EthnoScripts

Abstract

During ethnographic research on HIV-positive pregnant women in Lesotho, I found myself confronted with conflicting narratives, but what we do know is that MaMeli's baby passed away the day after she gave birth in the hospital. Trying to reconstruct what had happened, I interviewed the young mother, her mother-in-law, a midwife, and a paediatrician. Their stories differed significantly from each other. Yet, despite the inconsistencies between them, they proved valuable for my study. Ethnographic storytelling can reveal an informant's present view on past occurrences and give insights into the social roles of narrator and audience. A narration always implies two time periods: the past situation as experienced (erzählte Zeit) and the situation now when the occurrence is being interpreted (Erzählzeit). Hence, whilst analysing the stories did not bring me any closer to understanding what had happened to the baby, an examination of the four versions taught me much about each narrator's present situation and how they related to each other. In other words, the different renderings of the event allowed an understanding of the hegemony of interpretation. I argue in this paper that contradictions in narratives are more a chance than a challenge for ethnographic writing. I call on anthropologists not to erase out inconclusive stories in their ethnographic data but to delve into them and to find plausible explanations for why it is not possible to achieve conclusive solutions.

Factual Conflicts and the Hegemony of Interpretation: Four Narratives and the Anthropologist's Version

Lena Kroeker

Introduction

Often anthropological projects conclude their reports to the funding agencies by saying that the available time had been too short and the resources too little for a topic so complex and that more research was required. The publications that are prepared on the basis of the data collected, however, present only conclusive interpretations: inconclusive, puzzling findings remain unmentioned. Publications hardly ever tell about the matters that are left open and just did not make sense to the ethnographer. The story of MaMeli, one of my key informants, is one such inconclusive case. When writing my PhD thesis, I found myself with two options: either to silence her case completely or to use it as frame for my methodology chapter, where I could address the inconsistencies it threw up (Kroeker 2015: 49–51). I considered it more honest to account for the gaps and contradictions in my data and to identify how, in some parts, my analysis may be speculative rather than interpretative, and thus opted for the latter. I did so fully aware that ethnographic texts, in general, only suggest one amongst many possible interpretations. In this paper, I reflect on my experience with dealing with MaMeli's case: how I moved from my field notes, which documented my interactions with MaMeli, her mother-in-law, a paediatrician, and a midwife, to an interpretation where I extracted details and placed the four narrations in a cultural context. I examine how my version was at best an approximate reconstruction of the situation. I draw on Reyna (2019) who argues that in anthropology there are but 'approximate truths', each of which has to be based on an explanation. He underscores that in the end it is the anthropologist who judges certain explanations to be more reliable than alternative ones.

Between 2007 and 2009, I conducted ten months of ethnographic research at Lesotho's best HIV treatment site, the Mafeteng Government Hospital, located in Mafeteng, a town about eighty kilometres south of Lesotho's capital Maseru. I had set out to study how young women integrate the complex HIV programme to prevent passing on the virus to their babies. Lesotho was one of the countries suffering heavily under HIV/AIDS. At the time its HIV rate stood at 25% of those in the reproductive age range and the rate amongst pregnant women was even higher, at around 28% (ICAP 2009). HIV can be transmitted from mother to child in utero, during delivery, or through breastfeeding. Compliance with medical protocols allows significant reduc-

tion in HIV transmission from mother to child and promises a healthy life. Still, I had prepared myself for having to deal with cases of maternal and infant death.

During the first phase of research, I accompanied medical staff at the hospital, a facility that provides an excellent infrastructure for women during pregnancy and labour. I was able to observe and participate in the practices of antenatal care and HIV counselling. In the second phase, I identified thirty pregnant HIV-positive women who allowed me to accompany them to their antenatal appointments, visit them at home, meet their relatives, and engage with them in interviews, informal conversations, and through participant observation. One of the women I met was MaMeli, 19 years old and pregnant for the first time. MaMeli had completed Form B (Grade 11) and, for the last term of her pregnancy, was staying with her mother in a better-off neighbourhood of urban Mafeteng. During visits, I could feel the tensions between her mother, her mother-in-law, and MaMeli. Her mother would have preferred MaMeli to continue her schooling instead of getting pregnant from a much older man, a mine worker and the son of a neighbour. Because her mother did not agree to the liaison, MaMeli seemed to struggle more with her social situation rather than her medical condition – at least that was my perception. Medically, MaMeli's pregnancy was without complications and she was an understanding and informed client in antenatal counselling sessions. However, I began to perceive problems once the baby was delivered and passed away a day later. In an attempt to reconstruct the hours between the baby's birth and its death, I interviewed the young mother, her mother-in-law, the midwife, and the paediatrician who attended to the baby in its severe condition, but their stories differed so significantly that it was just impossible to discern with any conclusiveness what had happened to the baby and the reason for its death. Emotionally, I felt with the family, mourning the loss of a child; academically, I was puzzled by their narratives. MaMeli's case was one of those in my ethnographic sample that raised a whole set of methodological and analytical challenges as well as possibilities. The deliberations around the baby's death revealed etiquettes, tensions, and social roles that allowed important insights in the social drama.

The paper opens with a presentation of the four varying narratives of the birth and death of MaMeli's baby. The rest of the paper then examines how I wrote my ethnographic account of the event for an academic and ethnographically-trained audience. I do so in four steps: I discuss why informants tell contradicting versions of the same story, delve into the theory of storytelling, briefly examine the issue of lying, and examine the hegemony of interpretation. I argue that ethnographic writing is not necessarily about finding the truth but about finding plausible explanations for not finding the truth.

