UNIVERSITY OF LEEDS

This is a repository copy of *Social Exclusion and Care in Underclass Japan: Attunement as Techniques of Belonging*.

White Rose Research Online URL for this paper:
https://eprints.whiterose.ac.uk/157917/

Version: Accepted Version

Article:

Kim, J orcid.org/0000-0002-4777-6397 (2021) Social Exclusion and Care in Underclass Japan: Attunement as Techniques of Belonging. Culture, Medicine, and Psychiatry, 45 (1). pp. 42-63. ISSN 0165-005X

https://doi.org/10.1007/s11013-020-09678-2

© Springer Science+Business Media, LLC, part of Springer Nature 2020. This is an author produced version of an article published in Culture, Medicine, and Psychiatry. Uploaded in accordance with the publisher's self-archiving policy.

Reuse
Items deposited in White Rose Research Online are protected by copyright, with all rights reserved unless indicated otherwise. They may be downloaded and/or printed for private study, or other acts as permitted by national copyright laws. The publisher or other rights holders may allow further reproduction and re-use of the full text version. This is indicated by the licence information on the White Rose Research Online record for the item.

Takedown
If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.

White Rose
university consortium
Universities of Leeds, Sheffield & York

eprints@whiterose.ac.uk
https://eprints.whiterose.ac.uk/

For the Special Issue: “Embodied Belonging: In/Exclusion, Healthcare, and Well-being in a World in Motion” in *Culture, Medicine, and Psychiatry* (2020)

Social Exclusion and Care in Underclass Japan: Attunement as Techniques of Belonging

Jieun Kim (University of Leeds)

Abstract

While Japan boasts a universal healthcare system and state-of-the-art medical technology, healthcare has often been denied to those who do not conform to moral ideals of a deserving patient. In underclass enclaves known as *yoseba* (day laborers’ quarter), patients have been frequently turned away or blacklisted on grounds of their abnormality and non-compliance. As much as healthcare was enmeshed in the normative bonds of family and community sanctioned by the state, *yoseba* men were considered as outsiders who neglected their duties of care, thus, undeserving of any form of care themselves. Focusing on the struggle for healthcare in a *yoseba* enclave in Yokohama over the past three decades, this paper explores how various practices of care have been improvised in this last refuge for the underclass men. The relentless endeavor pursued by local medical activists reveals how attending to *yoseba* patients required creative techniques of spatio-temporal attunement to make healthcare a communal project. Here, a form of “embodied belonging” was sought through bodily care coordinated among various agents and things, rather than through claims for membership in a bounded entity.

Key words: social exclusion, care, temporality, embodied belonging, Japan

Introduction

In July 1993, Doctor Okubo[1] decided to spend his summer leave in Somalia to help build a hospital for refugees. After one month of preparation, he spent two weeks in Somaliland to inspect the facilities and equipment. Being his first time volunteering for medical service, the experience left an indelible impression on him. A life-changing event, however, occurred months later in his own turf, Nagoya city, where he lived and worked. It was in an open-air soup kitchen nearby where he volunteered to offer free medical counseling. Here, he was shocked at the level of deprivation suffered by his compatriots, which he felt to be worse than what he witnessed in Somalia. Recounting these experiences to me in an interview in 2016, Okubo made a vivid comparison: the refugee camp in Somalia received support from a host of international organizations like the WHO, UNHCR, UNDP, MSF and the Red Cross, whereas “the homeless in Japan had nothing but the weekly soup kitchen! They had clean water, but no housing, no

---

[1] All names, including that of the clinic, are pseudonyms. Publications from the clinic are anonymized accordingly.

clothing, no food. Even their safety was in danger." This realization led Okubo to get engaged in medical service for the homeless and impoverished in Japan.

Starting from Nagoya city, Okubo has since worked and volunteered for clinics in a number of underclass enclaves known as *yoseba*.[2] Once designated as day laborers' quarters in mid-twentieth century, these *yoseba* districts were hit hard by the collapse of the financial bubbles in the early 1990s, as increasingly more day laborers turned jobless and homeless. The free medical counseling service in Nagoya that Okubo participated in 1993 was part of the homeless support initiatives that sprang up across the nation in the wake of this "homeless crisis," from which *yoseba* enclaves never fully recovered. At the time of the interview, Okubo was volunteering at a free clinic in a *yoseba* in Tokyo while working at two clinics in Yokohama, one of which located in Kotobuki district, a *yoseba* where I have been conducting fieldwork on community welfare activism since 2009.

Taking Okubo's juxtaposition of Somalia's refugees and Japan's homeless people as a starting point, I would like to discuss how the social exclusion of the underclass in Japan makes a strong case for considering *yoseba* enclaves as "the other global South" (Meyers and Hunt 2014). Although Japan boasts one of the world's most robust health infrastructures with state-of-the-art medical technology and universal health insurance, the sick in *yoseba* enclaves have often been left in states of medical neglect. In theory, patients who cannot afford medical expenses should be offered full-coverage by the public assistance system. In practice, however, deep moral sentiments surrounding care in Japan have marked the underclass as undeserving members who dropped out of the affective weaves that make up the social fabric, and hence, unworthy of care themselves. Day laborers and homeless men, in particular, were seen not only as failed breadwinners, but also as a burden on taxpayers, who had no place in society except for within the bounds of *yoseba* enclaves. For decades since their appearance in postwar Japan, *yoseba* enclaves had remained to be medical deserts at the center of large cities, until local activists and health practitioners such as Okubo started to build strong advocacy of the right to healthcare for *yoseba* inhabitants and the homeless in the 1990s, a movement I call *yoseba* medical activism in this paper.

The case of *yoseba* medical activism, I argue, urges us to reconsider the emphasis on spatial isolation and boundedness in recent anthropological discussions of social exclusion (Biehl 2005; Hubert 2013; Low 2011). Indeed, the clear demarcation and policing of boundaries made *yoseba* enclaves carry distinctive health profiles characterized by higher rates of infectious diseases and shorter life expectancies.[3] *Yoseba* inhabitants' work and living environments typically exposed them to greater health risks,

---

[2] For ethnographies of *yoseba* enclaves, see Fowler 1996; Gill 2001; Stevens 1997.

[3] Although it is hard to find official health statistics of *yoseba* districts, memoirs and reports written by doctors, public health practitioners, and activists give us a glimpse of the patterns of disease and mortality shared by day laborers in these districts in the decades leading up to the bubble economy (Fujii 1990; Honda 1966; Koyanagi 1990; Nomoto 2003; Saeki 1982; Takayanagi 1987; Watanabe 1977). Since the collapse of the financial bubbles in the early 1990s, *yoseba* activists shifted their agenda from the right to labor to the right to survival, and *yoseba* enclaves have become rather exceptional protective refuge where impoverished and sick elderly men can spend the last years of their lives receiving welfare and social support (Gill 2015; Kim 2018).

which were then heightened by the inaccessibility of welfare and health care, a pattern that has been noticed elsewhere among similarly disadvantaged populations (Fassin 2009; Kim et al. 2012). A closer look, however, brings us to critically question the assumption of a spatial stasis that may be implied in the term "social exclusion." If we understand social exclusion as a state of being pushed out of the social collectives to which the majority belongs, then, we run the risk of reducing healthcare to matters of accessibility and inclusion while losing sight of the intricate and dynamic processes that render marginalized bodies unworthy of attention and care. What stands out in the case of *yoseba*, as we shall see later in this paper, is the endemic othering of underclass men that not only denies them access to healthcare, but entraps them in states of "invisibility" and "no future" (Edelman 2004). Social exclusion, in other words, generate unruly bodies that may work against the life-saving mission of healthcare.

