan from an external point of origin. Multilateral movements of bodies (Japanese and non-Japanese) along complex and extensive networks of power and influence are reduced to simple unilateral black lines. Similarly, in an article entitled, "AIDS Threatens Asia" the subtitle "Country by Country Fact Report" (Asahi shimbun 15 July 1994) leads the reader to a series of mini-features on Thailand, the Phillipines, Singapore, India and Korea. In what is almost a full page feature article the only mention of Japan is in relation to policies for the global containment of the spread of AIDS. In this context Japan is offered as an example of one of the developed nations that must help those countries where the battle against AIDS is still to be won. The countries treated in the article are generalized as representative of Asia, and then all the countries of Asia are grouped into a larger category of countries where the fight has not yet been won. Japan on the other hand is located among the ranks of the developed nations, where things are described as "under control."

In the specific case of North America the epidemiological lines of Japan's "defence" converge with the boundaries drawn by the language and practice of protectionist economic infrastructure on that other popular "front" of the so-
called U.S.-Japan Trade War. The attack-defence rhetoric of both the economic and epidemiological discourses are consistent. However, a very different and intensely contradictory picture emerges in the case of Japan's positioning of itself in relation to Asia. Within that framework popular, if controversial, categories of economic development based on a hierarchical model of chronologically sequential progress -- underdeveloped or late developing, third world nations versus developed first world nations -- become the basis for a conflation of patterns of epidemic transmission and economic status. Again the military metaphor predominates. Most significantly Japan is marked as not Asian. There are plenty of precedents over the last century for Japan’s rejection of an Asian identity in favour of a closer affiliation -- political, economic and cultural -- with Europe and North America. The familiar self-description of the Japanese as "the whites of Asia" is rooted in this desire for a politico-cultural (and even racial) distanciation from a geographically defined identity.

The popular resort to military metaphors when describing the human experience of disease and epidemic has already been widely and effectively critiqued by others, however, there are some details in the Japanese case worth drawing attention to. The Japanese "Battle Against AIDS" identifies the "enemy" or source of threat not just as the virus itself, but as specific strains of the virus that are linked to designated originary geographic spaces: North America and Asia in particular. The underlying principle is not dissimilar to that of the original WHO regional groupings but the implications are played out with profoundly different consequences. AIDS has certainly been deeply implicated in racist politics of othering elsewhere -- the treatment of Haitian and Dominican blacks in the U.S., misleading depictions of black Americans as the channel of epidemiological contagion between Africa and the U.S and Europe etc. There is a recent and disturbing echo resonating between the military rhetoric of AIDS discourse and the identity of the target countries of U.S. trade embargoes and political and military interventions. What is striking in Japanese discourses of AIDS is the contradiction between this rhetoric of epidemiological warfare and the contemporary policies of Japanese politico-economic integration with Asia. Both in the media and official rhetoric the "Asianization" of Japan has gained tremendous currency in the 1990s. The concept is underpinned by the same assumption that Japan is not Asian and therefore needs to be "Asianized" in order to takes its place at the centre of what is popularly predicted in the media of the region to be the coming Asian millenium. At the heart of this model is a rhetoric of open borders and free flows of trade and capital. In stark contrast to this, in the epidemiological "Battle Against AIDS" a prosperous Japan is located on the outside looking in at the uncontrolled spread of the epidemic in the
developing countries of Asia. The lines of inside and outside are clearly drawn and to be maintained. Race and HIV seropositivity (non-Japanese “carrier” and Japanese “victim”) are also easily conflated within this same framework. The focus becomes one of prevention and protection against any flow of contagion into Japan, and the isolation and expulsion of contagious non-Japanese bodies found within. The tension between the discourses of AIDS and the Asianization of Japan are played out around the increasingly controversial and contested body of the illegal female immigrant sex worker. Even the weight of her descriptive categories does not appease the fear generated by the perceived threat of her presence “inside” Japan -- fluid movement, border crossings, lines broken, illicit flows.\textsuperscript{20}

