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INTRODUCTION: AIDS, DEATH, AND THE POWER OF STORIES

Since the early 1980s, a vast enterprise of scientific inquiry has investigated the AIDS epidemic. Humankind knows much more about this epidemic than has ever been the case with afflictions of the past. One of the first discoveries, in the early 1980s, was that, since the virus was transmitted through the exchange of bodily fluids, the simplest way to prevent infection by this life-threatening agent was to avoid exposure to infected fluids. And since knowing who was infected was impossible in the early years – and is still difficult – the public health message was, in effect, to avoid all bodily fluids (unless you knew that they came from a trusted source). In its simplest form, the message became ABC: Abstain; Be faithful; use a Condom.

Vast amounts of time, money and effort were poured into promoting this message of behaviour change in Africa, where most HIV infections are found and most AIDS deaths occur. Little evidence exists, however, that the efforts of policy makers and planners to halt the epidemic by promoting behaviour change have been effective (Oster 2012; Padian *et al.* 2010; Potts *et al.* 2008). Nonetheless, the incidence of HIV infection has declined in most parts of sub-Saharan Africa since the turn of the century, indicating that changes in sexual behaviour have in fact occurred (UNAIDS 2013b: 5). Ordinary people, it seems, given a modicum of basic information about the disease – such as, crucially, that it is sexually transmitted – seem to have figured matters out for themselves and have acted to turn the tide of infection (Watkins 2004). They are doing so, we contend, not simply by acceding to public health messages but through the stories they tell each other in ordinary encounters in everyday contexts. The most important of these, since the consequences are so grave, are stories of death.

Narratives of death, and the illnesses preceding death, speak of highly significant events in the lives of individuals, families and communities responding to the epidemic. Analysis of these stories tells us much, not only about local responses to the epidemic, but also about the politics of blame and the quest for justice in the wake of AIDS deaths in Africa. Accounts of death are 'emplotted': that is to say, speakers and auditors work to situate the event of the person's death

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in a coherent, logical sequence of actions (Ricoeur 1985). Stories are accounts of a sequence of events, narrated by a narrator, in which characters, or agents of acts, effect some transformation in the subject of the narration (Todorov 1971).[1] These stories are accounts of causation that attribute events to actors, assign responsibility to agents, provide lessons on avoiding harm, and serve as evidence in the quest for justice. When a story is plausible within a particular context, it invites its audience to insert themselves into the narrative as a putative subject. The virtual experience of identifying with the subject of a story influences the ways in which a person responds in shaping his or her own life. How stories are created and shared, the conditions that establish the possibilities of plausibility, and the purposes to which they are put are thus of primary interest in understanding social change (Frank 2010; Tilly 2002). Predicated as they are on the question of blame, stories of death in Malawi in the time of AIDS, we shall argue, have important social consequences. We read about some of the consequences in the journals we describe below, but there are likely to be others that we cannot know.

Researchers both within and outside Africa have been interested in the potential impact of AIDS mortality on sexual behaviour change, a key to preventing infection (Macintyre *et al.* 2001). In Zimbabwe, for example, which experienced an early and dramatic decline in HIV, Muchini *et al.* (2011: 487) found that 'behavior change resulted primarily from increased interpersonal communication about HIV due to high personal exposure to AIDS mortality and a correct understanding of sexual HIV transmission'. In this paper, we argue that the key to understanding the experience of AIDS mortality lies in the stories that people tell to each other about those they know who are suspected of having died from AIDS. We show that narratives of death are predicated upon the question 'Who is to blame?' And we argue that a micropolitics of blame arises from practices of narrating death and shapes individual and collective responses to the epidemic.

Consider the story of Mr Dryson, reported to us by a young Malawian we call Alice as part of the journal project described below. Mr Dryson, an asthmatic, suffered from persistent coughing and diarrhoea, typical signs of AIDS, before he died in June 2003. Alice wrote that, at his funeral, 'people were saying he died of AIDS because his wife was a prostitute'. However, while it seems that there was some consensus about his wife, this story of AIDS was not the only one circulating at the funeral. People were also talking of witchcraft. Mr Dryson, according to his neighbours, was a witch who was killed by his 'fellow witches'; this was because, after dining with them on the flesh of their families, he had failed to reciprocate by providing the meat of his own kin for their feasting. Nobody openly doubted that the dead man had been a witch, just as no one disputed the claim that his wife was a prostitute. Nor did they question whether the iron-clad law of reciprocity applies even in the netherworlds of witches. The question was, simply, '*Who* killed him?'

[1]Our approach to the analysis of narrative in this paper is broadly in agreement with 'socio-narratology' (Frank 2010). For overviews of the narrative theory on which we draw, see Abbott (2002) and Bal (1997). We also draw on critical discourse analysis, particularly the work of Teun van Dijk, in thinking about the relations between interlocutors in the collective work of making these narratives and in creating the mental models through which they interpret and act upon (and in) their discursive contexts (van Dijk 2006). For a general overview of discourse analysis, see Blommaert (2005).

After much discussion among those gathered at the funeral, consensus was reached: Mr Dryson had indeed been sick with AIDS, contracted from his prostitute wife. However, witches, punishing him for his selfishness, caused his death at that particular time. Mortally ill, and deserving to die as punishment for having 'killed many people', the death of Mr Dryson was thus a case of murder. By speculating about AIDS, the gossipers were able to enjoy a sense of moral superiority over Mr Dryson and his family – they also spent some time talking about his granddaughter, whom they also considered a 'prostitute'. By attributing his death to witchcraft, however, not only were they able to agree that he suffered his just deserts, but they also felt reassured that a potential source of danger for all had been removed from the community.

The presumption that blaming individuals or categories of people for causing AIDS impedes efforts to prevent infection and ensure treatment for those who are infected has long been a staple of global AIDS discourse.[2] In the decades since the epidemic was first recognized in the West, when activist groups such as ACT UP began promoting slogans such as SILENCE = DEATH, the idea that an open, frank, non-moralizing discussion of AIDS is the key to the prevention of infection and to treatment with life-prolonging anti-retroviral drugs for all has become a global orthodoxy. Blame, in this view, is taken as one of the foundations of 'stigma and discrimination' (Herek and Glunt 1988), a 'second epidemic' shadowing AIDS. Massive efforts have been made to persuade Africans, and others, not to practise stigma and discrimination. Nonetheless, blame remains a central theme in talk of AIDS, in Malawi and elsewhere in Africa. In this paper we show how stories of deaths that would be clinically diagnosed as AIDS-related remain predicated upon the attribution of blame. Moreover – and surprisingly, in light of global presumptions of stigma and discrimination – in rural Malawi the micropolitics of blame for illness and death, along with the desire for justice it engenders and at times satisfies, do not appear to have deleterious consequences for HIV prevention or treatment, or even for the care of those dying from AIDS (Chimwaza and Watkins 2004; Peters *et al*. 2010).