By taking a relational approach, this paper explores how *yoseba* medical activists and patients tackled such an embodied dimension of social exclusion, as they turned healthcare into a communal project. If improvisation is "a defining feature of biomedicine in Africa," (Livingston 2012, p. 6), healthcare in *yoseba* similarly required improvisation. It was, however, less to compensate for the lack of medical personnel, equipment, and supplies as in Africa, but rather to resist the rigidly subscribed relations of care that deemed *yoseba* patients unworthy. In their relational improvisations, *yoseba* medical activists and patients gestured towards "spaces of the otherwise" (Povinelli and DiFruscia 2012, p. 89), where socialities can be instantiated beyond the normative. Belonging to the space of the otherwise was sought less through claims for membership in a bounded entity, but rather through spatio-temporal attunement of bodily care coordinated among various agents and things. In what follows, I will first provide a historical overview of the exclusion of *yoseba* inhabitants from social and medical care, and then discuss how *yoseba* medical activists and patients improvised alternative relations of care over the past three decades. For this latter part, I will focus mainly on the case of Minnano Clinic in Kotobuki district that Okubo worked for, drawing on the organizational publications of the clinic and other ethnographic materials I gathered in the district in 2010-12 and 2016.

Underclass Men as Exiles in Their Own Land

The conditions of marginalization faced by underclass men in Japan need to be considered in light of the institutional, social, and moral constellations that uniquely entangle the issues of belonging and care with one another. The Japanese social welfare has heavily relied on the reciprocal relations of care reinforced by the kinship care duty in welfare provision, systems of mutual aid and surveillance among neighbors, and lifetime employment at firms (Garon 1998, pp. 45, 57). In this political economy of care, the state's welfare provision should only come as the last resort, after all possible resources from these relations have been exhausted. The significance of this institutional configuration is expressed in the daily idioms demarcating those with -*en* (relations) and those without. *En*, commonly used to indicate relations, relatedness, bonds, or connections, derives from the Buddhist doctrine of codependent origination (*engi*) or karmic connection (*innen*) (Rowe 2011, pp. 45-6; Lock 2001, p. 220). While its Buddhist etymology connotes that everything in the universe is connected by weaves of causality, today *en* is most often used as a suffix in words such as *ketsu-en* (blood relations), *chi-en* (relations of a shared hometown or neighborhood), and *sha-en* (relations of shared affiliation in a company).[4] *Mu-en*, on the other hand, literally means the lack of -*en*, the state of being relationless, disconnected, and unbound. Typically associated with the death and the afterlife of isolated persons, *muen* indicates a state of total abandonment and unruliness, which stands in stark contrast to the harmonious world connected by -*en*.

Japan's high-growth period from the mid-twentieth century up to the collapse of the financial bubbles in the early 1990s can be characterized as a time period during which the binary view between the worlds of -*en* and *muen* was given material and symbolic foundations. The contrastive fates awaiting bodies from these two different worlds have been shown most emblematically at the time of death. While those with -*en* are expected to be cared for after death in funerary altars (*butsudan*) in daily space and in collective graves of families and even companies, those without -*en* are to be abandoned in anonymous graves and most likely suffer from loneliness and hunger in the afterlife (Kim 2016). As much as people with -*en* are presumed to be protected by perpetual attachment and endless duty, there has been a lack of sympathy to and even a strong contempt for *muen* people. The fact that Japan's biopolitical management has been built on this binary logic tells us that, for those disconnected from the imagined and embodied social collectives, power can be sensed foremost as an uncaring, and even, murderous force (Stevenson 2014, p. 73).

Underclass men, who typically find themselves isolated over the course of their lives, are rather treated as already being relegated to the realm of non-human and death, as evidenced by frequent violence and attacks against the homeless. The homeless in Japan commonly report having been subject to expulsion and harassment by the police and neighborhood watch groups who regularly patrol neighborhoods.[5] Equally common are mob lynching and bullying by children and teenagers, the most notorious case of which occurred in the early 1980s near Kotobuki district, leaving at least three homeless men dead and thirteen more injured (Gill 2001, pp. 176-179). While this incident alerted concerned citizens to advocate for the homeless in Yokohama and beyond (Kitamura 1997), homeless attacks continued to be an issue of concern at the time of my fieldwork,

---

[4] In understanding the current day meanings of *en*, it is important to distinguish its usage as a suffix from that as a standalone noun. When used alone, *en* maintains some of its Buddhist connotations, as shown in the idiomatic expression "we have *en*!" (*en ga aru*!) calling attention to the mysterious fate that brings strangers together (Goldfarb 2016; Nozawa 2015). As Kathryn Goldfarb decisively notes, these two different usages of *en*, nonetheless, converge in their emphasis on the prescribed and predetermined nature of human relations, which downplays the human agency in cultivating new relationships (Goldfarb 2016). For the purpose of this paper, I limit my discussion to the institutionalized relations of "-*en*" used as a suffix, as it is these –*en* that are put in question when people are categorized as being *muen*.

[5] According to the 2017 survey by the Cabinet Office, 31.4 percent of the 1,758 homeless respondents reported to have been harassed by passengers-by and local residents, while 34.2 percent reported to have been physically abused. https://survey.gov-online.go.jp/h29/h29-jinken/zh/z24.html accessed on February 19, 2019.

from stone-throwing to destroying the cardboard boxes and tents of the homeless. The degree to which the homeless face public hostility in Japan today is well captured by the fact that the homeless do not engage in panhandling but rather distance themselves from the public view as much as possible, such as by living in tents in the riverbanks, or staying secluded in *yoseba* districts. When the homeless occupy public space, they generally make themselves invisible by covering themselves in cardboard boxes often placed behind pillars or vending machines. If power operates as an all-encompassing gaze, as Foucault famously stated, these tactics of "invisibilization" direct our attention to how the binary logic of *-en* and *muen* has embodied consequences, giving rise to forms of lives that are merely sustained at the blind spots of the gaze, rather than being made to live (Foucault 2003a, p. 241).

For the underclass men in Japan, the hospital has been a site where this uncaring and murderous gaze is most acutely sensed, reconfirming their status as exiles in their own land whose "biolegitimacy" (Fassin 2009) is questioned and threatened despite their formal citizenship. *Yoseba* medical activists today point out the patterns of discrimination that continue, despite some improvements made over the years. According to the records of Minnano Clinic from 2006 to 2008, the seventy-nine Kotobuki patients that the clinic sent to hospitals by ambulance were rejected three to five times on average until they were admitted, in one case the record going up to fifteen rejections (Minnano Clinic 2009, p. 12). The "black-listing" of *yoseba* patients, which has been reported as early as the 1970s (Nomoto 2003, pp. 58-9, 238-9), still occurred in some hospitals (Minnano Clinic 2004, p. 35), categorically denying the chance of hospitalization for named patients on the grounds that they caused trouble to the medical staff or other patients, or drank alcohol, or did not comply to the treatments and self-discharged from the hospital. Some hospitals would say that they did not treat patients without health insurance, while others reluctantly accepted *yoseba* patients but with derogatory attitudes and below-standard care (Minnano Clinic 2004, p. 21).

For the underclass men, in this sense, "being seen," whether by pedestrians, the doctor, or the state, has always entailed the risk of exposing oneself to the uncaring and murderous gaze. Non-compliance and self-discharge, then, are very much constitutive of the techniques of invisibilization they embody in their pursuit of survival, signaling their refusal to put their bodies at the disposal of the clinical gaze (Foucault 2003b). As Alice Street incisively observes, the biomedical imperative of visualization is inevitably refracted by historical power relations and local quests for care, as well as by infrastructural limits (Street 2014). In the resource-poor hospital in Papua New Guinea, where Street conducted fieldwork, the biomedical failure to diagnose and treat diseases was met with patients' diverse attempts to "be seen" and "make themselves visible (reify themselves) as particular kinds of bodies or persons" to elicit recognition and care (Street 2014, p. 24). The underclass men in Japan, in contrast, rather avoided to "be seen," as the stakes were very high: they feared that, if they did not appear in the right form – as persons enmeshed in relations of care, they might be neglected or abused. During my fieldwork, I noticed how such fear of being seen, but not in the right way, often hindered people from seeking healthcare. A few raised suspicion that they may be rejected ("The hospital is a joke, they just send you right back to the district") or abused ("It's like they're doing some kind of experiment or something"), while many more others tried to prove themselves worthy by not burdening their family members ("I don't want the welfare office to call my family") or tax payers ("I don't want to get welfare"). For them, staying invisible on the street or enclosed in the *muen* space of *yoseba* district was preferable than being seen.