The AIDS education brochures clearly identify that the body most at risk and at the heart of the strategies of protection and prevention is the “body” of the mother/wife of the heterosexual nuclear family, gatekeeper of the heart/h of the contemporary Japanese body politic.\textsuperscript{21} Again and again the Japanese AIDS education materials and the media coverage of AIDS represent a healthy Japanese heterosexual woman as the potential innocent victim of AIDS. As already noted above, it is the Japanese male who is identified in the educational materials as anxious and worried. He is the one who may have contracted AIDS and may be putting his Japanese female partner at risk. Women are then also handed a considerable burden of responsibility to protect themselves against that potential risk of “secondary infection.” As early as 1990-91 AIDS prevention posters for community distribution focused on the heterosexual couple and the need for men to avoid the risk of “secondary infection” of Japanese women. One poster for example showed an image of the lower torso of a male and a female inverted in a position reminiscent of the water ballet movements of the female synchronized swimmers so popular in Japanese sport at that time.\textbf{Plate 7} The caption read simply “Are you emotionally prepared? Take responsibility together.” The language structure is clearly marked as female speech and even more specifically it suggests the tone a young woman might use when speaking to a male rather than a female friend. The message to Japanese men is twofold: be prepared to enter into committed longterm relationships(emotional preparedness) and wear condoms(shared responsibility).

In the Japanese case condom use has been widespread throughout the postwar period. It is frequently cited as the most common form of contraceptive.\textsuperscript{22} While this has been argued to be one of the reasons why HIV seropositivity rates remained so low for so long in Japan despite the size of the domestic sex industry and the popularity of overseas sex tourism this is only
one part of the picture. Japanese feminists have frequently pointed out that the use of condoms among young unmarried couples is widely accepted but that the issues of contraception and protection from STDs remain significant problems for women in two other contexts: marriage and the sex industry. While official surveys may indicate that condoms are the main form of contraception in Japan, feminists find that their research among married women generates a quite different picture. Anecdotal surveys performed in a familiar community context indicate that abstinence and abortion are the major reasons for Japan’s continuing low birthrates. Until the contraceptive pill is legalized Japanese women are dependent on the co-operation of their partner if a condom is to be used as the primary means of contraception. Women face a far more difficult situation after marriage than before in terms of gaining this co-operation. In a culture where the absolute conjugal rights of the husband still blur the legal viability of the concept of marital rape, wives face a range of difficulties gaining consistent co-operation in condom use. Various court cases in recent years have verified judicial support for a husband’s right to “enforce” conjugal access. All too often Japanese women describe their sexual relations with their husbands as being only occasional and frequently taking place under circumstances beyond their control. It is not uncommon for a husband to come home drunk from afterwork hours with colleagues in the bars and clubs. The combination of drunkenness and a lack of private spaces, separated from children or the ears of neighbours, leads many wives to take the path of least resistance. The feasibility of insisting on the use of a condom in the context of marital sex is simply dismissed by many Japanese married women. Even though they know that their husbands may be involved in unprotected sexual intercourse, they do not feel that they have the power, or sometimes even the opportunity, to insist that their husband use a condom in either the marital or extramarital context. Judicial rulings would appear to support this perception.