Every death has its story. Often, as we shall show, different narrators will tell the story of the same person's death in radically different ways. Typically, however, the death is depicted as an instance of harm inflicted deliberately. When we pay attention to the details of the production and exchange of these stories, we can see how the fact that narratives of death are predicated on the question of blame both expresses and produces a desire for justice, for the righting of wrongs. This desire for justice, we will argue, is a central feature of the social impact of AIDS. At times, too, the telling of stories that shame or damage the reputation of others in the community is used as a way to exact revenge or impose justice. And, in small local villages, often populated by both close and distant relatives, the micropolitics of blame and justice can have destructive consequences for the

[2]For example, in 1988, in an influential collection of essays entitled *Blaming Others*, Renée Sabatier wrote that there had been 'an explosion of accusation and blame which are following the advance of the AIDS virus across the globe'. The book was intended to 'show the dangers of blaming as a reaction to AIDS: not only does it blur the vision of the "blamer", but it endangers those who are singled out for blame, all the while inhibiting AIDS prevention' (Sabatier 1988: 4). The now classic, and most influential, statement of this position is to be found in Paul Farmer's *AIDS and Accusation* (Farmer 1992).

everyday reciprocity upon which many depend in times of scarcity and uncertainty.

The telling of stories about death in the time of AIDS, then, is not merely the exchange of information or the sharing of knowledge. Stories work. They produce effects. Stories casting blame, we shall argue, work both by naming the perpetrators deserving of punishment and, at the same time, by inflicting a form of punishment through damaging their reputation.[3] Conversely, deaths can also be narrated in ways designed to minimize friction and conflict by dispersing suspicion from those who might otherwise be blamed; they may also help relatives of the deceased sustain their relationships with those who they feel have injured them (Durham and Klaits 2002; Livingston 2005; Whyte 1997; 2005). A death narrated in a tale of witchcraft, for example, can serve to release a spouse from the blame that would be his lot were the story to have been told as one of AIDS in which a faithful wife became sick and died, innocent victim of her husband's promiscuity. Stories of blame, that is to say, can figure in the quest for both retributive and restorative justice (Elechi *et al.* 2010; Wenzel *et al*. 2008).

In Africa, as elsewhere, people usually know what is *not* being said as well as what *is* when a story is told. The decision *not* to blame possible putative perpetrators in a story of death will be noted, just as much as the imputation or accusation of blame. Families and communities have to live together, after all, long after this death and the next. Restoring harmonious relations is not only an ethical imperative – often expressed in terms of *ubuntu* – but a practical necessity, since people are more likely to try to kill you if they hate you, and by whatever means necessary, including witchcraft (Ashforth 2005). What is not said in the narration of death, then, is often – indeed, usually, in our experience – as important as what is stated or implied.

Of course, there is more to the experience of bereavement than the telling of stories, and we do not pretend to provide a complete account of that experience here. Nor should the fact that we focus on what might be construed as negative aspects of the response to AIDS be taken as suggesting that we do not recognize or respect the love, care and compassion that are also features of the response to the suffering caused by this epidemic, as is emphasized by Frederick Klaits in his work in Botswana (Klaits 2010). Rather, we are convinced that stories matter, and we seek to show *how* they matter. And when it comes to stories of death, we contend, it is the attribution of blame that matters most. Note that we are not making claims here about what really happened or is happening in any particular instance; instead, we merely retell how the stories that are being told are told and how those tales are being put to work.

With the advent of widely available treatment for HIV, even in poor countries such as Malawi, there is a tendency to talk as if antiretrovirals have vanquished death – or will do so imminently, with just a bit more effort. This is evident in both the global scientific literature and in everyday conversations in local contexts, such as those we study here. The UNAIDS strategy for 2011–15, for example, presents a vision of 'Zero new infections. Zero discrimination. Zero AIDS-related

[3]The dynamics of reputation and status in communities in relation to HIV/AIDS have changed substantially in the years since antiretroviral therapy became widely available, with old patterns of stigma much diminished (Johnson 2012).

deaths.'[4] Although AIDS mortality has declined markedly, however, AIDS deaths still continue. Indeed, if global funding for treatment fails to keep pace with need, as seems likely, and if second- and third-line regimens, with their more complex clinical requirements and greater cost, are inadequately implemented, death rates could increase once more. Our purpose in this essay, then, is to contribute to a better understanding of the social dynamics produced by the epidemic by showing how the narratives of death are told, the contexts in which they are told, and the uses to which they are put.

THE MALAWI JOURNALS PROJECT

In this paper we draw on a unique set of texts produced by rural Malawians reporting everyday conversations in their communities as part of what is now known as the Malawi Journals Project.[5] These texts contain several thousand instances of ordinary people telling each other stories in the ordinary course of their lives. Written as journals in notebooks by young Malawians commissioned by the authors with a brief to attend to conversations in public relating broadly to AIDS, these texts are a form of insider ethnography, accounts of everyday life written by people immersed in the lives of their communities. The journals have been anonymized and de-identified before being published online. The basis of this paper is formed by an analysis of these published texts, coupled with ethnographic observation by the authors in the places where they were written, and discussions with the journal writers over the course of more than fifteen years, beginning in 1999.

Malawi is a poor and predominantly rural country of 14 million people, of whom the majority, including our journal writers, depend primarily on subsistence agriculture. The journals we analyse were written in rural areas of Balaka District in southern Malawi. At the time when these journals were written, HIV prevalence in these areas was 8.4 per cent (MDICP/MLSFH data); typically, however, people vastly overestimated both community prevalence and their own risks of being infected (Anglewicz and Kohler 2009; Kohler *et al.* 2007). In 1998, people were well aware of AIDS: both men and women knew an average of five people who had died of AIDS; the median number of funerals attended in the last month was three for women and four for men; and 61 per cent of women and 52 per cent of men said that they were 'very worried' about getting AIDS (Smith and Watkins 2005: 652). At the turn of the century in Balaka, verbal autopsies showed that three-quarters of all deaths were AIDS-related (Doctor and

[4]See <http://www.unaids.org/en/aboutunaids/unaidsstrategygoalsby2015>.

[5]The larger study, of which the journals project formed a part, was the University of Pennsylvania's Malawi Diffusion and Ideational Change Project (MDICP), now known as the Malawi Longitudinal Study of Families and Health (MLSFH). Descriptions of the studies, the data and research papers can be found at <http://malawi.pop.upenn.edu/mlsfh-publications>. For an extended description of the journals project and the methodologies involved, see Watkins and Swidler (2009). The continuing Malawi Journals Project is now housed at the University of Michigan under the auspices of the African Studies Center. An archive of journals, including most of those cited in this paper, can be found at <http://investinknowledge.org/projects/research/malawian_journals_project>.

Weinreb 2003). The district is predominantly Yao, and predominantly Muslim since the eighteenth century.[6] Christian missionaries arrived later; recently, Pentecostalism, with its identity of the 'born again', has been booming, disseminated by local and international preachers purveying a gospel of health and wealth (Manglos 2010).