The enmeshment of belonging and care in Japan, then, poses unique challenges for the health professionals who strive to secure "good care" for *yoseba* patients. If the quest for "good care" in the retreating welfare state of Denmark means unsettling the "logic of choice" that reduces healthcare to a matter of patients' autonomous decision-making and will (Mol 2008), in Japan, it further requires disentangling biomedical care from the normative relational matrix that undergirds its moral and institutional foundations. It would mean finding ways to resist the impulse to define biomedical care as a merit to be earned through the relational histories of patients as dutiful members of families, communities and the state. In other words, one has to enact alternative logics of care that would not expose *yoseba* pateints as strangers or enemies to the collectively sustained local moral worlds in which biomedical encounters are situated.

The demarcation of bodies undeserving of care in Japan, then, highlights Cheryl Mattingly's metaphor of the hospital as "a borderland, " where boundaries are drawn and challenged among differently situated people (Mattingly 2006, p. 495). Mattingly's work on African American families with chronically ill children demonstrated how both parents and health professionals engaged in "border activities" to create a common ground across race and class divides. While "racial wariness and mistrust" may intensify in clinical borderlands, "[c]ommon worlds are routinely created" in activities as mundane as sharing jokes and playing Disney characters (ibid., p.497). We might say that hospitalization similarly required *yoseba* patients to cross boundaries, not only between their daily space and the clinical setting, but also between the rather atomized space of *muen* and the interdependent caring space of -*en*. Many accounts on medical care for underclass men in Japan reveal, however, that border-crossings for *yoseba* patients into the biomedical space rarely succeeded at least until the 1990s. Rather, indices of the *muen* state of *yoseba* patients, from their demeanor and smell to the lack of family carers and visitors, marked them as aliens in the clinical borderland. *Yoseba* patients were more likely to become keenly aware of the hostile and scornful gazes of doctors, nurses, and other patients and reject or drop out of clinical treatments.

Slow Suicide and the Medical Revolt

In the wake of the collapse of the financial bubbles in the 1990s, an increasing frequency of street deaths came to alert *yoseba* and homeless support groups across Japan (Kuroda et al. 2002; Ohsaka et al. 2003; Ohwaki 2003). Many of these deaths occurred to homeless men in their fifties to sixties,[6] well short of the nationwide average life

---

[6] According to the nationwide complete enumeration survey of the homeless in Japan that continued since 2003, the majority has been identified as men, with women consistently counting around 3% of the total homeless population (https://www.mhlw.go.jp/toukei/list/63-15b.html accessed on August 30, 2019). The gender gap is understood to result from a combination of factors including the narrow definition of the homeless (as those sleeping outdoors) adopted in these surveys and the

expectancy. For this, a renowned Japanese scholar of social policy, Masami Iwata likened homelessness to “slow suicide (*kanmanna jisatsu*),” a tendency she noted to prevail among underclass men who refused to seek help out of dejection (Iwata 2000, p. 275). While the term “suicide” might seem extreme here, it was precisely in this vein that Marcel Mauss characterized anomic suicide and its social origin, building on Emile Durkheim’s theorization. According to Mauss, this form of suicide has been typical and widespread in human societies where the group overpowers individuals’ consciousness to the degree that suicide can be committed as an act of resignation, simply completing what one has perceived to be suggested by the collective (Mauss 1979, p. 37). It would be an extension of this logic that Iwata defined the lack of initiative to escape from devastating states of homelessness, poverty, alcoholism, or illness as slow suicide.

The rise of medical activism in Kotobuki in the 1990s can be seen as one response to curb the trend of slow suicide in the district. Sudo, a long-term Kotobuki activist, who later came to help build Minnano Clinic captured the devastations felt by *yoseba* advocates around the time as follows.

> I have seen numerous people, who had a deep hole inside their body that was beyond their control, due to the lack of hope or future and “somebody” they could count on. On top of that, they were instinctually denying the current medical system –the hospital and medications – in various forms and drifted from hospital to hospital, slipped back to alcohol, and moved towards death step by step.[7]

A Kotobuki resident, Taro was one such person who was on track towards slow suicide when he moved into the district. Once an entrepreneur of a moving company, his life started to go downhill when his brother was convicted of homicide. The news threw him under sways of self-hatred and self-pity, instilling in him the thought that there was no good to come out of his bloodline: a father who abandoned the family and a brother who killed another person. His alcoholism took a serious turn, and together with their daughter, his Filipina wife left him for the United States. Having lost everything, he eventually found himself on the street where he drank for days and weeks until he had a blackout and was carried to the hospital by an ambulance. At the time I first met him in 2010, he was finally resuming his social life and attending Alcoholics Anonymous meetings after spending a year secluded in his lodging room in depression. Despite having access to public assistance with full medical coverage, his struggle seemed to perpetuate with the chronicity of his addiction, exacerbated by his sense of being doomed. Taro’s struggle demonstrates the limits of care in hopeless conditions shaped by the intertwinement of bad prognosis and social stigmatization. If hope constitutes a horizon that brings patients and carers together (Good et al., 1994; Mattingly 2006, 2010), hopelessness forecloses the possibility of any well-intended care to take effect.

The most radical implication of medical activism in Kotobuki then lied less in securing the right to public assistance for the homeless or in offering free medical counseling or service, but in conjuring shared horizons of recovery by allowing

---

gendered social policy that uniquely excludes single able-bodied men from welfare schemes, compared to families, women, and children.

[7] MCN 1996, p. 7

alternative “mutuality of being” (Sahlins 2013) to emerge among patients, the medical staff, and activist-cum-carers. “Making relations” (*kankei-zukuri*) was emphasized repeatedly in the narratives of key activists who took a leap from free medical counseling to found the Minnano Clinic. The initiative was led by Takahashi, a former social worker and activist who had been engaged in various community initiatives in the district since the 1960s. Facing the limits of free medical counseling in Kotobuki, Takahashi decided to take matters to his hands and acquired a medical degree to open a mental clinic just for Kotobuki residents. After Takahashi opened Minnano Clinic in 1996, Sato, who had been involved in free medical counseling as a student volunteer, also changed his major to medicine, and later succeeded Takahashi’s post as the director of the clinic. For activists like Sudo, Takahashi, and Sato, commitment to medical care was a new way to strengthen their relationships with *yoseba* residents, breaking out of the impasse of leftist activism. In the midst of rising “slow suicide,” they found gestures of care such as “come check your blood pressure” much more powerful than an appeal to fraternal solidarity and social revolution to form new alliances against governmental neglect and control (Kim 2018).

In this sense, the expansion of medical activism in *yoseba* enclaves contrasts to “the medicalization of homelessness,” a notable trend in American cities since the 1980s (Lyon-Callo 2000; Mathieu 1993; Willse 2010). As well-chronicled by many scholars, the U.S. homeless policies’ narrow focus on medical interventions has reduced homelessness to a matter of personal pathologies and made individuals responsible for their self-reformation. *Yoseba* medical activism, on the other hand, aimed at challenging the structural exclusion of the underclass by practicing medicine to evoke an alternative logic of belonging beyond the prescribed relations of *-en*. Using medicine as the basis of their relationship with *yoseba* residents, medical activists challenged the exclusionary moral logic that regarded the bodies of *muen* people as undeserving of any form of care. In Minnano Clinic, medical care in Kotobuki was considered as a way of social critique,[8] and further of “changing medicine itself” (MCN 1999, p. 13), as we will see later in this article. The following sections trace how an alternative belonging was pursued through spatial and temporal attunement between Minnano Clinic and its patients.