In the brochures described above, the “originary” source of domestic sexual transmission among Japanese men is explicitly identified as female foreign sex workers. One typical manga illustration of “high risk” activities depicts a man surrounded by three separate images -- a hypodermic syringe, a woman with dark skin wearing stiletto shoes, and two drops of blood. Plate 9 The woman’s skin is darker than that of any other person in the brochure, foregrounding her non-Japanese identity. High-heeled shoes are a standard marker of a bar hostess in the manga. The woman’s physical pose and the two heart shapes that decorate the image reinforce the codification of a “sexy” body. Thai and Filipina women constitute the two largest groups of illegal immigrant workers in the Japanese sex industry. In the popular media they are often collapsed into a
single wholistic category characterized/characateureed by darker skin. In the imagistic codification of the *manga*, foreign sex workers are designated by a combination of identifying markers of occupation and racial difference. In another illustration in the same brochure (*What You Need To Know About AIDS*) a female is shown singing - an activity that links her to the performative space of the barworld. She winks as she asks "Me?" The image appears with a text explaining that even though one is not showing symptoms of AIDS and is therefore unaware of having contracted it, there is still a high risk at this time of unknowingly infecting others. The language is constructed in such a way that it is clear the target reader is not a barworker but her potential male client. Another image of a double bed and a quilt marked with a pattern of multiple hearts links AIDS risk to the sex industry yet again. In the genre of Ladies Comics, double beds and hearts are popular motifs of the love hotels where unmarried young couples, sex workers and clients, and illicit lovers can all retreat for privacy. The couple sitting up in the double bed point accusing fingers at each other. Plate 10 Plate 11 The brochures unambiguously link unsafe or "high risk" sexual practices with the barworld and sex industry while setting in place the contrast of safe "low risk" sex within a monogamous longterm relationship. The motif of the heart symbol appears in a very different context in *What is AIDS* where a large single heart adorns the double futon of a happy couple. The text on the page features a list of "safe" activities and the caption under this particular image reads, "Sex with a longterm partner who has tested negative." Paired with the traditional *futon* in this context, the monogamous single heart acts to reinforce the contrast between home and the hotel bed. The pervasiveness of such images of happy, risk free, heterosexual, domestic scenes in the AIDS educational materials ignores the reality of the constant movement of bodies across boundaries (home/sex industry, heterosexual/homosexual, wife/sex worker) and works to create a mythology of highly differentiated unsafe and safe territories.

**PART FOUR: NOT THE OFFICIAL STORY**

Let me begin this section with a brief anecdote. A Japanese friend recently described with some pride how she had handed her husband a box of condoms and requested that he be certain to wear one when having intercourse with any prostitute or bar hostess. She described how difficult it had been for her to raise the issue. She was therefore relieved when he responded good humouredly that she didn't have to worry about him wearing a condom because he and his colleagues from work were also worried about AIDS, and had
therefore stopped patronizing bars that employed foreign hostesses. There are a number of assumptions underpinning both the request and the response other than the obvious one that the husband is engaged in extra-marital sex: that he is likely to be involved in extra-marital sex with sex industry workers, that only foreign sex workers might be HIV seropositive and that he needn’t wear a condom when having sex with anyone other than a foreign sex worker. All of these assumptions fit very neatly within the framing of AIDS in Japan promoted in the official documentation and the popular media. My friend perceives that she carries a responsibility to seek to protect herself, her husband accepts that his extra-marital sexual activity can place his wife at risk, he acknowledges a responsibility to protect her against that risk and the source of the risk is identified as the sex industry, and more specifically foreign women sex workers. Unfortunately the picture is far from being so straightforward or so neatly contained within a simple single narrative.

Nakajima Takehiro’s film Okoge was hailed in 1992 as the first serious treatment of Asian gay identity in a feature length film. Over time this work became quite controversial with its supporters and detractors becoming increasingly polarized. The key point of disagreement was the accusation from some critics that at the end of the film Nakajima resorts to a simple recuperation of gay identity within a normative structure of family. I have written elsewhere why I disagree with this particular reading of Okoge. (Buckley in Patton 1995) I do however have other criticisms of the film but would preface these by saying that Okoge was indeed a pathbreaking film and the space it opened up in Japan for the exploration of issues of gay identity in experimental film and video has had a major impact on the formative stages of a contemporary gay cultural practice. My criticisms of the film are each directly linked to the treatment (or lack of treatment) of issues related to AIDS in Japan at the time of filming. There are three specific references to AIDS in the dialogue of Okoge. The first occurs in the opening scene where a young woman tells her friend not to eat food she has just accepted from a gay man because she might catch AIDS. In another scene a man who frequents gay bars but determinedly asserts that he is not gay explains that he used to travel overseas to Thailand and other places but now it is too risky. In this instance AIDS is not named. The lack of necessity of naming the cause of the man’s reticence to travel anymore to Thailand underlines both the lingering tenaciousness of the taboo on naming AIDS, and the actual level to which the dominant narrative of AIDS as a foreign disease has permeated everyday life, even while it remains largely unspeakable. The third reference to AIDS takes place at lunchtime in a company cafeteria. A man who has hidden his gay identity from his colleagues forces himself to laugh
along with everyone else when, after a series of homophobic jokes, one of the other men at the table states that “it's gays who have brought AIDS to Japan and everyone would feel a lot better if they could just round them all up, pour gasoline over them and burn the lot.” Like many taboos it can only safely be broken in the context of humour.