Four stories with factual conflicts

It was after Christmas when my research assistant MaKhotso and I checked the delivery record at Mafeteng Government Hospital's maternity ward. Usually we passed by the maternity ward and the post-natal room every morning to see whether any of the thirty women participating in my study had arrived to deliver their babies. Because of the Christmas break, we had not been in for a couple of days. Noting from the delivery record that MaMeli had delivered a healthy boy and already left the hospital a few days ago, we decided to pay her a visit at home.

In Lesotho, first-time mothers and their babies normally stay at the mother's maternal home, not with their in-laws at the marital homestead.[1] We were surprised, however, to find MaMeli at her in-law's place. When we entered, she was sitting on the floor dressed with a white headscarf, a garment marking that she was in mourning. We greeted MaMeli but were unable to talk to her in private because her mother-in-law came into the room with us. The mother-in-law told us that the baby had passed away the day after the delivery. In the presence of MaMeli, the elderly woman harshly described what had happened. I summarise her account from my field notes that I made on the same day[2]:

> *MaMeli's baby passed away the day after she gave birth. After the delivery, the baby dropped out of the midwife's hands whilst a nurse was sewing the episiotomy. This fractured the head of the child, the mother-in-law claimed. The staff did not treat MaMeli, the baby, and the mother-in-law nicely at all. The nurse spoke in a rather rude way to her. She and MaMeli even overheard the nurses complaining that the in-laws were visiting too often and interrupted them in their duties.[3] When the midwife discharged MaMeli and the baby from the hospital, MaMeli was told to come back for a check-up in two days.*

[1]   The movement between households is linked to the rites of passage a woman undergoes with marriage. First-time mothers in particular go to their maternal homestead during the last trimester of pregnancy until three to four months after confinement. In this liminal phase, they are fully catered for by their own kin (Ashton 1952: 30; Kroeker 2015: 106–107). The movement between households sometimes interrupts the HIV prevention programmes the mothers are following.

[2]   See also Kroeker (2015: 49–51). I also carefully noted the mother-in-law's non-verbal expressions and any other observations I made during the event, as suggested by Girtler (2001: 141–143). Immediately after the meeting, I sat down with MaKhotso to recapitulate and complete the notes.

[3]   Relatives are not tolerated in the delivery room and the nurses and midwives strictly send them to wait outside the ward. Relatives are, however, allowed in the postnatal room. I doubt that the mother-in-law had been present during the delivery as she makes us believe.

But, the mother-in-law asked, turning to MaKhotso and me, was it usual for a baby to be brought in for a check-up after two days already? When I answered, 'No, it is usually after one week',[4] *she exclaimed that this proved that the nurse knew something was wrong with the baby but kept them in the dark. But MaMeli took the baby to the hospital again the very next day. The baby was bleeding from the nose. And the mother-in-law claimed that this must have been caused by its deformed head. The doctor examined the baby, wrote something in a book, tore out the page, and sent it to maternity ward, the mother-in-law recalled. He also immediately sent a call to the midwife who had delivered MaMeli's baby and who was again on duty. When the doctor asked the midwife about what had happened to the child, she did not say anything and just kept quiet.*

The mother-in-law strongly expressed her dissatisfaction with the nurse and claimed the staff behaved in a careless and rude manner in front of mother, child, and mother-in-law. Based on that experience, she argued, MaMeli should rather deliver her next baby at home.[5] Shocked to hear about the baby's death and the bad service MaMeli had received at the delivery ward, MaKhotso and I promised to investigate the case. Thus, on the following day, when the paediatrician who had attended to MaMeli's baby was on duty, I approached him to ask whether and what he remembered about MaMeli's case. He recalled having attended to her and her baby when MaMeli brought baby to the hospital one day after being discharged. The paediatrician gave me this account:

MaMeli arrived after 7 p.m. when he was on call for the night shift. The mother-in-law dropped in later and immediately started to talk angrily. She blamed the midwife for having dropped the child, arguing that this had resulted in the baby's malformed head. She claimed the bleeding was a consequence of a head fracture for which the midwife was responsible.

When he checked the baby, he noticed that the baby was bleeding from the nose, but it was not severe. He asked when the baby's condition started, but the mother-in-law was unable to answer. He figured that the mother-in-law was not with the child during the night and asked her, 'Who is the mother of this baby?' upon which the mother-in-law pointed to MaMeli. The doctor

---

4   I was here referring to the check-up one week after birth as stipulated by the 2009 medical protocol for the prevention of mother-to-child transmission of HIV.

5   From a medical perspective, home deliveries are not advisable for HIV-positive women.

interrogated MaMeli and she explained that the baby had been crying all day starting from 8 a.m. He told them that they had come too late. The baby had a neonatal sepsis, which he could have treated if they had come earlier. He added that traditional people often apply Vaseline or cow dung to the umbilical cord, which causes infections of the blood cycle.[6]

I then looked for the midwife who had delivered the baby, and she told me:

The doctor [paediatrician] only called her when the baby had already passed away. She remembers the baby's fontanelle had not been closed, but a malformed head is not unusual with newborns. Because the Apgar score[7] had been low, they had kept MaMeli and the baby in hospital for two days before sending them home. When the paediatrician called her [when MaMeli brought the baby back to hospital], she was surprised to find out that this baby, whom she remembered as having been big and healthy upon discharge, had passed away. The midwife suspected that the baby could have died of an undetected heart or lung problem.