The Clinic as a Place of Belonging

The nature of biomedical space has been a contentious topic in ethnographies of medical institutions with polarizing observations made between those that emphasize the totalizing biomedical control on the one hand and those stressing the permeation of sociocultural values and norms on the other. Recognizing the limitations of overstating either spatial boundedness or continuation, Alice Street and Simon Coleman (2012) called attention to the heterogeneous layering of multiple orderings that take place in biomedical space. According to them, biomedical spaces are “simultaneously bounded

---

[8] Among the middle class in Japan at the same time, a parallel case of medicalization took place around depression and suicide, which allowed psychiatry to become a powerful tool for a social movement against overwork, as well captured in Junko Kitanaka’s ethnography (Kitanaka 2012).

and permeable" (Street and Coleman 2012, p. 5), the intricacies of which can be captured by an ethnographic sensitivity to "the complexity, variability, and unpredictability" (ibid, p. 5) inherent to the configurations of physical spaces, technologies, representations, persons, and things according to multiple rationalities (biomedicine and others) and affects. The making of Minnano Clinic reveals how the porosity of biomedical space was intentionally explored from its foundation to its daily operation. It was this porosity that allowed *yoseba* medical activists to move away from techniques of visualization to techniques of attunement, making healthcare a communal project.

Since its opening in 1996, Minnano Clinic operated under the motto to become "a clinic with a low threshold" (Minnano Clinic 2004, p. 7), which was radically put by one of its staff as "a clinic like a convenience store" (MCN 2007, p. 6). Aspiring to become an easy stopover for the sick in Kotobuki, the founders and staff engaged in "boundary work" (Street and Coleman 2012) that simultaneously dismantled hurdles that might block patients from approaching the clinic, but also maintaining the clinic as a safe-space securely placed within the physical and symbolic boundaries of Kotobuki district. Building on the networks of persons and resources around Takahashi, the clinic mobilized relationships whose histories would often stretch beyond decades. Money was donated through these networks to rent a space in a residential building in the district, and long-term local activists and volunteers, including Takahashi's wife and daughter, were recruited to work at the clinic *pro bono* for the initial years. As much as the clinic was a place shaped by biomedical technology and knowledge, it was also inherently enmeshed in situated aspirations for survival against all odds: against the decline of leftist activism that Takahashi and other supporters have been engaged in for life as well as against the pressure of slow suicide on *yoseba* residents. In this sense, the commitment shown by *yoseba* residents in their willing collaboration in making the clinic a communal place, from helping to set up a signboard, to showing up to make appointments, or to contributing to the clinic's newsletters, indicates their recognition of the clinic's gesture towards "the otherwise" (Povinelli 2012) rather than their subjugation to the biomedical gaze and discipline.

While *yoseba* patients were usually regarded as being "out of place" in biomedical space, the very fact that Minnano Clinic appeared inside a *muen* district reversed the usual hierarchy. It was rather the clinic that was out of place, the liminality of which assuaged *yoseba* patients' fear of "being seen" and allowed them to pursue relationships with the staff beyond the normative roles assigned to them. Records of the initial years of the clinic are abundant with creative relational improvisations explored by both the medical staff and the patients, as nurse Yamada noted: "All the staff in the clinic is a nurse, a caseworker, and a receptionist. It's our unique character that we are "a jack-of-all-trades" (*nandemoya-san*). We don't have any stipulated nursing guidelines like other hospitals, but we respond extemporaneously according to the circumstances" (MC10 2006, p. 28). Yamada further listed the range of requests the staffers received from the patients: "Some want to get sterilized for their injuries from falling down, some ask for a poultice, some want to get ointment on the back they can't reach, some want to get the stitches out they got from a different hospital, some want their nails clipped… We receive all kinds of requests. Some come everyday to measure their blood pressure or get medications little by little just as an excuse to come more often, and others just come for a chat." (MC10 2006, p. 29) As far as the clinic remained open to the activities that were beyond biomedical control, the patients showed up, hung around, made themselves known to the staff.

Bustling with all kinds of activities, the waiting room of the clinic was more like a lounge for residents to mingle, who would have otherwise had to spend time rather isolated in their tiny single room occupancies or their homeless encampments. Takahashi's account of the waiting room conveys the conviviality of the scene soon after the opening of the clinic:

> The Clinic opens at six thirty in the evening, but these days, there are increasingly more patients who start waiting at five or five thirty. Often someone among the staff or town's people would bring out tea or coffee, and everyone amicably chats listening to the background music. As such, the waiting room is becoming a tearoom. One of our patients, Mr. S would often bring fish that he caught in Honmoku. Then, Mr. K, who used to be a cook, would handle the fish on site. Moreover, Mr. K would also bring some omelet he made, and everyone in the waiting room would peck at it together. Some people would bring in *bento* boxes and eat it. Others bring gifts of fruits, tea, coffee and so on. For these reasons, our clinic is quite abundant with food (MCN 1996, p. 2).

Here we see a range activities of making what Sarah Willen calls "an inhabitable space of welcome," "a small zone of familiarity, comfort, meaning, and safety in the shadow of laws, policies, and practices explicitly designed to make people … feel unwelcome" (Willen 2014, p. 86). In everyday Japanese parlance, such a space can be characterized as an "*ibasho*" (literally, a place to stay). As anthropologist Anne Allison notes, the phrase "*ibasho ga nai*" (lit. there is no *ibasho*) has made a common appearance in Japanese public discourses, emblematically conveying the heightened anxiety associated with the breakdown of social institutions amidst a prolonged recession, the rapid aging of population, and the triple disasters of earthquake, tsunami and nuclear meltdown on March 11, 2011 (Allison 2013). While Allison finds budding endeavors to create *ibasho* throughout Japan in sites as diverse as commercial cat cafés to NGO-led local gatherings, for the homeless and many *yoseba* residents, even those *ibasho* prepared by well-intended groups may turn out to be exclusionary. Similar to Willen's undocumented migrants, underclass men are keenly aware that they might get turned away, face unfair treatment and misunderstanding, or even become prey to predatory schemes wherever they go. *Yoseba* men protect themselves from such unwanted encounters by carefully selecting where they stay and gauging whether and how much to expose their vulnerability. The reappropriation of Minnano Clinic's waiting room as a communal lounge may seem messy and chaotic; it nonetheless projects the intentions of various actors who are working to create an ambiance of hospitality to preempt forms of hostility and exploitation from taking shape. As Yamada portrayed, the clinic's patients, by socializing in the waiting room and entrusting their bodily matter to the medical staff, obliged the staff to provide them with more than professional service but also with something akin to familial care.

Narita[9] was one of the patients who hung around in the waiting room of Minnano Clinic from the very beginning. Once imprisoned for arson in his youth, he came to Kotobuki in his late forties and started receiving public assistance on the premise of treating his heavy alcoholism. In the initial years, however, he refused to get treatments for his addiction. When Minnano Clinic opened in 1996, it was insomnia that brought him to the clinic. Ten years later, Narita looked back on his clinic visits at that time in an interview by the clinic's staff member as follows:

> To me, the clinic had a nice atmosphere where I felt at ease to stop by. So I came to visit the clinic about three times a week for consultations or to hang out. At the time, the waiting room was full of drunkards, and I remember the staff had a hard time quieting them down. As one of them, I probably had caused a lot of trouble to the staff…. My life was at its lowest with debts for drinks and money spent at bars, and I was skipping most of my meals every day, so my health was worsening day by day (MC10 2006, p. 60).