In this cafeteria scene Nakajima sets the audience up with a sequence of familiar and tired gay jokes. A low level of audience laughter matches that on the screen. However, when the screen laughter escalates to hilarity with the gasoline joke the Japanese cinema audience falls silent, unlaughing. A raw nerve has been touched, the excess exceeds humour and melts into horror or embarrassment for the audience. The silence in the cinema confirms that Nakajima has hit his target. Throughout Okoge Nakajima creates opportunities to foreground the need to overcome the ignorance and confusion that surround male homosexuality for so many Japanese. His film is itself a major contribution to that project. Unlike the “Age of AIDS” series in the Asahi shimbun, Nakajima does not promote a strategy of “Coming Home.” From beginning to end the film is a condemnation of the normative contemporary heterosexual family. In Okoge neither the families represented, nor the individuals these families produce, can reasonably be described as “normal.” Families are depicted as nothing short of destructive. Each of the major characters in Okoge is one more of the walking wounded, the victims of home and family. Nakajima calls for an end to both the demonizing of difference and the deification of the heterosexual family. His characters are headed anywhere but home -- at least in any familiar sense of what that might be.

Although Nakajima uses an AIDS-related joke to shock his audience into a realization of the excesses of homophobia he doesn’t attempt anywhere in the film to grapple with the seriousness of the impact of AIDS on gay communities across Japan. He deals nowhere with the fear of the spread of AIDS within the communities, the impact of fear and risk on gay relationships and sexual practices or the escalation of homophobic attitudes in the wake of increased levels of AIDS among gay men. It could be argued that Nakajima chose strategically not to foreground the issue of AIDS in a film that was clearly intended to produce a more sympathetic and accessible imaging of gay identity and sexual practice than had previously been attempted for a mainstream audience in Japan. He may have feared that references to AIDS would risk distancing the audience and confirm rather than contest existing stereotypes. The two explicit references to AIDS in the film -- fear of eating food received from a gay man and the gasoline joke -- are both presented in such a way as to
highlight the absurdity and ugliness of ignorance and prejudice. However, Nakajima goes no further than to identify the problem, stopping well short of attempting to begin the process of raising understanding and awareness of AIDS related issues. Perhaps he sees the more prudent strategy of chipping away at homophobia as a safer approach to preparing the ground for a change in attitudes towards AIDS.27

The same explanation can be offered for Nakajima’s decision to film all the lovemaking scenes without condoms. A condom in the context of homosexual intercourse would function as a visual reminder of AIDS in the same moment that it functioned to reinforce safe sex strategies. Nakajima’s filming of the love scenes between the two male protagonists Tochi and Goh, are carefully constructed at every level of the cinematic apparatus to create the maximum potential to capture the viewer in the erotic and aesthetic tension of the screen image. The languorous movement and timing of the camerawork draw the viewer into the embrace and touch of two passionate bodies. Nakajima was right to imagine that the visual disruption of a condom would break the scopic flow of intensities he was labouring to effect. However, the decision to film unprotected anal and oral sex in the specific context of the relationship of these two men -- the histories of their past relationships are narrated in fragments over the course of the film narrative -- constitutes a decision to drop AIDS and safe sex practices off his list of aesthetic and political priorities, and runs counter to the narrative of a caring, nurturing and protective relationship between the two lovers. The same concerns surface again in relation to a scene where the female protagonist of the film, Takako, is raped by the same male character who previously admitted to no longer travelling to Thailand for fear of the risks. In the scene immediately before the rape Takako questions him again about his denial of any homosexual desires and he recalls that while he was in the military there were times...including one occasion when he and friends gang raped a gay in their troop. He is depicted as actively seeking out dangerous situations and activities in every aspect of his life. Although the relationship she enters into with this man, with whom she has a child before finally fleeing, is identified as high risk in every other way from financial destitution to physical violence and abuse, Nakajima chooses to remain silent on the issue of Takako’s risk of contracting AIDS or any other STD.