With that information, I asked MaKhotso to accompany me back to MaMeli. This time, we met her alone. MaMeli, in the absence of her mother-in-law, gave us a slightly different version of events:

MaMeli already realised in the postnatal room that her baby was unwell. When I asked her what symptoms led her to think this, she mentioned the deformed head, which her mother-in-law had interpreted as caused by a fracture. MaMeli stated, however, that the nurse had told her that 'the baby won't have a problem with the head'. She also noted that the baby was crying a lot whilst all other babies in the postnatal room were quiet. The other mothers in the postnatal room told her that she must have lived in a noisy place during her pregnancy to have a baby that was crying so much. MaMeli recalled thinking that the baby may calm down at home, but the crying got even worse.

When they were discharged, MaMeli spent the first night at her mother's rural home some forty kilometres away from hospital. The baby cried all night long and had hot flushes, like a high fever. It was also having trouble breathing. She called her sister-in-law to accompany her to the hospital in the evening. The

---

6   I have been unable to find any further indication of such traditional practices in the literature or on the ground. The paediatrician was not of local origin and did not have children himself.

7   The Apgar score is a method to quickly appraise the health of a newborn baby.

mother-in-law joined them at the hospital. By this point the baby had a severe nosebleed and, when they undressed the baby upon arrival at the maternity ward, they realised that the insides of its clothes were all bloody. Mother and child were then referred to casualty, where they were attended to by the paediatrician.

The four perspectives show some overlaps but also contain some diverging interpretations that left me puzzled. Whilst the baseline of the story became clear, the versions did not seem to fit together and there was little chance for me to get the full picture. Who was present when? What time was the baby delivered, when were mother and child discharged, and when did they return to the hospital? When did baby die and was its death caused by a fractured head, a neonatal sepsis, or some cardiovascular problem? Why did MaMeli let her mother-in-law tell the story to the paediatrician and to us, when the mother-in-law was not even present during delivery or at discharge, or when MaMeli went back to hospital with the baby? Who rewrote, intentionally or unintentionally, the story and why?

I tried to reconstruct the scene and looked for any information that would allow me to consolidate the versions. I learnt through participant observation that the paediatrician habitually blamed 'those traditional people' and was easily annoyed by relatives of patients who 'bothered' medical staff. I also found out that MaMeli had been all by herself the night after the delivery. Indeed, I established that MaMeli had no experienced women around her who could have assisted her in the first hours with her baby and who could have noted much more quickly that something was severely wrong: her mother was unable to be there because she was working night shift at a textile factory; and her mother-in-law had only the previous day returned from a six-month training period as a traditional healer. The hospital delivery record was incomplete yet attested that no abnormalities were detected during or after childbirth. The delivery had been without complications and the baby's Apgar-score high (contrary to what the midwife had indicated). Even MaMeli's medical booklet and the baby's health record gave no indication that mother or child were advised to stay in hospital for medical treatment or observation. And, in contrast to the mother-in-law's claim, the booklet and health record both indicated that mother and child should come back after seven days for the baby's first check-up. There was no record at all that a visit of the clinic was recommended two days after discharge. From the hospital practices I learnt that relatives are in fact not allowed in the delivery room, and yet the mother-in-law claimed to know that the midwife had dropped the baby in this room shortly after birth whilst a nurse was sewing the episiotomy. And despite knowing the situation best, as the only person who had been present at all times, MaMeli did not make any effort to correct inconsistencies in the storytelling; nor did the midwife add any clarifying

information. In fact, I had the suspicion that the midwife was confusing the case with another one altogether.

Generally I took the approach during fieldwork to believe the key informant's version, for the sake of our further collaboration. In MaMeli's case, however, I gave up on finding reliable information and concluded that the details I gathered were selective and reductive. This threw a shadow over the reliability of the information I had gathered earlier about MaMeli. Speaking to her relatives revealed that she had indeed lied to me about her marital status. MaMeli had told me she was married whilst the wedding had only taken place upon the mother-in-law's return to town. I concluded that she was likely an unreliable informant. At this point I had to decide that MaMeli's case contained little information about the HIV prevention programme I was examining and so completed my research without seeing MaMeli again. Yet, when I now engaged with my other informants, I began to wonder about the truthfulness of the information they gave me. This reflection on methodological limitations led to me dedicating a complete chapter of my dissertation to the topic. I took MaMeli to showcase that there is always uncertainty in research and there can be situations where it is impossible to believe a story one did not witness oneself. How can one tell facts from fiction?[8] Is it my job as anthropologist to do so? Would I turn fiction into claims of fact for the insight of my readership, to make a story compelling and real (Fine 1993: 277)? Would it not be more plausible for my ethnographic writing to state that informants at times err, lie, or manipulate? Do I have the authority to tell what version is wrong? And what is my role in writing that story down?

Writing an ethnographic version of MaMeli's story

The bottom line is that I was not able to reconstruct exactly how and why MaMeli's baby had died, but the case was nevertheless an eye opener for me as ethnographer. I now turn to discuss how inconclusive stories such as this one have informed my ethnographic writing and how and why it is possible to produce ethnographic knowledge from unreliable data. My knowledge production follows the postmodernist notion that there is no factual and correct truth but a multiplicity of equally valuable interpretations. Such interpretations relate closely to the narrator's knowledge embedded in a respective 'frame of reference'. In an analysis of global and local knowledge systems, Loimeier and his colleagues (2005: 12) defined a frame of reference as

---

8   I follow Hastrup (2004) in understanding 'facts' as information that is organised as undeniable, general knowledge. Whilst facts are generally agreed upon, there may be different interpretations on whether a certain fact answers a particular question. Only in the service of a claim or a question do facts become significant.

the standards of evaluation and orientation which can be applied by actors in a specific situation and which make fundamental statements about the actual and ideal nature of the world. Reality is interpreted with the help of and within central frames of reference.