Narita soon became a well-known figure in the clinic for openly avowing to never quit drinking. One staff member recalled Narita at the time coming in to the clinic all red and drunk groaning, "oh, the anti-alcohol drug is working" (MCN 1997, p.1). Nonetheless, Narita continued to come to the clinic, and the staffers came to accept the presence of patients like Narita who had nowhere else to go but to spend time in the clinic. For the clinic's staff, the seemingly purposeless waiting of patients like Narita came to be construed as part of a larger pattern detectable in their medical records: a sort of temporal affliction that seemed to impinge on *yoseba* patients in unique ways. According to the 2001 survey by the clinic, 189 of its 248 regular patients (75.9%) were taking sleeping pills for insomnia. Their patients also had high demands for enemas and IV therapies due to constipation and dehydration, because they tended to stay immobile in their rooms without going to the toilet, drinking water or eating meals (MCN 2001a 11, p.15). Irregular lifestyles also interfered with treatments, as patients were at a loss with instructions to "take medicines in-between meals": some simply skipped medications, while others took them at once before going to bed (MCN 2007a 23:5-6). Some patients even developed bedsores, not because they were sick or disabled, but simply because they spent too much time lying down (MCN 2001b 12, pp. 10-11). Although the majority of their patients have been secured housing in Kotobuki district, thanks to the hard-won victory of the local activists' battle against the municipalities in 1994 (Hayashi 2014, pp. 181-186), life in these single room occupancies seemed to entrap *yoseba* patients in a state of isolation and block their movement forward in time.

Emphasizing the existential and moral imperative of "dwelling comfortably in a world," Jarrett Zigon writes that "attunement" is "an ontological condition" that allows us to "become engaged with and become entangled in diverse and particular relationships

---

[9] By the time I started my fieldwork, Narita had already passed away, yet the story of his miraculous recovery from alcoholism was frequently recounted in the conversations I had with the medical activists in Kotobuki district and in the publications by Minnano Clinic. Narita's story presented here is reconstructed from these imprints of his life circulated in and around the clinic.

that makes possible the vast diversity of ways of living we find in the social world" (Zigon 2014, p. 22). The temporal entrapment observed among the Minnano Clinic's patients, then, highlights how such an ontological condition is profoundly disturbed by the intertwinement of bodily affliction and social isolation. Good care in this context would require, foremost, efforts to synchronize temporalities between the caregivers and the afflicted toward a shared horizon of recovery. Narita's continuing commute to the clinic and the staff's acceptance of his indifference to alcoholic treatment tell us that synchronization may involve a long period of waiting on both sides. When the clinic opened its annexed day care center in 1999, then, it not only provided an *ibasho* for patients like Narita, but also secured "the interval" (Braun 2007) to improvise and experiment with techniques of synchronization. One of the most effective techniques of synchronization, as we will see in the following section, was surprisingly found in the very task that the staff and patients struggled with the most: medication.

Attunement to therapeutic rhythms and milestones

Today, anyone visiting Kotobuki district on a weekday morning will be greeted by the scene of a long queue of patients in front of the Minnano Clinic waiting for the Directly Observed Treatment (DOT). While DOTS (Directly Observed Treatment Short-course), a TB treatment regime originating in global health, was first introduced to Kotobuki in 2000 by the city government to stop the spread of tuberculosis in the district (Kotobukichō Kinrōsha Fukushi Kyōkai 2010, p. 9), Minnano Clinic has since broadened its application. The majority of DOT patients today come to take alcohol deterrents like cyanamide or disulfiram, but there are also patients with dementia, intellectual disability, and other kinds of mental illnesses. Since its implementation, DOT has attracted a surprisingly large number of patients – from thirty to fifty a day, who show up voluntarily every morning, debunking the reputation of *yoseba* patients' noncompliance. Not only do they show up, but they would come very early – even several hours before the clinic opens. Meanwhile, for the clinic's staff, patients' commitment to DOT came to be perceived as an invitation to become involved in the patients' lives as primary caregivers and stay attuned to their bodily needs. Today, absence to DOT has become the main reason that the clinic's staff visits patients in their single room occupancies, often to discover them in states of medical emergency. DOT, in other words, has come to constitute "social cues (Zeitgeber)" (Coe 2016, p. 41) that set daily rhythms of treatment for both the staff and the patients, while effecting "care entrainment" (ibid., p.41-43) in a timely manner, so that the staff takes over a proportion of care duty that would have been performed by family carers in normative settings.

Narita's sudden decision to quit drinking in his sixth year into the Minnano day care center was also punctuated by his daily commitment to DOT. According to Narita, it was in the hospital bed after another accident of drunkenness that caused multiple fractures in his arm that he finally made up his mind: "I realized that I might really die if I continue drinking." (MC10 2006, p. 61) The hospital staffers were rather amused by his sudden resolution. In Sato's words, "[w]e all thought that it was impossible for him to quit unless there was a miracle…. We all thought he was joking, but those words turned out to be true" (MCN 2009, p. 12). Once Narita made his declaration, a corps of people joined his struggle for abstinence. Sato and other staffers played Narita's favorite hobby, Japanese chess (*shōgi*), on a regular basis, while the free medical counseling group ran the chess quizzes Narita drafted in their quarterly newsletter. A staffer at the day care center lent him books to occupy his mind in the lonely evening times at home. The staff at a sheltered workshop where Narita commuted in the morning awarded him with a handmade medal every month congratulating his sobriety. Then Narita would proudly come to the clinic for DOT wearing the medal and take a memorial photo with the staff at the clinic holding his daily dosage of alcohol deterrent drug. Recollecting his recovery process, Narita attributed merits to all these practices coordinated around him: "It was the chess activities, the programs and my relationship with people at the day care center and the sheltered workshop that sustained me to stay sober" (MC10 2006, p. 61). In this sense, practices such as DOT could lead to healing, not because it induced compliance to treatments, but because it brought together the staff and patients in the daily rituals and milestones endured and celebrated together.

If Narita's story accentuates DOT's potential to induce "fidelity" through "the ethical maintenance of the relations" that constitute the patients' world (Zigon 2014, p.24), I found that for others, it was the possibility of disentanglement and reorientation that made DOT a viable relational technology. This was a point made clear to me by Taro when he said that he was grateful to the Minnano Clinic's doctors for not referring him to the alcoholic addiction facility nearby and recommending DOT and AA meetings instead. In the years prior to getting alcoholic treatments at the Minnano Clinic, Taro's life had been caught in the loop of relapses and blackouts punctuated by periods of hospitalization and rehabilitation. In Taro's self-narrative, the chronicity of his addiction was deeply entangled with the expectations of moral failure in his relations: "there was one thing that my ex-wife told me that stuck with me, that I grew up in a family without love so I didn't have love inside me." Just as his bloodline set him up for a failed father and husband, the institutionalized care locked him in the role of an inmate to be tamed: "once I cleaned the [homeless rehabilitation] facility in the evening, but the staff came to scold me. I was just trying to help, what did I do so wrong?" Taro's trials and errors with DOT and AA, on the other hand, were explained to me as a journey driven by his own will to change his life (*jinsei wo kaeyō*). He started DOT half in doubt – "I even tried drinking to see if it [alcohol deterrent] really worked," yet he continued it for six months, and eventually joined an AA group. Taro's treatment at the clinic was not without failure – he relapsed once again, but in his narrative, this failure did not appear as any moral betrayal, but rather a part of a process of adjustment in finding the "right balance" in his life. When he did get back on treatment, it was punctuated with his recommencing of other social activities that he considered to be virtuous, such as helping out in soup kitchens and joining in the nightly visits to the homeless in the area. In other words, the very possibility of disentanglement from and re-commitment to the relationships formed around DOT helped him restore his moral agency that tended to be subdued in the expectations of chronicity (Garcia 2010, p.18) that he sensed in institutionalized care settings and familial relations.