A central storyline is developed around the character Tokio and his dual life as a married man, and as a man deeply committed to his gay lover, Goh. The film returns several times to Tokio’s conscious decision to marry and suppress his homosexual attractions to other men. He describes how over time he could no
longer ignore the strength of his desires and began looking for male lovers in the hope of finding a more meaningful relationship than he had been able to achieve with his wife. Unfortunately his career and marriage are intimately linked due to the fact that it was an arranged marriage and the go-between was a senior colleague at Tokio’s company. His wife is also related to another of the managers. Tokio is reluctant to give up everything -- marriage, security, job, status -- as he is certain would be the inevitable outcome of revealing his gay identity. The lunchroom scene in the company cafeteria supports this fear. He discourages his lover Goh from being pressured into an arranged marriage citing his own frustration and unhappiness. Goh’s family trick him into an omiai (arranged marriage) rendezvous with a potential bride and her family. He rejects their pressure to marry, but does have intercourse with this woman at a later stage in the film. While the woman clearly harangues him into a difficult and awkward attempt at heterosexual intercourse, it is again a concern that they do not use a condom during this brief encounter.

Goh fluctuates between being supportive of Tokio’s decision to marry, condemning him for lack of courage and begging him to leave his wife. Tokio’s eventual decision to live openly as a gay man and the spectacular manner in which he performs his “coming out” are a focus of the last stages of the film after he and Goh have already ended their relationship. Tokio appears as the host at a company sponsored wedding for one of his junior colleagues but brings with him a gay friend. This friend is a transvestite cabaret performer. S/he accompanies Tokio to the wedding cross-dressed in the formal kimono befitting a wife on such an occasion. The excessive style of the hair and makeup parody the precision and restraint of the appearance of all the other wives in the room. Together, they sing an outrageously comic song overflowing with sexually explicit punning about gay men and erect penises. This performance in front of the wedding guests functions as both a blatant declaration of Tokio’s gay identity and a mockery of the tradition and ceremony of marriage. This is one more occasion when Nakajima explicitly rejects the normative institutions of contemporary Japan -- marriage, family, company. The wedding banquet scene is undoubtedly one of the highlights of the film, a display of Nakajima’s skill at teasing complex politics out of humour and parody. Confronted with the complicitness or absurdity of the sound of their own laughter the audience frequently finds itself in an ethical corner. This scene creates just such a corner and it could be said that it is at this juncture in Okoge that the film intersects three other narrative trajectories: my friend’s discussion of condom use with her husband, the official story of categories of transmission (heterosexual, homosexual, other) and origin (Japanese and foreign) of the
official story, and the unilateral black lines that trace the “arrival” of AIDS in Japan (see Plate 7). The most widely used Japanese word for wife is *okusan*. “San” is an honorific suffix attached to names, ranks and functions to designate respect on the part of the speaker. “Oku” is translated in the *Kenkyusha New Japanese English Dictionary* as “the inner most recess,” “the heart.” The primary motivation of the range of cultural materials considered here has been the protection of this “person at the heart.” The healthy body that is represented as vulnerable to attack is the body politic of Japan, and its most vulnerable organ is the family, and at the heart/h of that organ is the mother body. In Plate 4 when the HIV positive child stares accusingly at the mother it addresses her not in Japanese but in English: “You.” The single English word designates more than just an attribution of blame. An infected and infecting mother body is denied the mother tongue. She is now addressed in the language of trade of the foreign sex workers. The seropositive mother body is a foreign body.