Two features of the Malawi Journals Project make these texts unique, and uniquely valuable, for the study of everyday narratives in a time of AIDS: the mode of their production and their public availability. Native speakers of the languages in which the conversations occurred wrote the texts. They were also intimately familiar with the contexts of which they wrote. The journals are written in English, often with the original Chichewa or Chiyao usage noted. Since the beginning of the project, twenty-two people have written, with a core set of five writing journals since the inception of the project. Some of these have proved to be gifted observers of life in their communities: these are the journal writers whose work we rely on most. The journals have been anonymized and are publicly available online; in the near future, they will also be available through the Inter-university Consortium for Social and Political Research at the University of Michigan. This allows us, and others, to cite ethnographic source materials directly. More importantly, the existence and availability of this large archive of quotidian narrative allow us not only to make the claim that it is virtually impossible to tell a story about a death in contemporary Malawi without explicitly or implicitly raising the question of blame, but also to invite our readers to examine the materials for themselves with a view to refuting or qualifying that claim.

A BRIEF HISTORY OF AIDS-DEATH NARRATIVES IN RURAL MALAWI

Stories about relatives, friends and neighbours suffering from AIDS appear to have begun to circulate widely in rural Malawi in the early 1990s (Watkins 2004; Forster 1998). By the late 1990s, when more than 50,000 people were dying of AIDS each year in the country, they had become commonplace (UNAIDS 2013a). When the journals project began in 1999, Malawians were constantly reminding each other that 'AIDS is here'. Survey data from 1998 showed that all but 4 per cent of women and 5 per cent of men had been to the funeral of someone who had died of AIDS, with 47 per cent attending four or more funerals in the past month (Smith and Watkins 2005). In 1999, our journal writer Alice attended the funeral of a woman born in 1903. After the funeral, her friend asked: 'Do you think we shall reach as many years as she lived in this world?' Alice replied: 'Aaa! I don't think so.' To which her friend concurred: 'We can't live for ninety-six years. Nowadays there is AIDS disease. Nobody will come to be an old person as she was.'

[6]The classic ethnographic study of the region is J. Clyde Mitchell's *The Yao Village* (Mitchell 1966). For insight into the character of colonial rule in the region through the eyes of a loyal Yao subject, see Vaughan (2005). For a recent, and exemplary, ethnographic study of a community similar to those in which our journal writers live, see Verheijen (2013).

People had heard the message that the disease was due to a virus that somehow had reached Malawi, that it was sexually transmitted, and that it could be prevented by abstinence, fidelity and condom use (Watkins 2004). But technical accounts of deaths caused by a microscopic entity named HIV, even when the virus was given the Chichewa nickname of *kachirombo* (Probst 1999), seem never to have been entirely satisfactory in everyday contexts. As we shall see, they did not satisfy the demand for justice, the imperative that for a particular death someone must be blamed, and, if possible, punished, or restitution made so that the world could be seen as being just.

When news of AIDS reached rural Malawians, it entered a world where witchcraft narratives were the primary means of apportioning blame and seeking justice from perpetrators of any harm that resulted in an untimely death. Witchcraft narratives tell of harm done to others by people deploying invisible, secret means. They are, in essence, murder (or attempted murder) stories. Deaths attributed to witchcraft are narrated as being the result of the malice of a particular individual driven by envy, jealousy, hatred or the need to provide human flesh for feasting with his fellow witches, of an individual deploying occult forces to cause harm to others with intent to kill.

The AIDS awareness messages that spread through the country from the 1990s onwards offered competing explanations for deaths that ordinarily would have been interpreted as resulting from witchcraft.[7] Students of the epidemic have long observed the ways in which AIDS has been interpreted in terms of a witchcraft paradigm, aware that discourses about illness and death invoking witchcraft are not necessarily mutually exclusive with those invoking AIDS (see, for example, Ashforth 2002; Fassin 2007; Forster 1998; Johnson 2012; Liddell *et al.* 2005; Mshana *et al*. 2006; Peters *et al*. 2010; Rödlach 2006; Schoepf 1992; Stadler 2003; Thomas 2007; Yamba 1997). Our concern here is not to add to this literature by documenting further instances of witchcraft discourse in the context of AIDS illness and death, but rather to show how debates emerge that relate to the appropriate narrative within which to situate a particular death, and in ways that both reflect and shape the politics of blame and desire for justice within families and communities.

The prevention programmes authored by global experts named a virus as the agent of infection and blamed the categories of actors who transmitted the virus: first commercial sex workers and truck drivers, then unfaithful husbands and 'vulnerable women' selling sex to survive.[8] When ordinary people took up narratives of AIDS to explain particular deaths, however, they named particular people as the perpetrators in a manner reminiscent of witchcraft narratives. Despite widespread knowledge about AIDS and the modes of HIV transmission, 'witchcraft' remains a powerful idiom for telling stories of deaths that might otherwise be attributed to AIDS.

[7]For a description of indigenous notions of disease documented prior to the emergence of the AIDS epidemic, see Morris (1985).

[8]See, for example, the *Balaka District AIDS Plan 2000–2010* (Balaka District Assembly 2000), which claims that 'poverty has also been an issue in that those affected with it have been vulnerable in the way that they find prostitution as a way of earning money'. For a critique of the 'vulnerable woman' paradigm, see Higgins *et al.* (2010).

A striking feature of all narratives of AIDS-related death is a compression of timescale in assessing responsibility for infection: mostly, responsibility for infection is attributed to actions and partners in the present or the recent past. For example, one Mr Mkasa spent five years in South Africa before returning home sick to die. He was thus most likely to have been infected before he left Malawi, but no one speaking of his death at his funeral attributed it to anything other than his behaviour in South Africa. The reason for this truncation of timescale, we would argue, is not simply ignorance of the course of HIV disease but rather the demand for an effective narrative. In telling a convincing story about a death from AIDS, it is imperative to name agents responsible for infection, not simply to identify vectors of infection. Recent events and moral agents in the present are always more vivid in a story, particularly when the object of the story is to assign blame.

Often, competing narratives regarding AIDS and witchcraft are produced about a particular death, with distinctively different social implications, provoking debate among interlocutors as to which is most appropriate. People know what they are talking about when they name 'AIDS' as the cause of a death, just as they know about witchcraft. The point is to understand what they are doing when telling stories of the dead.

DEATH AND THE POLITICS OF NARRATIVE: THE CASE OF MRS CHANDIWIRA'S UNCLE

The story of Mrs Chandiwira's uncle provides a fairly typical narrative of death in the time of AIDS. One morning in mid-July 2003, our journal writer Alice escorted her friend Mrs Chandiwira to the funeral of Mrs Chandiwira's uncle. Funerals in Malawi, as in most of sub-Saharan Africa, are public events to which neighbours and strangers are welcomed as well as relatives and friends of the deceased (Durham and Klaits 2002; Jindra and Noret 2011; Klaits 2010). Alice learns that Mrs Chandiwira's uncle had been sick for some time with persistent and ever-worsening diarrhoea. He also suffered from malaria. He had been admitted to the district hospital, recovered, and discharged. But the diarrhoea returned. He was taken to traditional healers, with no success. Finally, he died. His family said he died as a result of witchcraft. Others, outside the family, said he died of AIDS. No one doubted, however, that *someone* was to blame.