Meanwhile, for Kaneda, another resident and patient, DOT worked because it allowed him to reorient himself within the multiple therapeutic rhythms and horizons. Initially signing up for DOT at the Minnano Clinic, Kaneda soon decided to take his alcohol deterrent with his AA peers: "everyone brought theirs to the AA meetings and took them together, so I didn't want to be left out." Synchronizing his daily rhythm of medication with that of his AA comrades (*nakama*), Kaneda also had another companion in mind to celebrate his milestones with: his caseworker at the welfare office. For this, he felt nothing but betrayed and dejected when she told him that he had done enough and will no longer need to bring proofs of AA meeting attendance to the office. In one AA meeting I accompanied Kaneda in 2012, he exclaimed, "What was all that for, for two years and a half, getting stamps for three meetings every day?" Although Kaneda went on to conclude that working towards recovery is for nobody else but the alcoholic himself, I noticed that, in doing so, Kaneda was also realigning himself back to the temporality of his AA comrades. Taking on the role of the senior (*sempai*) sharing his stories of doubt and awakening, he was drawing novice members into a communal horizon of recovery beyond the daily rhythms of treatment: "there is a reason why you have to continue three meetings a day, since you don't understand anything in the beginning. I have never missed a single meeting, except for two times I had to leave early because I was too painful with gout."

Kaneda's story emphasizes how, in their long-term career of sickness and recovery, patients may alternate their roles between giving and receiving care in a larger therapeutic community. By continuing their course to recovery, as well as by directly caring for the sick and disabled in various capacities, chronic patients also set exemplars for those in worse conditions. The recursive temporality of chronicity, taken collectively, can form a larger arc that afforded a forward movement to people: any individual patient may get better or worse, but the stories of their treatment and recovery feed back into the history of the therapeutic community, providing meanings to the sufferings and keeping alive rhythms and horizons of care for the newcomers. The dominant affective and moral qualities of such commitments are, then, different from hope for any individual's miraculous recovery, which many in *yoseba* warned against as a common trap that would lead to relapse – but rather closer to endurance (Povinelli 2012) for collective survival. The very resilience of these relational commitments is highlighted in their potential to unsettle the finality of death.

Necrosociality: Belonging as Attunement Beyond Death

While the death of patients can potentially annihilate the life-affirming care carried out by health professionals, for *yoseba* medical activists death becomes an occasion to reaffirm their bonds with patients. When Narita died in 2009 at the age of sixty-seven, four obituaries appeared in the clinic's newsletter written by the staff members of the clinic and its day care center. Each obituary conveyed memories of being involved in Narita's recovery process. In these narratives, Narita's life and death figured as a shared journey through treatments, as shown in the following remark by an acupuncturist who had been performing moxibustion for Narita: "He succeeded at quitting drinking, succeeded at diet, and succeeded at his hip-joint surgery. I think Narita departed after carrying through everything. Thank you for your hard work, Narita. And thank you for everything." (MCN 2009, p. 11) In a certain sense, patients like Narita continue to give back to the clinic after their death, as their life stories, in the form of the clinic's publications as well as of the voice of the medical staff, reach beyond the district to draw a larger pool of supporters.

Meanwhile, it is not just memories of dead patients, but also the material representations and tokens of their bodies that continue to circulate in and around the clinic. Most often, photos of the deceased would appear in the obituaries section of the clinic's publications and be displayed in the day care center, as was the case for Narita. Occasionally, even the patients' funerary urns containing their cremains stay in the clinic's space. In 2016, there was one such urn in the care of the clinic's staff. It contained the cremains of Park, a Korean woman with schizophrenia who had been the longest standing patient of the clinic and its day care center. When Park died of uterine cancer earlier that year, no one could reach her son, so her cremation was carried out with only a few of the clinic's staff members present. Meanwhile the Korean embassy, who helped locating Park's relatives in Korea, notified that her parents and sister have already passed away, while the surviving brother was ill and could not reclaim the urn. Typically, unclaimed cremains from the Kotobuki district would be buried in an anonymous grave in the Kuboyama municipal cemetery, a dreaded fate that is commonly evoked in a self-deprecating expression among the locals, "I will end up in Kuboyama anyway (*dōsei Kuboyama dana*)." But for patients like Park whose lives have been entangled with the clinic, a more likely destination lied ahead in the communal grave in a Buddhist temple nearby, where long-term activists and residents regularly visited for memorial services (For more on this communal grave, see Kim 2016).

Similar to Minnano Clinic, Okubo's free clinic in Tokyo also reserved a place for the dead close to the living. In the lounge room above the clinic, small picture frames of dead patients are placed in shelves besides an elaborately decorated funerary altar made of dark colored fiberboard. When I visited the clinic in 2016, there were three recently deceased patients enshrined in the funerary altar. Three wooden tablets with their names and a photo were carefully placed behind an incense burner, a singing bowl (*orin*) and offerings of sweets, fruits, *sake*, rice, and flowers. In the interior, next to a miniature golden statue of *kannon* stood a marble statue of Saint Mary of the same size, reflecting the religion of the major donors of the clinic as well as some patients. The clinic had also built its own communal grave in 2015, having successfully raised 255,000 yen through an online crowd-sourcing bid.[10] Okubo, guiding me to the grave in a Buddhist temple located a five-minute walk away from the clinic, carefully poured water over the gravestone and offered his prayers. The gravestone had the capacity to hold fifty funerary urns, and as of that time already seven patients had been interred. Once the full capacity is reached, the cremains would be taken out of the urns to be interred in a colossal cinerarium guarded by the merciful figure of bodhisattva *kannon* in the front of the graveyard. Pointing out the double-cross necklace on *kannon*'s statue as indicative of the temple's openness towards various religious traditions, Okubo added that he wished to have parts of his cremains buried in the cinerarium to eventually join those who had gone ahead. The relationships of care enacted around patients' bodies then, continued after death, inviting even more people to sustain these relations. The very fact that both clinics supported the living and the dead alike attracted larger flows of supporters and resources,

---

[10] For an ethnographic account on this grave and its making, see Marr 2019.

while also activating a horizon of recovery beyond death for the chronically ill and elderly patients.

The Sociality of *Muen*

In discussing the relational improvisations in *yoseba* medical activism, this paper does not intend to argue that social exclusion is resolved altogether in *yoseba* today, much less to present a model answer on how to improve access to healthcare. Rather, it aims to consider what it takes when striving to make biomedicine work for the marginalized and the excluded. For *yoseba* medical activists, one crucial step is to tackle the exclusionary logic that separated the *muen* space and people from the caring world of -*en*, which is embodied by the underclass men through their tactics of "invisibilization" and eventual subjection to "slow suicide." The spatio-temporal attunement between *yoseba* medical activists and patients around bodily care, in this sense, becomes a technique to do away with the binary logic of -*en* and *muen* by gesturing towards an alternative "mutuality of being" (Sahlins 2013). While Marshall Sahlins suggests the term as a universal definition of kinship in which biology plays little role, both the normative logic of belonging and the relational improvisations in Japan remind us that material engagement with the body is essential in our "participation in one another's existence" (Sahlins 2013, p .18). Although different from biological ties based on procreation and genealogy, circuits of care coordinated around the body have the potential to draw persons into a common fate through physical proximity and shared temporalities. It is this potential that *yoseba* medical activists and patients strive to tap into in their search for an alternative mode of belonging and care.