Barth (2002: 3) identified three aspects of knowledge. Like Loimeier and his colleagues, he rejects that knowledge is an object or that there is such a thing as objective knowledge; rather people host a 'corpus of substantive assertions', based on experience, embodied knowledge, and inferences. Second, knowledge is instantiated as words, symbols, or performative actions. Third, knowledge is dissemination in social interaction, which means that knowledge production takes place during an exchange. In MaMeli's case, knowledge production happens at the various meetings, with MaMeli, her mother-in-law, the midwife, and the paediatrician staging their performances. Yet knowledge production takes place not only in the field but also in the engagement of me, as ethnographer, with you, my readers. Hastrup (2004: 465) rightly notes that 'the anthropologist in the field engages the world as a "double agent", being both a trained researcher and a character in the local drama'. Knowledge is produced in relation to an audience, which in my case is an imagined, invisible community of readers. The anthropologist has the authority to select and arrange the information and gather it as a text, for the end of providing a meaningful and convincing statement. Given this selection and interpretation of data, it is not the empirical material that counts but rather the art of making the interpretation convince a (present or imagined) audience. It needs to be noted that scientific knowledge often claims to be the dominant frame of reference, and yet, as Neubert and Macamo (2005: 246) state, 'scientific knowledge only represents one of several possible frames of reference and is therefore the result of interactions, and is historically specific, culture-bound, and not value-neutral' (my translation). Following this premise of the sociology of knowledge, I now offer my own writing of MaMeli's case from an anthropological frame of reference. Whilst one could argue that, by presenting my version, I intentionally or unintentionally claim that my version trumps all others, I rather consider my version as entering into a dispute over the 'hegemony of interpretation' (Neubert and Macamo 2005: 254) with the four narratives presented above. I present my version in three steps, first by looking at why stories matter, then by examining biographic illusions and, lastly, by analysing the link between power and authoritative knowledge.

The narrators err but their stories matter

In my version of the story, the four narrators embellish some parts of the story and conceal others. They interpret what they know about what hap-

pened in the few hours between the birth and death of the baby in line with their frame of reference and their audience. Their versions are marked by significant differences, suggesting intentional or unintentional acts of erring, manipulation, or lying. Often ethnographers will sift out indications of such glaring inconsistencies, something I first intended to do. But van der Geest offers an explanation of lying that allows a deeper understanding: he argues that lying is a way of keeping face. He takes an obvious lie as indicator that he has touched a sensitive issue, with the false information pointing to the relevance of the hidden information (van der Geest 2018; see also Salamone 1977). Van der Geest argues that hiding information in a public conversation shows demeanour and respect, and helps people defend each other's respectability. Based on Erving Goffman's concept of 'face', van der Geest shows that lying is sometimes the most respectful and tactful way of evading having to give difficult answers. Passin (1942: 235) also sees possibilities for using field notes that contain obvious lies: 'it is possible to use lies very profitably as field-data, in some cases even more significantly than truthful statements'. Salamone draws out that 'lying is a form of communication, not its negation' and that anthropological investigations 'can lead to the discovery of cultural values, dynamic aspects of social organisation and the informal structure of networks' (Salamone 1977: 120, 117). And despite the methodological problems that lies pose in the field, McGranahan (2017: 247) sees the following potential:

> *Witnessing [lies] is to see and experience from the inside of a community, to gain an experiential sense of its logics and rhythms, and to be able to mark and explain how truths and fears and lies combine to eliminate certain histories in favour of felt or desired beliefs.*

The authors argue that whilst checking information might prove that an informant has lied, it does not answer the question as to why the person has lied and in what forms of social relation the person is embedded. Revisiting my field notes I found that keeping 'face' was crucial for young urban women in Lesotho, particularly in their interactions with men, elders, and in other hierarchical social relations like with medical staff. Many young women intended to show their compliance with behavioural protocols and tried to avoid open disputes; they would rather lie, manipulate the expected outcome of a process, or simply abscond.[9] If an informant was trapped between candour and seemliness, seemliness was often favoured, argued Goffmann (1963: 75), and my observations support his statement.

To gain some understanding as to whether MaMeli, her mother-in-law, the paediatrician, and the midwife lied intentionally (also see Luncă, this

---

9   I elaborate on these modes of dealing with conflict in asymmetrical social relations in Kroeker (2014).

issue), we need to place MaMeli's case into the social context of premarital relationships in Lesotho. Earlier studies show that Basotho people generally discourage premarital sexual relationships and rather encourage early marriage (Maqutu 2005: 36), although secret premarital relationships must be considered the norm rather than the exception. This is even more so the case in times of HIV/AIDS. However, if a relationship became known, parents (and specifically parents of girls) were blamed for the lax moral upbringing of their offspring or their lack of supervision. Parents, therefore, tried to avoid this stigma from their neighbours. In cases where a relationship was kept out of the public eye and did not have any consequences such as a pregnancy, many parents would turn a blind eye (see also Bochow 2007). But if a pregnancy became visible, the parents of the girl would certainly demand to know who had impregnated their daughter. To avoid a loss of face if the daughter were labelled lose or spoilt, parents often felt compelled to marry off their daughters to the father of the child (Kroeker 2015: 92; Maqutu 2005: 152, 155): a child born out of wedlock would serve as a constant public reminder that 'something is wrong with the mother of this child' (Ashton 1952: 33), and the bad name given to the child would serve as a continuous lesson to the mother (Kroeker 2015: 87).