The lines of defence are drawn around the potential or actual mother body of the heterosexual female. The black lines of contagion on a map trace the movement of “carriers” across the border of “inside” and “outside.” The simplicity of this narrative of invasion masks the fluidity of the identities that may be performed by a single body across a multitude of spatio-temporal migrations. A Thai woman working as a hostess in Tokyo is also a mother of five in Bangkok. A Japanese man dancing in a tight embrace with a male transvestite in a Singapore bar is husband and father back home. The Japanese hostess pouring another whiskey for her lunchtime client has to hurry or she won’t have time to pick up her husband’s business suit from the drycleaners and still get home before the children. My friend was relieved when her husband agreed to continue to be careful what bars he frequents, but she added later in the conversation over a glass of wine, that her real concern was that he might get caught up in “those” bars again. We both knew the unspoken issue was the love affair he had two years before with another young married Japanese lawyer like himself, who also went to “those” bars. The categories cannot keep the bodies in their “proper” places. Perhaps the only credible category is “Other/Uncertain.”

In *Okoge*, the crossdressing of the gay friend as Tokio’s wife plays with the assumption that the married body performs its sexuality and gender within a familiar and predictable script. There is a clear allusion to Tokio’s deviation from the prescribed performance of his role as husband. Throughout the film, bodies
are crossing the lines drawn so clearly in the AIDS education brochures and official statistics. There is no place in Nakajima’s film for static, predictable categories of identity and practice. The story of Okoge is written in the cracks of the statistics and categories of the official story. The performance of gender and sexuality is in flux. Boundaries are porous and permeable and fluid identity oozes through the cracks. A statistician’s nightmare is Nakajima’s delight. Although Okoge does not foreground AIDS it breaks the ground for the telling of other stories, not stories of othering. As Nakajima paints over the official stories the simple black lines of maps and statistical tables begin to fade to a palimpsest. 31

1 The Japanese usually designate two specific categories of AIDS victim and person infected with HIV. A Japanese transliteration is used for AIDS (pronounced EIZU) while the English acronym is used untranslated for HIV. It is very common in the literature for “person infected with HIV” to be further explicated in parenthesis as individuals diagnosed as HIV seropositive. The term seropositive is widely used in transliteration. In 1993 and 1994 PWA was still generally only used in Japanese in combination with a descriptive translation. However the acronym is not widely used without explanation in AIDS related literature and research. PWA is more widely used than PLWA (Person Living With AIDS) as in most of North America.

2 Japan is not the only country to argue a unique case scenario in relation to the AIDS epidemic however, the predominance of hemophiliac infections in the early stages of the documentation of AIDS cases in Japan became an important factor in masking the potential for other groups in the population to also be exposed to the virus in other contexts.


4 The Japanese feminist and Asahi shimbun senior editor Matsui Yayori has established strong relationships with activists for foreign women sex workers in Japan, and frequently speaks in public forums on behalf of the interests of these disenfranchised women.

5 This colleague is currently working in the Fillipino community in Yokohama and has requested anonymity although she is happy for the anecdote to be published.

6 For a more detailed discussion of this issue see my article in Gelb 1994 where I discuss levels of overprescription and unnecessary surgery among Japanese women. In addition see Locke 1993 for discussion of questionable practices within the medical profession in relation to the diagnosis and treatment of menopause in Japan.

7 The term Family With AIDS is my own and not in current usage in Japan.


9 I have not been able to locate a copy of the brochure Laughing AIDS. Information is drawn from anecdotal material and the article Fatal Error Far Eastern Economic Review 7 January 1993.