Here is an extract from Alice's journal on the subject of the death of Mrs Chandiwira's uncle:

> I escorted Mrs Chandiwira to Manyungwa to attend the funeral. Her uncle died there …
>
> When I asked her about her uncle's illness she told me that … he was bewitched by his friends at his job because he was loved very much by his boss. He was a cook for the Arabs who stay in Blantyre doing their businesses. But his friends were jealous at him because he was the one working at the kitchen therefore he was … given many things like food, clothes, and other things …
>
> Since his boss was loving him he was sent to the hospital when he was staying in Blantyre and he got admitted until he got recovered then he was back to his job, but it was very unfortunate that the disease started all over again after [a] few days from the

day that he was back from the hospital … [H]is friends were not happy with him therefore so that they were adding other medicines to him. They were still bewitching him until he started the diarrhoea again and malaria was now an additional disease to the diarrhoea.

His boss then got tired with him and he just asked him to go back home to look for the treatment from home … He was ill while at home and he began to refuse taking any type of medicine. He was saying that it was better to die than meeting with problems in the world. But he stayed for a long time while ill before he died.

Now when he died, the message came to Mrs Chandiwira that her uncle was dead; when I heard about that I escorted her to the funeral but what I heard there was opposite to what Mrs Chandiwira was telling me. While there, I heard some women talking about the death of that man. During that time, Mrs Chandiwira was in the house where the funeral was and I went out because the room was very tiny. It was full of people who went to the funeral so that it had [not] enough space for many people to stay. I decided [to go] outside to stay with other people who were there and stayed somewhere under the tree because it was a good place for ventilation. While I was there, I saw three women coming and they sat near me. Nobody among them went into the house where the funeral was. One of the women put on the grey *chitenje* suit [a suit with brightly coloured fabric sewn into it], the other one put on black traditional wear and the last one was in the coffee body suit.

They began talking about the funeral, that the man has died of AIDS which he took in town. The woman who put on the grey *chitenje* suit said that she heard that in town he was moving with other women where he got that disease of AIDS.

Her friend who put on the black traditional wear also commented that she is sure that the man died of AIDS because she was staying there in Blantyre … near his house where he was staying with his wife. But he was too movious [promiscuous], especially at night when he knocked off from his job. In the most of the times, he was quarrelling with his wife because of his movements and she added that she also heard in Blantyre that his other partner is also ill …

Her friend who was in the coffee [coloured] clothes also said that the man who died had a girlfriend in the village. That woman is not looking healthy. She is thin and she [is] mostly found ill … coughing and opening bowels. She has been suffering from that disease for a long time only that she has not yet become serious but everyone has suspected that she has AIDS. And when people saw that this man has come here with this disease they also concluded that the woman got infected with the disease from him.

The woman in the *chitenje* suit said even the wife [of Mrs Chandiwira's uncle] is not healthy … Her body looks illness so that her children will suffer a lot when she will die.

They now began talking about the dangerous and the badness of AIDS. The woman who put on the *chitenje* suit was the one who was very concerned and she was very sorry [for] that family. She said that AIDS is the most dangerous disease which will kill anybody in the world. The badness is that if one is infected with it, it means that he/she will contract it to other people and it is spread in that way. It is very painful that some people are faithful but their spouses are not, therefore if one of them in the marriage is infected with that disease it means that the other one will also get infected though he/she was faithful. The most painful thing is that if the woman is infected while she is pregnant or she is breastfeeding her child that child will also be infected and die yet the child has not done sex at all and there is nothing wrong that the child has done in the world but he or she dies.[9]

In addition to that, AIDS always kills both mother and father leaving the children suffering from anything since they are young. They don't have anything to depend on … Because of the problems that the orphans meet with, they cause some of them to

[9]Treatment to prevent transmission of HIV from mother to child was not yet routine.

> become thieves and prostitutes. [It should have] been that AIDS kills all the people who are not faithful only and not those who depend on their spouses only. It should also not be killing the children because they do nothing wrong. All the three women were talking, getting much worried about the killer disease AIDS. They stopped talking about the funeral and continued by giving out other examples of people who died of AIDS and left their children as orphans. They were talking about how those people [children] are looking like since their parents died.
>
> The woman who was in the traditional wear said that she … knows about many people who left their children as orphans because of the AIDS disease and the children are staying in a difficult life and some of them are thieves because they have nothing to eat and wear. They stopped there because other people came and joined them where they sat therefore they were not comfortable to talk about the disease and the death.[10]

This account of talk at Mrs Chandiwira's uncle's funeral is typical of discussions aroused by the occasion of death. The family of the deceased insisted that the cause of death was witchcraft perpetrated by 'friends' – murderous friends – of the deceased. The motive was jealousy, the usual stimulus for acts of witchcraft. His co-workers, according to the family, were envious of the uncle's good relations with their employer.

When a death is attributed to witchcraft, the deceased is a victim of a murderer: the witch. The deceased may not be fully innocent in motivating the murderer, but he or she is not the agent of death in these narratives. He or she is, by definition, a victim. With AIDS, the story is different. When the death is attributed to AIDS, the deceased may be a victim of a murderer (a virtuous wife, an innocent child), a suicide (he was 'movious' and died as a 'profit'; she was a 'prostitute', similarly punished) or both (a promiscuous man married to a virtuous wife who kills himself and murders her). It is not surprising, then, that the relatives and loved ones of the deceased often find the witchcraft narratives more compelling, at least in their public statements: better to have one's son or daughter or beloved brother, particularly when they are also a benefactor, cast as an unambiguous victim rather than as a possible perpetrator of suicide or murder, or both.

Two assumptions of the everyday understanding of the epidemiology of HIV need to be understood in order to grasp the framing of AIDS deaths as murder narratives. The first assumption is that HIV is highly infectious – that a single unprotected encounter is not only sufficient but highly likely to pass on the virus; the second is that virtually everybody involved in promiscuous or adulterous sex is already infected (Anglewicz and Kohler 2009). Given these assumptions, to suggest that a person has indulged in sexual immorality is to imply that he is *deliberately* trying to kill his partners. (In all of the AIDS awareness and HIV prevention interventions designed to provide Africans with scientifically valid knowledge about the epidemic, the fact that HIV is a difficult virus to transmit and contract is rarely, if ever, mentioned. This speaks volumes about the attitude of the global public health community's attitudes to Africans' ignorance – but that is another story.)

Mrs Chandiwira's narrative of witchcraft as the source of her uncle's suffering, then, frames the deceased as an innocent victim murdered by his co-workers. This

[10]Alice_030618_anon.rtf. All citations to journals from the Malawi Journals Project refer to files available online at <http://investinknowledge.org/projects/research/malawian_journals_project>.

supposition of murder by witchcraft might have been a conviction passionately held, at least by some of the people involved in seeking a cure for his illnesses. By the same token, however, the witchcraft story might have been adopted by the family as a convenient way of deflecting culpability from their loved one, as would occur if the death were named as AIDS, as it was by the three gossiping women under the tree at the funeral. Moreover, by laying the blame on persons far away in Blantyre, the family's narrative serves to exonerate the deceased's wife from responsibility for the death – both as a perpetrator of witchcraft (wives are prime suspects in this regard) and as a possible source of HIV infection. Their story of witchcraft by unnamed co-workers also exonerates other relatives as well as neighbours in the local community who might be suspected if the perpetrators were left unspecified. By framing the narrative in this way, the family therefore avoids the possibility of open accusations against particular suspects with the consequent demands for justice, vengeance or redress that direct accusations often arouse.