MaMeli had told me, in light of her parents' reluctance to accept her relationship with their neighbour's son, she had planned her pregnancy in order to speed up the process of marriage negotiations. Thus, expecting the wedding to ensue in due course and in light of the moral stigma accorded to unmarried mothers, MaMeli already began to call the father of her unborn child her husband. She considered herself already 'as if' married and thus avoided scrutiny from medical counsellors and relatives about her premarital sex life. To me, it looked like a lie meant to conceal that the baby was born out of wedlock. But when I compared my field notes on MaMeli with those on other young women, I realised that the avoidance of disputes and the attempt to solve conflict non-verbally was a strategy they all tended to use. For instance, out of respect MaMeli avoided a discussion of her HIV status and used a strategy of indirect disclosure instead. It would have been a dishonour to explain to her mother or her mother-in-law her amorous relation, premarital sex, and how this led to her infection with HIV, about which she had learnt in antenatal care. Instead, as MaMeli told me, she left her medical booklet lying around, expecting that her mother would look at it and thus find out about her medical condition 'by surprise'. Like this she disclosed her HIV status without having to talk about it.

Taking such social constellations into consideration, I argue that MaMeli gave false information in order to keep face. But not only did MaMeli manipulate her story. It seems that all narrators tried in one way or another to keep face and to make their story more meaningful. I explore one form in which this was done in greater detail in the next section.

The biographic illusion

Besides the desire of keeping 'face', the narrators were driven to tell their specific stories due to a 'biographic illusion'. This term refers to a sociological debate that discusses whether a 'good story' is necessarily a 'true story' (Apitzsch and Jansen 2003: 195–110). When analysing situations and information, we need to remain aware that experiences are not told the same way they took place: narrations rather depend on the narrator's current state of mind, the situation in which they are told, and the way in which memories develop over time. As memory fades, the narrator fills in gaps, and as recipients express comprehension (or incomprehension) of a story, the narrator adjusts. Interactions, therefore, already imply an analysis of the past in the way the stories are narrated. In general, a narration draws on two aspects: the situation as experienced (*erzählte Zeit*) and the present situation (*Erzählzeit*), the perspective through which the past is interpreted (Lucius-Hoene and Deppermann 2002: 24–29). As Apitzsch and Jansen (2003) show, autobiographic narrations may not necessarily match an objective description. A narrator may, with or without the intention of faking a story, consider other parts and explanations more important than the listener. Occurrences that would be of importance for explaining the self of that past time might not be considered relevant when narrating what had happened in the present. Information might have faded or might not be worth telling due to different assumptions of the topic under study, by the informant and by me, the recipient. Ochs and Capps (2001: 45) warn that researchers need to bear in mind that 'narratives of personal experience do not present objective, comprehensive accounts of events but rather perspectives on events. [. . . They must be considered] as selections rather than as reflections of reality'. Details will be generalised, selected, or completely neglected if they did not seem valuable for the core of the story. Hence, a narrative may become an illusion that is enshrined in the telling of the occurrence rather than the memory of the occurrence itself. Besides the inability to memorise and narrate occurrences accurately, a narration conveys a message to the audience and aims to 'construct an over-arching storyline' that embellishes the narrator's presentation of the self (Ochs and Capps 2001: 4).[10]

When we apply this to MaMeli's case, we see that MaMeli and the other speakers reinterpreted the events and, in the narratives presented to MaKhotso and me, each focused on blaming another, absent person. Whilst the mother-in-law placed the emphasis on the midwife's bad medical and social skills, the doctor blamed the mother's ignorance and 'those traditional peo-

---

10   Ochs and Capps (2001: 4) note: 'All narratives exhibit tension between the desire to construct an over-arching storyline that ties events together in a seamless explanatory framework and the desire to capture the complexities of the events experienced, including haphazard details, uncertainties, and conflicting sensibilities among protagonists'.

ple'. The midwife found the reasons for the baby's sudden death in the medical realm, but one unrelated to her expertise and practice. MaMeli indirectly blamed the other mothers in the postnatal room for accusing her of having stayed in noisy places during her pregnancy and for advising her to go home and calm down the baby. The narratives already entailed foreshadowing and back shadowing which hinted at what the narrators aimed to convey (Ochs and Capps 2001: 5). With this technique the narrators already forecast their point of blaming someone else and justified their own actions.

In summary, the performative act of telling a story entails information about the social constellation of narrator and listeners that is crucial for an anthropological analysis. However, the actual happenings move to the background, as they can hardly be reconstructed retrospectively.

Power and authoritative knowledge

One line from an ethnography of childbirth struck me and made me once more revisit MaMeli's case in the process of writing my thesis. The line read: 'the power of authoritative knowledge is not that it is correct, but that it counts' (Jordan 1997: 56). This raises two questions: how did the narrators in MaMeli's case make their stories count? What authority could they draw on to make their versions gain value?

MaMeli, the only person who had attended to her baby in its first and last hours, kept silent (and 'saved face', for that matter) whilst her mother-in-law talked to the doctor and, again, when telling the story to MaKhotso and me. Obviously MaMeli had her reasons: she had the knowledge to answer the questions, but she lacked authority to make her version be heard. Revisiting my field notes and interview transcripts opened my eyes and broadened my perspective on the rest of my data.