10 I’ve used the term “gay” in the context of this young Japanese expatriate, however the use of the term in relation to male homosexuals in Japan is far more problematic. The article by Jackson in this volume describes the complex issues surrounding the mobilisation of this term in the context of Thailand. The term “gay” is also not unproblematic when used in the Japanese context. For the most part I will restrict my use of the term to contexts where the individual(s) and community contexts are involved in a process where there is an active identity politics in
place. I'm making this distinction to reflect the fact that organised "gay" community structures remain controversial among Japanese male homosexuals. See Berry (1994) A Bit on the Side for a discussion of the need to complicate the transfer of the term gay into diverse Asian cultural contexts.

11 Despite valid criticisms of the work, Susan Sontag's (1989) AIDS and its Metaphors offers a useful description (and performance) of the levelling of difference between illnesses into simple holistic metaphors of contagion. For an example of the critique of Sontag's work see D.A.. Miller Sontag's Urbanity in H.Abelove et.al. (1993) The Lesbian and Gay Studies Reader

12 The issue of reproductive technologies in Japan is discussed in more detail in Buckley, Broken Silence. In the interviews with Aoki Yayoi, Mie Yoshiko and Kanazumi Fumiko. Many of the ethical issues raised in these interviews are relevant to the screening techniques used in the reproductive technologies in the context of the prevention of vertical transmission in the hemophiliac community.

13 For a detailed discussion of traditional conceptions of male homosexual relations see the introduction to P. Sharlow's translation (1990) of Ihara Saikaku's, The Great Mirror of Male Love.


15 The 1994 Stop AIDS campaign did use individual media personalities in both television and poster advertising for AIDS prevention.

16 A more developed analysis of the interactive reading processes of the manga can be found in Buckley, Penguin in Bondage, 1992.

17 Ueno Chizuko made this comment when discussing this issue at an informal workshop on pornography at Seika University in 1992.

18 See Buckley, Effacing the Feminine in S. Buckley and B. Massumi (1991) Bodies and Boundaries East and West. Social Discourse Volume 3 Nos 3-4 1991, for further discussion of body modification and the manga.


21 Simon Watney's The Spectacle of AIDS in Abelove et.al., discusses the mobilisation of the category of "homosexual" in the policing of home and family in contemporary Britain. This offers an interesting point of contrast to Japan where similar dynamic can be observed in relation to the foreign woman sex worker.


24 I thank my graduate student Cathy Bums for drawing my attention to the excellent analysis of judicial rulings on questions of the sexual freedom of prostitutes and married women in Japan in the work of Yumonae Tomoko (1989).

25 My friend agreed to the publication of the anecdote but wishes to remain anonymous.

26 Many non Japanese readers may find the assumptions worrying and be surprised by the open attitude towards the sex industry and the pervasiveness of that industry. For an overview
in English I would recommend Anne Allison (1994) *Sexuality, Pleasure, and Corporate Masculinity in a Tokyo Hostess Club*.

27 The complexities facing artists in Asia involved in the creation of an emerging "gay" identity are discussed in detail in Berry (1994). Berry is also presently involved in an as yet unpublished project on the construction of alternative narratives of identity in contexts where there is no historical foundation for the narrative of "coming out".

28 Nakajima's treatment of family, marriage and wedding ceremony is in stark contrast to Ang Lee's *The Wedding Banquet* where the fundamental strategy is one of conciliation and recuperation.


30 My thanks to my research assistant Kaye Broadbent for pointing out the use of English rather than Japanese in this caption.

31 My research assistants Minako Sakai, Keiko Mukai, Kaye Broadbent and Cathy Burns provided essential support at different stages over the three years of research for this project.
通常HIV検査（エイズ検査）といえば、抗体検査のことを指します。抗体は、HIVないしはその一部に反応して生体側で作られるものです。抗体検査には、PA法、ELISA法（EIA法、エライザ法）というスクリーニング検査法と、IFA法、WB法（ウェスタンプロット法）と呼ばれる確認検査法があります。スクリーニング検査と確認検査の両方に陽性が出た場合に、HIV陽性と呼び、HIVに感染していることになります。
エイズの現状

"最近はアジアにエイズが広がっているんだよ。"