These techniques of attunement, then, bring us to consider the potential of healthcare, and bodily care in more general, in assisting in our existence as relational beings in the world (Zigon 2014). Is it possible to enact caring relationships without conjuring the dictates of an overpowering collective or the callous gaze of a bureaucratic power? What kinds of modalities of care would allow us to make life inhabitable without also inviting the exclusionary and oppressive dark side of care? These questions are particularly pertinent in Japan today, where the fear of becoming a "disconnected society" (*muen shakai*) looms large (Allison 2013; NHK 2010). While the limits of family care have long been felt by women overburdened by their domestic caregiving duties (Lock 1995) and by people with non-normative families (Ezawa 2007; Goldfarb 2016), the precaritizaton of employment and the super-aging of population have made care deficit a major policy concern for the state (Mackie 2013) and an everyday reality in many local communities (Dahl 2019; Danely 2019). *Yoseba* medical activism today counts as only one among the many community initiatives that sprung up throughout Japan to grapple with the crisis of care. The common dilemma manifested in these new initiatives, however, is that they can easily slip back into old programs of mutual surveillance, evoking the wartime specter of the "family-state (*kazoku kokka*)" (Gluck 1985). Healthcare, here again, is susceptible to becoming "anonymous care" (Stevenson 2014) that reduces its charges to mere numbers to be monitored, as epitomized in the measures promoting a society with zero dementia (*ninchishō*) or zero lonely death (*kodokushi*).

What I find compelling about the case of *yoseba* medical activism is its ability to activate a viable relational logic that is not quite kinship, but nonetheless brings disparate persons together to make their lives matter to each other, forging what we might call the "sociality of *muen*." Unlike the conventional logic of *-en* that predicates on vertical flows of care across generations for the perpetuation of bounded entities, the "sociality of *muen*" is solidified through constant spatio-temporal attunement, allowing circuits of care to be activated in multiple directions: in these communities, anyone – a patient, a doctor, a nurse, a neighbor, or a voluntary supporter – can be summoned to recognize someone else's therapeutic milestones; chronic patients can become caregivers to other patients; and the medical staff could eventually receive care after death. As far as one joins in practices of waiting and enduring together in life, one can potentially become a giver and receiver of care in these communities. In this enactment of care circuits, the underclass men are no longer disposable bodies who are left to die but crucial protagonists in the biographies and histories that are kept alive, even beyond their biological deaths.

References

* Minnano Clinic's Publications
MCN: Minnano Clinic's biannual newsletter
MC10: Minnano Clinic's 10th Anniversary Commemorative Publication
Minnano Clinic. 2004. "Kotobukichō Doyagai 1: Kotobukichō No Chiiki Iryō to Fukushi (Kotobuki District Doyagai 1: Community Healthcare and Welfare in Kotobuki District)." Yokohama: Minnano Clinic.
———. 2009. "Kotobukichō Doyagai 5: Kotobukichō Ni Okeru Iryō (Kotobuki District Doyagai 5: Healthcare in Kotobuki District)." Yokohama: Minnano Clinic.

Allison, Anne. 2013. *Precarious Japan*. Duke University Press Books.
Braun, Kathrin. 2007. "Biopolitics and Temporality in Arendt and Foucault." *Time & Society* 16 (1): 5–23. https://doi.org/10.1177/0961463X07074099.
Coe, Cati. 2016. "Orchestrating Care in Time: Ghanaian Migrant Women, Family, and Reciprocity." *American Anthropologist* 118 (1): 37–48. https://doi.org/10.1111/aman.12446.
Dahl, Nils. 2019. "Governing through Kodokushi. Japan's Lonely Deaths and Their Impact on Community Self-Government." *Contemporary Japan* 0 (0): 1–20. https://doi.org/10.1080/18692729.2019.1680512.
Edelman, Lee. 2004. *No Future: Queer Theory and the Death Drive*. Durham: Duke University Press Books.
Ezawa, Aya. 2016. *Single Mothers in Contemporary Japan: Motherhood, Class, and Reproductive Practice*. Rowman & Littlefield.
Danely, Jason. 2019. "The Limits of Dwelling and the Unwitnessed Death." *Cultural Anthropology* 34 (2): 213–39. https://doi.org/10.14506/ca34.2.03.
Fassin, Didier. 2009. "Another Politics of Life Is Possible." *Theory, Culture & Society* 26 (5): 44–60. http://dx.doi.org.proxy.lib.umich.edu/10.1177/0263276409106349.

Foucault, Michel. 2003a. *"Society Must Be Defended": Lectures at the Collège de France, 1975-1976*. Translated by David Macey. Reprint edition. New York: Picador.

———. 2003b. *The Birth of the Clinic*. Routledge.

Fowler, Edward. 1996. *San'ya Blues: Laboring Life in Contemporary Tokyo*. xxi, 262 p. Ithaca, NY: Cornell University Press. http://hdl.handle.net/2027/.

Fujii, Katsuhiko. 1990. "Sasajima Ni Okeru Iryō Mondai (The Healthcare Problem in Sasajima)." *Yoseba* 3: 41–60.

Garcia, Angela. 2010. *The Pastoral Clinic Addiction and Dispossession along the Rio Grande*. xv, 248 p. Berkeley: University of California Press. http://site.ebrary.com/lib/umich/Doc?id=10402708.

Garon, Sheldon. 1998. *Molding Japanese Minds*. Princeton, N.J.: Princeton University Press.

Gill, Tom. 2001. *Men of Uncertainty: The Social Organization of Day Laborers in Contemporary Japan*. Albany: State University of New York Press.

———. 2015. *Yokohama Street Life: The Precarious Career of a Japanese Life Laborer*. Lanham, MD: Lexington Books.

Gluck, Carol. 1985. *Japan's Modern Myths: Ideology in the Late Meiji Period*. Studies of the East Asian Institute, Columbia University, xi, 407 p., [8] p. of plates. Princeton, N.J.: Princeton University Press.

Goldfarb, Kathryn E. 2016. "'Coming to Look Alike': Materializing Affinity in Japanese Foster and Adoptive Care." *Social Analysis* 60 (2): 47–64.

Good, Mary-Jo Del Vecchio, Tseunetsugu Munakata, Yasuki Kobayashi, Cheryl Mattingly, and Byron J. Good. 1994. "Oncology and Narrative Time." *Social Science & Medicine* 38 (6): 855–62. https://doi.org/10.1016/0277-9536(94)90157-0.

Hayashi, Mabito. 2014. *Hōmuresu to Toshi Kūkan: Shūdatsu to Ika, Shakai Undō, Shihon-Kokka (The Homeless and City Space: Exploitation and Dissimilation, Social Movement, and the Capital-State)*. Tōkyō: Akashi Shoten.

Honda, Yoshihiro. 1966. *Nippon Kamagasaki Shinryōjo (Nippon Kamagasaki Clinic)*. Tokyo: Asahi Shimbunsha.

Hubert, Jane. 2013. *Madness, Disability and Social Exclusion : The Archaeology and Anthropology of "Difference."* Routledge. https://doi.org/10.4324/9781315812151.

Iwata, Masami. 2000. *Hōmuresu/Gendai Shakai/Fukushi Kokka (The Homeless/Contemporary Society/Welfare State)*. Tokyo: Akashi Shoten.

Kim, Jieun. 2016. "Necrosociality: isolated death and unclaimed cremains in Japan." *Journal of the Royal Anthropological Institute* 22 (4): 843–63. https://doi.org/10.1111/1467-9655.12491.

———. 2018. "The Other City: Alternative Infrastructures of Care for the Underclass in Japan." *Asian Anthropology* 17 (1): 1–23. https://doi.org/10.1080/1683478X.2017.1417676.

Kim, Taewoo, Charlotte Haney, and Janis Faye Hutchinson. 2012. "Exposure and Exclusion: Disenfranchised Biological Citizenship among the First-Generation Korean Americans." *Culture, Medicine, and Psychiatry* 36 (4): 621–39. https://doi.org/10.1007/s11013-012-9278-7.

Kitamura, Toshiko. 1997. *"Hōmuresu" Shūgeki Jiken to Kodomotachi: Jakusha Ijime No Rensa o Tatsu Tameni ("The Homeless" Attack Incidents and Children: To Cut the Chain of Bullying the Weak)*. Tokyo: Tarōjirōsha.