Not everyone was convinced by the witchcraft story, however. Neighbours, who our journalist did not know personally (which is why she identifies them by their manner of dress), attributed the death to AIDS. Instead of blaming co-workers for the uncle's death, these neighbours hold the deceased responsible for his own demise. The neighbours' narrative of AIDS, unlike the witchcraft narrative of the family, identifies Mrs Chandiwira's uncle as a perpetrator, not a victim. Not only has he killed himself through his 'moviousness', a favourite Malawian vernacular term for promiscuity, but he has infected his wife, plus a girlfriend in town and another in the village. In this narrative, Mrs Chandiwira's uncle is a killer. To add to this chronicle of his crimes, when his wife dies, as the women foretell she will, Mrs Chandiwira's uncle will be responsible for inflicting unnecessary suffering on his orphaned children as well.

AIDS DEATH AS SUICIDE

When AIDS is named as a cause of death in these narratives, the possibility arises that the death was self-inflicted, akin to suicide: that is, the deceased killed himself or herself by wilfully disregarding the dangers of sex in the time of AIDS. When such a death is framed as self-inflicted, the subject is said to 'choose death' by 'moving' with many partners, or to 'choose death' by 'not choosing who to have sex with'. As one man put it to Alice: 'the world nowadays has changed … if he keeps on falling in love with women unknowingly [i.e. without paying heed to what he knows about their behaviour], he can commit suicide by getting infected with the diseases which are spread by sex'.[11] Or, as is commonly said in Chichewa: *Wamwalira ndi Edzi zofuna, zadala pano ine ndipite ndi kazisake ndipeze chakudya chapakhomo!* ('He/she has died of AIDS; that's what he/she chose, and now I have to go to hunt to get food for the household').[12]

The general attitude to responsibility for infection among those who choose not to follow the path of the dominant HIV prevention message – the ABC (Abstain;

[11]Alice_040508_anon.rtf.
[12]Simon_131104_anon.rtf.

Be faithful; use a Condom) – was well summarized in January 2008 by a young man chatting about sex under the ntondo tree in a village trading centre with a group of friends, including our journal writer Simon:

> It's [a] waste of time to be warning a friend nowadays about the virus/*kachilombo* because the messages of this *kachilombo* that we said avoid is being said everywhere at the political rallies, church meetings, at funerals and the messages are enough now that he who doesn't listen and follow, it's up to him and that's his or her problem for everyone has his own life.[13]

Choosing death through AIDS is not merely a problem for the deceased and his family in this world, however. In both Christian and Muslim traditions, suicide is a sin punishable by eternal damnation. Few relatives and loved ones of the deceased are willing to countenance such a future for those they loved or cared for, let alone embrace the shame and disgrace such a death would bring to their family. Small wonder, then, that circumspection is the norm when giving the name 'AIDS' to a disease and a death. Although international actors, in an effort to combat stigma, have urged those who are HIV positive to 'break the silence' by publicly disclosing their status, breaking that silence is not as simple as it might seem (see also Durham and Klaits 2002).

Since 2005, when antiretroviral therapy became more widely available – and increasingly in recent years as awareness of the effectiveness of therapy has become widespread, if not universal – deaths named as 'AIDS' have often been framed in terms of the patient's irresponsibility in not seeking, or delaying seeking, treatment. AIDS is no longer seen as an automatic death sentence, so when deaths do occur the default position is to blame the victim. Here is a young man telling our journal writer Alice in August 2012 about the death of his sister a week or so earlier:

> Though she was my sister … I was not happy with her behaviour [she was, he said, a 'prostitute' in the bars]. She knew that with her behaviour, it was very easy for her to be found with HIV and maybe she knew that she had it but she was not bothering of going to the hospital for [a] blood test and [to] start to receive the ARVs [antiretrovirals]. The time she was found very ill was the time that she was tested and told to start taking the ARVs. What I saw was that time she was late to start the ARVs and they did not work in her.[14]

Alice describes the young man as the relative of a friend. She met him by chance one morning at the market in her home village, to which she had returned after a long absence. It is relevant for what follows that Alice lives in a matrilocal village: men marry into the village and, if there is a divorce, leave the village, but the women stay. The young man opened their conversation by asking Alice if she had heard of the two deaths occurring in his family on the same day. The coincidence of two sisters dying on the same day was sufficiently unusual to prompt remark. Not only that, but it later emerged that the daughter of another sister who lived in the compound died around the same time. Shortly after this

[13]Simon_080104_anon.rtf.
[14]Alice_120910_anon.rtf.

conversation, Alice encountered the parents of the young man and the two deceased sisters as they returned from cultivating their fields. They greeted each other and she asked about the funerals:

> [The] mother told me that people bewitched them. There are some people who are not happy with their family so that they hate them. To her there is no death which can come and kill three people of the same compound at the same day unless it is an accident or the time of war.[15]

Such an account of murder need not preclude recognition by the parents that their daughters suffered from AIDS. But they insist that the ultimate blame lies on those who perpetrated the witchcraft. The young man's story, however, places blame on the deceased herself as a suicide. Her parents would probably not be happy about him speaking thus. Alice herself is highly sensitive in matters of respect. In her account of this interaction, Alice records nothing of what the young man says about the third sister's death, presumably because he did not narrate her story. But in a subtle rebuke to the young man, she tells us she replied to his narrative of his 'prostitute' sister's AIDS by invoking 'God's wish' as the real cause of death – a typical strategy for the foreclosing of narratives by those who would not speak ill of the dead. 'We loved them,' she told him, conjoining the two dead sisters in one invocation, 'but God loved them more than us. We shall meet again in the Day of Judgement.' In response to the parents' story of witchcraft, on the other hand, Alice, ever the peace-maker, implicitly accepts their account and implores the grieving mother 'to cool down her heart and ask Allah to forgive those who killed her relatives'.[16]

In most discussions of deaths where AIDS would most likely be the clinical diagnosis, participants – other than those closely connected to the deceased – usually debate who is the perpetrator and who the victim. Consider the case of Ndijamasi, a close friend of Alice's, who was dying. Knowing her time was coming, she called Alice to her home, where she told her sad story: she was dying of AIDS and her movious husband had infected her. At the funeral, however, this narrative competed with a quite different one casting the blame on Ndijamasi herself:

> Some people [at the funeral] were exaggerating that she was working in the rest house cleaning the rooms and she was sleeping with many different men there and then she got infected with AIDS. But some people who knew about the funeral's [deceased's] background were refusing and telling their friends that she was a good woman and she was very faithful but her husband was the one who got infected with that AIDS disease and contracted it to her.[17]

Alice, as she recorded her account of these competing stories, also narrated the story of her friend's death in such a way as to defend her virtue and exonerate her of blame. 'Exaggerating' is her polite way of saying that they were lying. The gossiping neighbours, however, were inclined to cast Ndijamasi as both

[15]Alice_120910_anon.rtf.
[16]*Ibid.*
[17]Alice_030618_anon.rtf.

murderer and suicide: responsible for her own death and the death of her child, who had died shortly before her.