Within the biomedical frame of reference, patients speak frankly and openly about their complaints. From the perspective of health policy makers, patients are democratic and self-determined individuals who are able to make informed decisions over their bodies and do not need to consult family members for this. This position explains why the paediatrician wanted to know who the mother of the baby was and gave MaMeli the opportunity to tell her version of the happenings. From the perspective of the patients, the situation looks quite different. The medicalisation of health gives privileges over the patient's body to experts and their machines and thus disenfranchises the patient. Biomedical staff thus gain strength and decisive power over clients with the help of scientific 'evidence-based' operations. Women and their reproductive health are a particularly heavily medicalised field (Jordan 1997; Davis-Floyd and Sargent 1997). Medical technology 'exalts practitioner over patient in a status hierarchy that attributes authoritative knowledge only to those who know how to manipulate the technology and decode the informa-

tion it provides' (Davis-Floyd and Sargent 1997: 8). The relation between staff and patient in biomedical facilities is based on professional distance and authority (Jordan 1997: 70). This dual perspective on hierarchies explains why MaMeli was unable to speak openly to the doctor; neither could the midwife speak openly in the presence of her patient when the doctor called her in. Otherwise the midwife would have lost face.

In addition, childbirth is a contested field. Power relations within the medical realm are no less restrictive than systems of kinship and familial interdependence. Anthropologist and midwife Brigitte Jordan argues in her book *Birth in Four Cultures* (1993) that familial systems claim hierarchies of age, respect, and decision-making power over young and inexperienced mothers. Mothers-in-law in many cases take care of a newborn and thus make decisions in the mother's stead as part of their care obligations for mother and child. Elder women have a profound effect on decision-making during pregnancy, delivery, new motherhood, and childcare, which means that new mothers need to accept subordination to and advice from their female elders (such as mothers or mothers-in-law) for the sake of the well-being of the family. Jordan argues that certain aspects in the discourse on the 'right' behaviour in pregnancy, delivery, and childcare gain value, which qualifies a statement as decisive and authoritative, even if the young mother may have alternative opinions or feelings. The expecting or new mother needs to balance conflicting opinions against each other in relation to the speaker:

> *The central observation is that for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both. (*Jordan 1997: 56*)*

Sich (1983: 21–40) argues that even in situations where a young mother might have contrasting information at hand, she is likely to comply with the recommended behaviour of authorities, despite better knowledge. She argues that in this way the young person lets the elder keep honour and save face. Scott (1990: 82–83) explains that such gerontocratic orders are very stable since young people expect in time to achieve a similar powerful position for themselves. Expecting in future to become a respected parent allows young women to accept a subordinated role and compliance with authoritative orders in the present. Gerontocratic dominance and subordination seem, thus, a matter of being and becoming. Thus, in generational debates youngsters comply with directives for the sake of showing respect and honour to their elders. Such respect for elders is an integral part of many African societies and younger people avoid openly questioning the advice of elders as this would be seen as disrespectful and offensive. This explains why MaMeli would not

speak up in front of her mother-in-law and the doctor and why she allowed her mother-in-law to tell her misstatements.

Despite this authoritative setting, I found the young mothers to be actors in their own right. Eager to avoid conflict, they found creative ways to solve problems (see also Kroeker 2014), for instance by involving another person. Such a person would hold legitimacy through access to one or more of the following resources: money, social status, the control over supernatural forces (Eckert 2004: 20), authority of age (as in the case of Lesotho), or the backing from a domineering medical system. Goffman (1963: 28, 31) calls such an ambassador 'the wise' and uses this term to refer to a person who knows about a stigmatised identity, but one in the face of whom the individual affected does not feel shame or the need to hide the stigma. Involving an ambassador is a usual strategy of conflict resolution in Basotho culture, one which is institutionalised and non-violent. It is likely that MaMeli put her mother-in-law in this position to explain to the doctor what had happened to her baby. This would explain why the mother-in-law, who had not witnessed the events, dared to enter into a discussion with the doctor and the midwife on behalf of MaMeli. Her authoritative position made it legitimate for her to act as ambassador.

This brings me to my own role in the set-up of my study: as study participants gained trust and confidence in MaKhotso and me, they began to ask us to step in as ambassadors to assist them. They expected us to be knowledgeable as well as convincing. We had observed their family situations and knew a great deal about the relationships and conflicts present. Often we already knew some of the household members through our home visits and interviews. The informants had taken our conversations as a chance to air unresolved life events, particularly generational and marital conflicts (see also Ochs and Capps 2001: 7). Indeed, some even approached me directly to take on the role of ambassador, as I had researched their stories and they felt I could therefore speak to third parties on their behalf. At first I did not consider this role as an opportunity for participant observation; actually, I did not like to become an ambassador and avoided this role as far as possible. Taking on such a role in a situation of conflict seemed to me to be a form of undue interference in the lives of my research participants and thus a hindrance to my study. It was only when I analysed my field notes that I started to appreciate the value the position holds. As a social function, the role of ambassador between generations incorporated me into the local structures of conflict management; it also allocated to me a set of rights and duties. It was when I took on the role despite my earlier hesitation that I began to recognise the social positions and hierarchies that were underlying the social relationships. It is thus in hindsight that my involvement at the request of informants can be characterised as active participant observation (Girtler 2001: 63). In MaMeli's case, however, I had missed that opportunity.

It was with the literature on face saving, biographic illusion and the power of authoritative knowledge that I finally sat down to write. Some parts of MaMeli's story began to make sense when read through the lens of this literature, though others remained unclear. Going back and forth between the literature and the field notes helped me cross-check and identify certain gaps, though some might also have been the result of imprecise note taking on my part. I was unable to fill the gaps of knowledge fully, though I noted that these gaps become more visible and defined: what conclusions can I draw? What knowledge did I produce? What is it that I do not know?