Kitanaka, Junko. 2011. *Depression in Japan: Psychiatric Cures for a Society in Distress*. Princeton, N.J.: Princeton University Press.

Kotobukichō Kinrōsha Fukushi Kȳokai. 2010. "Ayumi." 29. Yokohama: Kotobukichō Kinrōsha Fukushi Kyōkai.

Koyanagi, Nobuaki. 1990. "Kamagasaki Ni Okeru Iryō Mondai (The Healthcare Problem in Kamagasaki)." *Yoseba* 3: 61–77.

Kuroda, Kenji, Takako Ohsaka, and Yoshio Sakai. n.d. "Osaka-Shi Ni Okeru Nojukusha Oyobi Kan'i Shukuhaku Shisetu Jukusha No Shibō No Jittai (The Survey Results Regarding the Deaths of the Homeless and Users of Temporary Lodgings in Osaka City)." *Shelter-Less* 2002: 3–9.

Livingston, Julie. 2012. *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic*. Durham N.C.: Duke University Press. www.dukeupress.edu/Improvising-Medicine/.

Lock, Margaret. 2001. *Twice Dead: Organ Transplants and the Reinvention of Death*. Berkeley: University of California Press.

———. 1995. *Encounters with Aging: Mythologies of Menopause in Japan and North America*. London: University of California Press.

Low, Setha M. 2011. "Claiming Space for an Engaged Anthropology: Spatial Inequality and Social Exclusion." *American Anthropologist* 113 (3): 389–407. https://doi.org/10.1111/j.1548-1433.2011.01349.x.

Lyon-Callo, Vincent. 2000. "Medicalizing Homelessness: The Production of Self-Blame and Self-Governing within Homeless Shelters." *Medical Anthropology Quarterly* 14 (3): 328–45. https://doi.org/10.1525/maq.2000.14.3.328.

Mackie, Vera. 2014. "Japan's Biopolitical Crisis." *International Feminist Journal of Politics* 16 (2): 278–96. https://doi.org/10.1080/14616742.2013.780938.

Marr, Matthew D. 2019. "The 'Ohaka' (Grave) Project: Post-Secular Social Service Delivery and Resistant Necropolitics in San'ya, Tokyo." *Ethnography*, May, 146613811984539. https://doi.org/10.1177/1466138119845393.

Mathieu, Arline. 1993. "The Medicalization of Homelessness and the Theater of Repression." *Medical Anthropology Quarterly* 7 (2): 170–84. https://doi.org/10.1525/maq.1993.7.2.02a00030.

Mattes, Dominik. 2011. "'We Are Just Supposed to Be Quiet': The Production of Adherence to Antiretroviral Treatment in Urban Tanzania." *Medical Anthropology* 30 (2): 158–82. https://doi.org/10.1080/01459740.2011.552454.

Mattingly, Cheryl. 2006. "Pocahontas Goes to the Clinic: Popular Culture as Lingua Franca in a Cultural Borderland - MATTINGLY - 2006 - American Anthropologist - Wiley Online Library." *American Anthropologist* 108 (3): 494–501.

———. 2010. *The Paradox of Hope: Journeys through a Clinical Borderland*. xv, 268 p. Berkeley: University of California Press. http://hdl.handle.net/2027/.

Mauss, Marcel. 1979. *Sociology and Psychology: Essays*. Sociologie et Anthropologie.English.Selections, viii, 135 p. London ; Boston: Routledge and K. Paul. http://hdl.handle.net/2027/.

Meyers, Todd, and Nancy Rose Hunt. 2014. “The Other Global South.” *The Lancet* 384 (9958): 1921–22. https://doi.org/10.1016/S0140-6736(14)62270-4.

NHK. 2010. *Muen Shakai: “Muenshi” Sanman Nisennnin No Shōgeki [Relationless Society: The Shock of 32,000 Relationless Deaths]*. Tōkyō: Bungei Shunshu.

Nomoto, Sankichi. 2003. *Nomoto Sankichi Kojinshi Seikatsusha 1972-2002*. Vol. 1. Tokyo: Shakai Hyōronsha.

Nozawa, Shunsuke. 2015. “Phatic Traces: Sociality in Contemporary Japan.” *Anthropological Quarterly* 88 (2): 373–400. https://doi.org/10.1353/anq.2015.0014.

Ohsaka, Takako, Yoshio Sakai, Kenji Kuroda, and Ryoji Matoba. 2003. “Osaka-Shi Ni Okeru Hōmuresu-Sha No Shibō Chōsa (The Investigation on the Deaths of the Homeless in Osaka City).” *Nihon Kōshū Eisei Zasshi* 50 (8): 686–96.

Ohwaki, Katsuya. 2003. “Nojukusha No Kenkō Mondai: Karei Ni Yoru Eikyō (The Homeless Health Problem: The Influences of Aging).” *Shelter-Less* 19: 101–7.

Povinelli, Elizabeth A. 2011. *Economies of Abandonment: Social Belonging and Endurance in Late Liberalism*. Durham N.C.: Duke University Press Books.

Povinelli, Elizabeth A., and Kim Turcot DiFruscia. 2012. “A Conversation with Elizabeth A. Povinelli.” *Trans-Scripts* 2: 76–90.

Rowe, Mark Michael. 2011. *Bonds of the Dead: Temples, Burial, and the Transformation of Contemporary Japanese Buddhism*. Chicago: University Of Chicago Press.

Saeki, Teruko. 1982. *Onna Akahige Doyagai Ni Junjōsu: Yokohama Kotobukichō Shinryōjo Nikki Kara (Ms. Red-Beard, Gives Her Pure Love to the Doya-District: From the Kotobuki Clinic Diary in Yokohama)*. Tōkyō: Ikkōsha.

Sahlins, Marshall. 2013. *What Kinship Is-And Is Not*. Chicago: University Of Chicago Press. https://www.press.uchicago.edu/ucp/books/book/chicago/W/bo14365377.html.

Stevens, Carolyn S. 1997. *On the Margins of Japanese Society: Volunteers and the Welfare of the Urban Underclass*. The Nissan Institute/Routledge Japanese Studies Series, xiii, 282 p. London ; New York: Routledge. http://hdl.handle.net/2027/.

Stevenson, Lisa. 2014. *Life Beside Itself: Imagining Care in the Canadian Arctic*. 1 edition. University of California Press.

Street, Alice. 2014. *Biomedicine in an Unstable Place: Infrastructure and Personhood in a Papua New Guinean Hospital*. Duke University Press.

Street, Alice, and Simon Coleman. 2012. “Introduction Real and Imagined Spaces.” *Space and Culture* 15 (1): 4–17. https://doi.org/10.1177/1206331211421852.

Takayanagi, Kinichi. 1987. *Gendai-Han Aka Hige: Dokutā Kin-Chan Funtōki (The Contemporary Version of Red-Beard: The Chronicle of Doctor Kin-Chan’s Struggle)*. Tokyo: Aoyama Shobō.

Watanabe, Yukiko. 1977. *Kotobuki-machi hokenfu nikki (The Dairy of a Public Health Nurse in the Town of Kotobuki)*. NHK bukkusu. Tokyo: Nihon Hoso Shuppan Kyokai.

Willen, Sarah S. 2014. “Plotting a Moral Trajectory, Sans Papiers: Outlaw Motherhood as Inhabitable Space of Welcome.” *Ethos* 42 (1): 84–100. https://doi.org/10.1111/etho.12040.

Willse, Craig. 2010. “Neo-Liberal Biopolitics and the Invention of Chronic Homelessness.” *Economy and Society* 39 (2): 155–84. https://doi.org/10.1080/03085141003620139.

Zigon, Jarrett. 2014. “Attunement and Fidelity: Two Ontological Conditions for Morally Being-in-the-World.” *Ethos* 42 (1): 16–30. https://doi.org/10.1111/etho.12036.