Guilt on the part of a perpetrator in these stories is seldom simply sexual. In AIDS death narratives, culpability typically derives from greed. Men are said to be greedy for sex, women for money. Men are presumed to be movious by nature, but it is when men are *too* movious that trouble arises. The knowledge, now universal, that 'AIDS is here' transforms ordinary promiscuity into a murderous disregard for the lives of others. Similarly, the fact that women trade sex for money is a given. But women are supposed to depend on one man alone. When that man proves improvident, she may find herself compelled to seek support from others at the same time. When she ensnares more than her fair share of providers necessary for survival, however, whether through love of sex or money, she is denominated a 'prostitute'. Women, our journals show, are quicker to label their sisters thus, although men also share in the practice. Why they do so is a subject we are unable to address here.[18]

DEATH, BLAME AND THE DESIRE FOR JUSTICE

When people tell stories of hurts they construe as harms, assigning blame in the process, questions of justice inevitably arise. As Charles Tilly taught us, the question of 'Who is to blame?' precipitates the question 'What is to be done?' (Tilly 2008). In the case of Mrs Chandiwira's uncle, discussed above, Alice does not report whether the relatives of the deceased sought justice or vengeance against those so-called friends whom they claimed were responsible for his death by witchcraft. The fact that the purported perpetrators were far away in Blantyre makes it unlikely that the relatives would be able to take direct action against them even if they felt the need. This same fact, however, also means that the family can be spared the demands of a quest for retribution in their homes and local community, with the potential for discord and conflict that such a quest might arouse. Nevertheless, the desire for justice remains. And the ways in which stories of deaths are told in families, raising questions of justice, create complicated politics.

Narratives of death in the time of AIDS are not just stories of suffering endured by innocent victims, and certainly not stories without import. They are stories of harm: harm inflicted deliberately. This is why they are predicated on the question 'Who is to blame?' Sometimes the harm is posited as self-inflicted; at other times it is represented as being inflicted by malicious or negligent others. Who those others are, and how they perpetrated their crimes, varies. In AIDS narratives, they are sexual partners. With witchcraft narratives, suspicion and accusation can be

[18]For an extraordinary account of the dynamics of sex and subsistence in a Malawian village, see Verheijen (2013). Iddo Tavory and Michelle Poulin, who have both worked with the Malawi Journals Project, provide an extensive discussion of actual sex work in the region (Tavory and Poulin 2012). Mark Hunter's notion of 'provider sex', based on fieldwork in South Africa but more generally relevant, also provides a powerful antidote to the moralistic presuppositions preventing people from understanding how coupling happens in African contexts, as does Ann Swidler and Susan Watkins' paper on 'ties of dependence' (Hunter 2010; Swidler and Watkins 2007). See also Ashforth (1999) for a discussion of how young men in Soweto in the 1990s embraced conceptions of property to understand their relations with girlfriends.

cast more broadly – beyond the scope of bodily fluid exchange, but still within networks of intimacy and social proximity. In each case, however, the stories tell us that a wrong has been committed: someone has been *fucked*. This death has been perpetrated by *someone*. It is a murder.

Who tells the story casts the blame. The only way to avoid casting blame is to avoid telling a story in the first place; to refuse to speak of the change in a person's condition from health, through sickness, to death; to retreat into platitudes such as 'it was his time' or 'he has been called by God' or 'she has joined her daughter in heaven', which, in fact, is what often happens. But these are not stories, in the sense we discussed above. They are, rather, anodyne statements that allow stories *not* to be told. Sometimes, as with Alice's response to the young man telling the story of his 'prostitute' sister's refusal to seek treatment for HIV, they serve as reminders that stories *should not* be told of the dead. To do so is to invoke an imperative of justice – which is why, in response to the story told by the mother of the same woman, Alice tells her to let Allah forgive those who have killed her daughter (with witchcraft).

Stories attributing blame for death are told most freely among those not intimately connected to the deceased, since they are removed from the immediate politics of seeking justice. For example, the women whose funereal gossip Alice reported in our first story are clearly not closely connected with the deceased, Mrs Chandiwira's uncle. We can infer this because they do not go inside the cramped home to pay their respects. They have no qualms about suggesting that the deceased got what he deserved. For these women, then, the question of justice is speculative rather than imperative. Because they were not close to the deceased, they will not be required to do anything about his death. Nonetheless, while they feel free to speculate on the question of justice in their conversation, they are sufficiently sensitive to the politics of narrative to cease their talk when others who might be connected to the deceased come within earshot. Their gossip, however, has consequences for the social standing of those featured in the stories that are told. Word gets out about their HIV status, or their witchcraft. Friends, neighbours and family are forewarned.

For the women gossiping about a dead neighbour under a tree on a hot afternoon in Malawi in 2003, this disease is fundamentally unfair: it kills deserving and undeserving alike. As one of the women put it, it would not be so bad if 'AIDS kills all the people who are not faithful'. That would merely be just deserts for the fornication and adultery that pretty much everybody agrees is sinful – despite the fact that it is fun (Watkins 2004). But it also kills faithful spouses. Worse yet, it kills innocent children. In their gossip, the women were happy to share with one another their judgements on Mrs Chandiwira's uncle's guilt. But the fact that innocents suffer raises more troubling questions, for Christians and Muslims alike: what is God's role in all this African suffering?

God, all agree, is the final arbiter of questions of justice. For most of the thousands of interlocutors reported in our journals, the answer to the question of why God allows the collective suffering that is the AIDS epidemic is simple: He is punishing our sins, just as in the days of Noah. Trinitapoli and Weinreb spoke with hundreds of religious leaders in Malawi and found the same conviction (Trinitapoli and Weinreb 2012: 53). Amidst this collective punishment, justice for individuals – victim and perpetrator alike – will be found only in the next life, on the day Alice knows as 'Judgement Day'. This does not mean, however,

that the desire for justice in this world is either negated or becomes insignificant in the lives of the living. Nor does it mean that people stop seeking justice, retribution, recompense, restitution, recognition, reparations, restorations, and all the other responses to injury and insult that humans are heir to.

Another narrative pertaining to what might be called the 'cosmic' question of the meaning of AIDS suffering is also widespread: the disease was created by Whites to kill Africans. Rather than an instrument of cosmic justice, the disease is but another manifestation of the *injustice* so long endured by Africans at the hands of Whites (Rödlach 2006). Although scientific evidence has no relevance to the plausibility of this narrative in Africa, the evidence points firmly in the direction of European colonialism as the key factor in the creation of the HIV epidemic. Once the virus had crossed species from chimpanzees to humans, its spread was facilitated by forced labour and the growth of densely populated cities, and by widespread – and well-intentioned – public health campaigns against trypanosomiasis that reused hypodermic needles (Pepin 2011; Timberg and Halperin 2012).