I the fifth version of the story, my own, MaMeli is troubled by conflicting demands. An analysis of the narrations indicated that her social role was one of a minor towards her mother-in-law and within the medical realm. I assume that MaMeli was neither in a position to confront the paediatrician nor her mother-in-law and that her inability was not only due to the trauma she had just experienced but lay in the social structures of power relations. These power relations are representative for the frames of reference, all of which claimed to explain the happenings around the baby's death. MaMeli actively made room for her preferences whilst acting in a subordinate role by using the tools at her disposal. She behaved according to the norms of respect for elders and refused to challenge the existing social order when she avoided conflicts – by lying about her marriage, leaving her medical booklet for her mother find out about her HIV infection, or planning a pregnancy to hasten marriage negotiations. I also sensed that she felt insecure at being left alone with her baby without the support of experienced women who could have told her that newborn babies usually sleep a lot and that she should be alarmed by her baby's incessant crying.

This is as much as I feel comfortable to say that I know. I am sure, however, that I lack detail on the following: the events in the delivery room; those at MaMeli's home; with whom she interacted; and how the midwife reacted to the accusation of having dropped the baby and fractured its skull. There is no convincing portrayal of those parts of the story. However, by defining my gaps of knowledge in this clear-cut manner, it was easier for me to write about what I had learnt, my version, in the name of science, not in the name of MaMeli.

Conclusion

Do the stories matter? Yes and no. Taken literally, the different narratives of MaMeli's story were contradictory and confusing and I did not know whom to believe. The case challenged me methodologically and analytically. Methodologically, I was unable to verify the information: the happenings around the baby's death were in the past and I had missed the opportunity of establishing their facticity through first-hand observation (and perhaps to change

the course of events) (see Hastrup 2004: 467). Having heard four versions of the same story revealed some congruency but also quite a bit of inconsistency, so that the material seemed to be useless to recapture the course of events. How was I to bring such diverse accounts into resonance with each other? This opened up analytical challenges.

First, the way I tell the story is a fifth version, one that I as anthropologist and author decided to tell you, my imagined readership. I directed your thinking (foreshadowing) by adding my thoughts on approximate reconstructions, frames of reference, lying, biographic illusions, and authoritative knowledge, and posed a line of questions that I am unable to answer. One could counter that I did not try hard enough to check the facts that constitute the narratives. That is correct: I chose rather to work towards providing a plausible explanation for how the individual narrators presented the information and their selves.

Second, the material collected on MaMeli entailed a blessing in disguise. Revisiting the material in the process of writing, I began to recognise its value. Analysing the speech act in the present (*Erzählzeit*) was more informative for my study than what happened in the narrated past (*erzählte Zeit*). The stories had errors and inconsistencies and were manipulative; beyond the surface, they were suggestive in regard to culture, power, and conflict. What was said and unsaid pointed out the power relations between those who were involved in the various situations, including MaKhotso and me. That was the relevant data I had at hand. I may have over-interpreted the social relations (who can tell for sure?), yet I did so with the best intention and in respect of my theoretical and empirical knowledge. In the text, I established that knowledge happens in social interactions. My double-agent role as researcher and actor in the social drama suggests that I migrated between different social frames of reference that allowed me access to knowledge exclusive to me and my academic audience. Such knowledge was not accessible to MaMeli, her mother-in-law, or the medical staff. Given this, I saw something in them and in their interactions that the interlocutors themselves might not have been aware of. This position gave me the authority to present in my version the whole dispute over the hegemony of interpretation, from an apparently more holistic point of view that encompassed all other frames of reference. It is from this position that I as anthropologist judged certain statements as embellished, neglected, selected, authoritative, or silenced and, lastly, saw narrations as performative acts of self-representation.

Third, I agree with Piker (2011: 985) that 'lies reveal deeper truths, examining the process of constructing and maintaining lies helps us to appreciate the interconnectedness and insecurity of our subjects'. It feels unjust to call the four stories lies, and it seems more plausible that informants intentionally or unintentionally interpreted the events in different ways. It is not my task as an anthropologist to correct the stories and to make them fit

nicely, but it is my task to point to why these contradicting stories matter. If different accounts do not fit nicely, I argue it is my task as anthropologist to inform my readership accordingly. I second Passin (1942: 246) in his conclusion that 'it remains for this writer simply a catch-all for such lies as he cannot now explain, pending their future disposition as a consequence of greater knowledge'. Let us be open about the gaps in knowledge and not pretend that the answers we find match the questions we posed.

Acknowledgements

References

Apitzsch, Ursula and Mechtild M. Jansen (eds.) (2003) Migration, Biographie und Geschlechterverhältnisse. Münster: Westfälisches Dampfboot.

Ashton, Hugh (1952) The Basuto. A Social Study of Traditional and Modern Lesotho. 2nd ed. London: Oxford University Press.

Barth, Fredrik (2002) An Anthropology of Knowledge. Current Anthropology 43 (1): pp. 1-18. https://doi.org/10.1086/324131

Bochow, Astrid (2007) Valentinstag in Kumasi, Ghana: Sexualität und Generationenbeziehungen im Wandel. Africa Spectrum 42 (2): pp. 195-218.

Davis-Floyd, Robbie E. and Carolyn F. Sargent (eds.) (1997) Childbirth and Authoritative Knowledge. Cross-Cultural Perspectives. Berkeley: University of California Press.

Eckert, Julia M. (ed.) (2004) Anthropologie der Konflikte. Georg Elwerts konflikttheoretische Thesen in der Diskussion. Bielefeld: Transcript Verlag.