Few people in the areas most affected by the epidemic are aware of recent advances in genetic science that have made it possible to identify the origins of HIV and the emergence of the AIDS epidemic. But most have no doubt that Whites were, and are, behind the disease. Even as access to antiretroviral therapies has improved – mostly due to increased funding from American and European sources – and mortality has declined, suspicion of Whites remains strong. This has little to do with racial antipathy. On the contrary, Africans generally accord white people inordinate respect. The imputation of blame, however, is a requisite of narrative. Since someone must be to blame, when the question of collective suffering of Africans is posed (and the absence of suffering by Whites is noted), the answer is obvious: Whites. Standard answers to the question of why Whites would bother to create a virus to eradicate Africans vary from versions of 'This is what they always do' (remember the slave trade) to 'They are tired of always giving us aid so they want to reduce the African population' (see also Trinitapoli and Weinreb 2012).

The desire for justice in AIDS death narratives is mostly satisfied with the death, or the promise of an inevitable death, of the perpetrator, who is typically spoken of as receiving his or her 'reward' or 'profit' from God in the form of death. In the simpler AIDS death narratives, there is consensus as to who is to blame. When the notorious 'prostitute' Tiyeze died, for example, it was taken for granted that she had murdered many men, and, as collateral damage, their innocent wives. Her death itself was, therefore, seen as just. Tiyeze's neighbours pronounced that '[s]ince she was having sex with men as a business she was making the profits of money and God wanted to give her a price'.[19] AIDS and death, for Christians and Muslims alike, serve in these stories as a reminder of the punishment awaiting a sinner.

Often, however, the likely perpetrator is still alive and healthy and the desire for justice among those who loved the deceased is frustrated, as it was in the following account.[20] The story, related to Alice by her friend Mrs Thom, a relative of the deceased, tells of a young woman who fell ill along with her husband. She was

[19]Alice_030618_anon.rtf.
[20]Alice_030727_anon.rtf.

taken first to traditional healers, but made no progress. When she was taken to the hospital, she was given an HIV test. The results were positive. At this point, Alice was told, the brother got 'annoyed' (in the idiomatic English of Malawi, 'annoyed' is a strong emotion akin to anger). Everybody knew the sister was a faithful wife and that her husband was a drunkard and a womanizer. 'He [the brother] went home after hearing that his sister was infected with AIDS. He went home to beat his brother-in-law.'

The brother threatened to kill his sister's husband if she should die: '[H]e cannot remain alive if it is true that his wife is infected with AIDS.' The sick woman's brother wanted to summon his brother-in-law to a hearing at the chief's court, as might be done were his sister deemed bewitched, arguing that the case was tantamount to murder. 'He [the husband] knew that the world has changed,' Alice wrote, 'he was doing that deliberately. He had the aim to kill his sister.' In reply to the brother's tirade, the brother-in-law's friends argued in mitigation that, although the husband was surely to blame, he had not been deliberately trying to kill his wife with AIDS since 'he was sleeping with other women when he was overdrunk … he was not knowing what he was doing.' Because there was no attribution of witchcraft, the brother had no recourse to the political authorities; he could only rant and rave. His relatives comforted him with the assurance that if his sister died, her husband would surely soon follow her: that is to say, justice is in the hands of God.

Many, perhaps most, people who fear imminent or continuing witchcraft attacks on themselves or on their families choose oblique methods of dealing with the danger rather than confronting the witch directly. They pray to God, or Allah, and/or consult traditional healers, who ground their healing practice in witchcraft cases on a promise of justice – usually in the form of capital punishment. In cases of witchcraft, healers usually promise that the curse (for want of a better word) will rebound upon the cursor, causing the death of the witch rather than of his or her victim. 'Hoist with his own petard,' one might say.

NARRATING STORIES OF DEATH IN SEARCH OF JUSTICE: THE POWER OF GOSSIP

A wide variety of motives for recounting narratives of death are found in the Malawi journals. The most common is simply the desire to pass on news about the death of a friend, relative or neighbour. Sometimes this news carries, or implies, a summons to attend the funeral; at other times it serves simply to inform interested parties after the event. Other motives for narrating death can be more complex, including a search for solace through understanding the meaning of a tragic event, usually in a restatement of religious commitment. Often the motive is simply the pleasure of malicious gossip.

By apportioning blame for a death to a perpetrator or perpetrators, named or unnamed, stories express, and to a large extent produce, a desire for justice. Although our reading of the journals suggests that this is the exception rather than the norm, sometimes such stories produce demands for action to bring a perpetrator to justice. More often, as noted above, the desire for justice is satisfied by

the narrative device of noting the perpetrator's recent, or impending, death. The telling of a story about a death, however, can also serve the cause of retributive justice by disrupting relations with perceived perpetrators within a family or community. Simply telling a story that names a perpetrator and details his or her crime, whether sexual or occult, can be an act of great consequence – especially in communities where survival in hard times can hinge on good relations within families and with neighbours. Damaging a person's reputation in such a context can make it more difficult for him or her to draw on support during times of need. Nothing damages a reputation more than the imputation of responsibility for murder, as in these narratives of death.

Gossip is considered a dangerous and powerful force in these communities, and is something that virtually all in authority regularly warn against. Preachers and sheiks, for example, regularly inveigh against gossip. In a sermon at the Ulongwe Church of the Central African Province, on Sunday 24 July 2005, for example, one of our journal writers reported the preacher castigating the congregation by saying: '[Y]ou are busy with adultery, witchcrafts and gossiping so that these are the things you are busy with where then you don't have the time to pray to your Almighty God so that I am telling you today my beloved fellow Christians that you have to kneel down and pray to the Almighty God so that you conquer Satan'.[21] Both Muslims and those who proclaim themselves 'born again' proudly forswear the pleasure of gossiping, along with adultery, witchcraft, drinking, and a raft of other sins.

As well as being uncharitable, or impolite, gossip about witchcraft in a context where witches are feared can also be dangerous: if word gets back to the subject of the gossip, it can cause enmity and thereby motivate witchcraft attacks (Mitchell 1966). Despite these dangers and admonitions, however, gossip is a pastime regularly indulged and much enjoyed – as is speaking ill of the dead. Discretion is nonetheless advisable. As we saw in the case of the women gossiping about the death of Mrs Chandiwira's uncle, they stopped gossiping when others arrived, people whom they did not know and who might have included friends or relatives of the deceased. Generally, people are inclined to respect the sensitivities of those close to the deceased and do not talk about them in their presence. At the heart of this seeming reluctance to speak openly of AIDS, then, is not some form of denial but rather an awareness of the interpersonal politics of blame in families and communities. Deliberately spreading rumours and defamatory gossip can also result in acts of overt violence, thereby providing further satisfaction of the desire for revenge.

CONCLUSION: THE POLITICS OF BLAME IN THE PREVENTION, CARE AND TREATMENT OF AIDS

Stories about death in the time of AIDS – predicated as they are on the question 'Who is to blame?' – are rarely of the sort advocated by those who preach the message of 'break the silence'. Pauline Peters and her colleagues have argued that:

[21] Diston_050724_anon.rtf.