Fine, Gary A. (1993) Ten Lies of Ethnography: Moral Dilemmas of Field Research. Journal of Contemporary Ethnography 22 (3): pp. 267-294. https://doi.org/10.1177/089124193022003001

Girtler, Roland (2001) Methoden der Feldforschung. 4th ed. Wien: Böhlau Verlag.

Goffman, Erving (1963) Stigma. Notes on the Management of Spoiled Identity. Englewood Cliffs: Prentice-Hall.

Hastrup, Kirsten (2004) Getting it Right: Knowledge and Evidence in Anthropology. Anthropological Theory 4 (4): pp. 455-472. https://doi.org/10.1177/1463499604047921

ICAP (International Centre for AIDS Care and Treatment Programs) (2009) Prevention of Mother-to-Child Transmission: Mafeteng Hospital. Internal Document.

Jordan, Brigitte (1993) Birth in Four Cultures. A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States. 4th ed., revised and expanded by Robbie E. David-Floyd. Prospect Heights: Waveland Press.

Jordan, Brigitte (1997) Authoritative Knowledge and its Construction. In: Davis-Floyd, Robbie E. and Carolyn F. Sargent (eds.) Childbirth and Authoritative Knowledge. Cross-Cultural Perspectives. Berkeley: University of California Press: pp. 55-79.

Kroeker, Lena (2014) Meidung als Alltagshandlung in langfristigen Abhängigkeitsbeziehungen – Schwangere Frauen mit HIV/AIDS und ihre Kommunikation in asymmetrischen Machtverhältnissen. Zeitschrift für Ethnologie 139 (2): pp. 179-198.

Kroeker, Lena (2015) In Between Life and Death. Decision-Making of HIV+ Mothers in Lesotho. Berlin: Lit Verlag.

Loimeier, Roman, Dieter Neubert und Cordula Weißköppel (2005) Introduction. In: Loimeier, Roman, Dieter Neubert, and Cordula Weißköppel (eds.) Globalisierung im lokalen Kontext. Perspektiven und Konzepte von Handeln in Afrika. Münster: Lit Verlag: pp. 1-21.

Lucius-Hoene, Gabriele and Arnulf Deppermann (2002) Rekonstruktion narrativer Identität. Ein Arbeitsbuch zur Analyse narrativer Interviews. Opladen: Leske und Budrich.

Maqutu, W. C. M. (2005) Contemporary Family Law. (The Lesotho Position). 2nd ed. Roma Lesotho: National University of Lesotho Publishing House.

McGranahan, Carole (2017) An Anthropology of Lying: Trump and the Political Sociality of Moral Outrage. American Ethnologist 44 (2): pp. 243-248. https://doi.org/10.1111/amet.12475

Neubert, Dieter and Elisio Macamo (2005) Wer weiß hier was? Lokales Wissen und der Globalitätsanspruch der Wissenschaft. In: Loimeier, Roman, Dieter Neubert, and Cordula Weißköppel (eds.) Globalisierung im lokalen Kontext. Perspektiven und Konzepte von Handeln in Afrika. Münster: Lit Verlag: pp. 237-276.

Ochs, Elinor and Lisa Capps (2001) Living Narrative. Creating Lives in Everyday Storytelling. Cambridge: Harvard University Press.

Passin, Herbert (1942) Tarahumara Prevarication: A Problem in Field Method. American Anthropologist 44 (2): pp. 235-247. https://doi.org/10.1525/aa.1942.44.2.02a00050

Piker, Joshua (2011) Lying Together: The Imperial Implications of Cross-Cultural Untruths. American Historical Review 116 (4): pp. 964-986. https://doi.org/10.1086/ahr.116.4.964

Reyna, Stephen (2019) 'Often Forgotten': Uncomfortable and Approximate Truths. Paper presented to the Anthropological Colloquium, University of Bayreuth, 10 November.

Salamone, Frank A. (1977) The Methodological Significance of the Lying Informant. Anthropological Quarterly 50 (3): pp. 117-124. https://doi.org/10.2307/3317591

Scott, James C. (1990) Domination and the Arts of Resistance. Hidden Transcripts. New Haven: Yale University Press.

Sich, Dorothea (1983) Geburtshilfliche Pathologie im Schnittpunkt des traditionellen und modernen geburtshilflichen Systems in Korea. In: Schiefenhoevel, Wulf and Dorothea Sich (eds.) Die Geburt aus ethnomedizinischer Sicht. Beiträge und Nachträge zur IV. Internationalen Fachtagung der Arbeitsgemeinschaft Ethnomedizin über traditionelle Geburtshilfe und Gynäkologie in Göttingen 8.-10.12.1978. Special Issue, Curare 1: pp. 21-40.

Van der Geest, Sjaak (2018) Lying in Defence of Privacy: Anthropological and Methodological Observations. International Journal of Social Research Methodology 21 (5): pp. 541-552. https://doi.org/10.1080/1364 5579.2018.1447866

Lena Kroeker is a visiting professor at the Institute of Cultural Studies of the Universität der Bundeswehr München. She obtained her PhD in social anthropology from the Bayreuth International Graduate School of African Studies (BIGSAS), University of Bayreuth. This paper emerges from her PhD research on decision-making by HIV-positive pregnant women in Lesotho, published in 2015. Her current research focuses on the social security of the Kenyan middle classes. Other research interests include the rise of the African middle classes, social welfare policy, medical anthropology (HIV/AIDS, reproductive health, fertility), and the future.

Institute of Cultural Studies, Universität der Bundeswehr München, Munich, Germany

Email: Lena.Kroeker@uni-bayreuth.de