> [t]he general avoidance of the term *edzi* (AIDS) in favor of a whole range of 'roundabout' labels that, nevertheless, are perfectly understood to refer to the new disease complex, and the avoidance of attributing a person's death to HIV/AIDS in public homilies at funerals are attempts to hold at bay the hopelessness that a disease 'without a cure' might inspire, and to give everyone a proper farewell at the final obsequies. (Peters *et al.* 2008: 96)

We see the politics of naming illnesses and causes of death somewhat differently. Holding hopelessness at bay and giving a proper farewell are important, but, as we have shown in our analysis of blame, another dynamic is in play as well. Our primary finding is that whenever people tell stories about death in this time of AIDS, they imply that *someone* is to blame. Attributing blame may be satisfying for the relative of the deceased, but, because it has implications for relations within families and communities, it is not to be done lightly. This is why, when people want to avoid the politics of blame, they resort to anodyne clichés, such as 'it was his time' or 'God has called her to his side': that is, they avoid narrating the death.

Nonetheless, we agree with the findings of Peters *et al*., as well as with those of others who have shown that the avoidance of direct speech about AIDS does not necessarily signify denial. Among the burdens of this epidemic is the problem of how to talk of its inevitable result: death. Every way of telling a story about a death has implications – the most important of which, we have argued, is answering the question 'Who is to blame?' These implications have consequences, shaping relations among the living – and between the living and the dead.[22]

Now that antiretroviral drugs are widely available, with a resulting decline in AIDS mortality, the politics of blame is somewhat less intense in the communities in which our journal writers live. Although it is not clear that in everyday contexts people make a clear distinction between what medical science would call treatment and cure, people with whom our journal writers interact seem clear that the failure to seek treatment when suffering from illnesses that are widely understood as AIDS is entirely the responsibility of the patient.[23]

The narratives we have described in this paper ingeniously weave together customary sexual and social morality, international prevention messages, and advice from friends and from the government, in ways that are generally beneficial, were they to be followed, for the prevention of HIV infection. Promiscuous sex in these stories is invariably cast as physically risky: you cannot know for sure who is HIV positive and who is not. Sex kills. Adulterous and promiscuous sex is also seen as eternally risky: after your death, you may still be blamed by your friends for murdering others and for committing suicide, not to mention condemned to eternal damnation in hell. Nor does the fact that

[22]For an exploration of the significance of relations with the dead – and a framework for thinking about relations with the 'living dead', amongst whom AIDS patients are sometimes included – see Ashforth (2005).

[23]For example, in Alice_100712_anon.rtf, Alice reports the story of a man who was taking antiretrovirals but decided to get remarried and hid his status from his new wife. This made it impossible for him to continue treatment. Eventually he fell sick with AIDS. He received no assistance from his family as everyone thought it wrong both that he discontinued treatment and that he failed to tell his wife.

deaths are sometimes spoken of as resulting from 'witchcraft' undermine the imperative of AIDS prevention; assertions of witchcraft are almost always challenged, if not always directly, by speculations that focus on the deceased's sexual history.

The ways in which narratives of death are structured around issues of blame complicate practices of care in many ways, most of which we have not been able to explore here. Victims and perpetrators are not automatically entitled to equal care and concern, in rural Malawi as elsewhere. The politics of blame also perhaps explains why it is not obvious to rural Malawians that the government and NGOs should devote resources to people with AIDS. Survey respondents, when asked to rank their preferences for resource allocation to various services, ranked AIDS services last, behind greater access to clean water, increased health services, more agricultural development and better education programmes. In interviews with chiefs who were also asked these questions, they explained that everyone needs the other services but not everyone needs AIDS services (Dionne *et al*. 2013). The journals record instances where parents or other caregivers refuse to expend resources on taking patients to hospital because of the moral turpitude of the patient. But, given the hundreds of stories of illness and death we find in these texts, far more impressive is the simple recitation of a patient's quest for a cure, with the taken-for-granted background assumption that those who should be caring for patients, primarily women, are actually doing so (Chimwaza and Watkins 2004).

Regarding modes and methods of treatment, nothing in the narratives of death as we read them suggests that sick people and their families are disposed to resist the quest for a cure or fail to seek treatment wherever it can be found, despite the fact that, since these are stories of death, all such efforts have proven futile. Treatment failure, however, is another matter. Any failure of biomedical treatment in the region has long been taken as a sign that the forces responsible for illness are not natural. Since 2004, the Malawian government has been providing antiretroviral therapy for HIV infection for steadily increasing numbers of patients. Talk of antiretrovirals[24] has been appearing more often in the journals in recent years, as more people in rural areas gain access to treatment. The basic structure of narratives of death, however, remains unchanged, and is still shaped by the question 'Who is to blame?' But once that question has been answered, justice can be found only in the next world.

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[24]Such drugs are colloquially known as *maUnits*, after the ubiquitous mobile phone recharging units sold in stores and on the street – units to 'top up' life.

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ABSTRACT

The key to understanding the experience of AIDS mortality lies in the stories that people tell each other about those they know who are suspected to have died from AIDS. We use a unique set of texts produced by rural Malawians reporting everyday conversations in their communities. These texts, drawn from the online archive of the Malawi Journals Project, consist of several thousand instances of ordinary people telling each other stories in the ordinary course of their lives. They are a form of insider ethnography, accounts of everyday life written by people immersed

in the lives of their communities. Through analysis of these texts, we show that narratives of death are predicated upon the question 'Who is to blame?' We argue that a micropolitics of blame arises from practices of narrating death and shapes individual and collective responses to the epidemic. When we pay attention to the details of the production and exchange of these stories, we can see how the fact that narratives of death are predicated upon the question of blame both expresses and produces a desire for justice, both for the righting of wrongs through retributive punishment and for the restoration of harmonious social relations among the living. This desire for justice, we argue, is a central feature of the social impact of AIDS.

RÉSUMÉ

La clé pour comprendre l'expérience de mortalité par le SIDA réside dans les récits que les personnes se racontent mutuellement à propos de ceux qui sont suspectés d'être morts du SIDA. Il utilise pour cela une collection unique de textes produits par des ruraux du Malawi relatant des conversations du quotidien au sein de leurs communautés. Ces textes, tirés des archives en ligne du Malawi Journals Project, consistent en plusieurs milliers de cas de personnes ordinaires se racontant des récits dans le cours ordinaire de leur existence. Ils sont une forme d'ethnographie de l'intérieur, des récits de la vie quotidienne rédigés par des personnes immergées dans la vie de leur communauté. À travers l'analyse de ces textes, l'auteur montre que les récits de mort reposent sur la question « À qui la faute ? ». Il soutient qu'une micropolitique du blâme résulte de pratiques de récit de mort et façonne les réactions individuelles et collectives à l'épidémie. L'étude des détails relatifs à la production et à l'échange de ces récits montre comment le fait que les récits de mort reposent sur la question du blâme exprime et produit un désir de justice, à la fois pour rectifier des tors par une punition rétributive et pour rétablir des relations sociales harmonieuses entre les vivants. Ce désir de justice est, selon l'auteur, un élément central de l'impact social du SIDA.