

**Importation of manufactured herbals in
West Africa: the case of AIDS treatments in
Benin¹**

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Abstract

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The beginning of the AIDS epidemic saw the appearance in Africa of myriad manufactured herbals indicated in the case of AIDS. This paper considers these new therapeutic treatments as social objects and situates them in the wider array of available therapeutic resources. This study examines this category of medicines by considering the relationships between imported manufactured-herbal and locally-produced “neo-traditional” remedies. These relationships pertain to processes of instrumentalization, to ideas of similarity or difference and are explored by combining the examination of packaging and advertising materials with the analysis of discourses from both prescribers and consumers.

Keywords: manufactured herbals, alternative medicine, neo-traditional medicine, prescription, consumption, health globalization, AIDS.

At the beginning of the 21st century various manufactured herbals appeared in the therapeutic space of AIDS in Africa. These products were multiple compounds, including plant extracts, vitamins or minerals that border on health, nutrition and cosmetics.

As a social object, no treatment can be understood unless it is situated in the locally available therapeutic recourses (Dagognet, 1964). Different links are forged between the imported manufactured herbals and “improved traditional remedies” (Simon, forthcoming).² New therapists (homoeopaths,

² “Improved traditional medicines” are also called “traditional medicines,” “phytotherapeutic products,” and “improved remedies.”

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nutritionists, naturpaths, etc.) are involved in the promotion of “traditional medicines,” “improved traditional remedies” or “African phytotherapeutic products.” They undergo a local transposition, while simultaneously relying on the revival of traditional therapies (Simon, 2003; Le Marcis 2004). Also, many neo-traditional therapists³ borrow new therapeutic techniques (reflexology, acupuncture, French phytotherapy, Chinese phytotherapy) and use imported herbal remedies, vitamins, dietary supplements and even pharmaceutical drugs with unconventional indications (e.g. AIDS indication for aspirin).

“Traditional,” “neo-traditional,” “biomedical” and “alternative” are thus not separate and distinct categories but rather pluralist categories resulting from rapid movement and changes in a global world. Ayurveda has become an alternative medicine through its exportation to the West (Zimmerman, 1995), taking a reverse path, many of these new treatments have become neo-traditional⁴ through their exportation to Africa. Nevertheless, it seems to be relevant to uphold a distinction, which is not a matter of convention, between traditional treatments, neo-traditional

These products are traditionally inspired (with real or invented filiations) but are distinguished from “recipes” because of their “readymade” presentation. The packaging may be combined with a label, directions or even advertising.

³ Neo-traditional therapies mobilize doctrines, beliefs, rituals and practices that interact with the “mainstream” of biomedicine by combining multiple sources of inspiration (local or imported tradition, alternative health practices). Additionally, they are founded on a plurality of sources for legitimacy (Pordié, Simon, forthcoming).

⁴ This includes all products promoted by neo-traditional therapists (Egrot, 2007, Simon, forthcoming).

treatments, biomedical treatments or pharmaceutical medicines and alternative treatments (Tan, 1989). Also, when dealing with these treatments both in terms of their filiations with the alternative sector and their insertion into the neo-traditional healthcare sector (for improved traditional treatments), this article intends to provide several elements in understanding the constant expansion of their supply and the craze they trigger locally.

Method and corpus

Adopting the approach introduced by Akrich (1995), this article undertakes to portray manufactured herbals, using interviews, but also all the information provided in the packaging, instructions and documentation that circulate with the products. The description of these materials makes it possible to understand how a treatment “by its very form defines the actors and the relations between these actors, attributes certain competencies to these actors and supposes a certain environment in order to ‘function’” (Akrich, 1995, p. 129).

The results presented here come from an ethnographic study (semi-directed interviews, in-site observations, collection of documentary) conducted in Benin between 2005 and 2007 of various actors in the production, distribution and consumption of neo-traditional treatments for AIDS. Limited surveys were conducted in Lomé (Togo). Semi-closed questionnaires were also administered at three sites for biomedical care for PLHIV (in

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Cotonou and Porto Novo) regarding the use of neo-traditional treatments for AIDS. Approximately 70 treatments were collected for which just over 20 must be counted as imported products. Imported treatments came from North America (USA), from Europe (France, Czech Republic and Malta), from Australia (Hutt River⁵) and from China.

For the purpose of this article, imported Chinese neo-traditional products for AIDS will be included in the same category as western manufactured herbals. This choice was made because they share a number of strategies to position themselves in the local therapeutic scene. Moreover, it has been noted that these products make a detour to the North before arriving to the continent. The literature from the Tianshi Company (see below) circulating in Benin has been developed in part from translated documents intended for the American public, as seen in the numerous references to the FDA (Food and Drug Administration: regulatory agency). Raw materials can also make this detour, as in the case of “Immuboo”, promoted by a Burkinabe. This product, which also circulated in Togo, is composed of Chinese mushrooms imported from the USA. Hence, the local symbolic construction of these treatments is also based on the meaning and uses that have been ascribed in the North. However, it is advisable not to generalize; many Chinese treatments circulating in Benin have not taken this detour through the West. Chinese medicine has been known in Benin since the communist period

⁵ Hutt River is an independent frontier principality in Australia.

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when several collaborations were established between Benin and China. Thus, currently in Cotonou, there are three Chinese medicine clinics (acupuncture and reflexology). Also, many biomedical Chinese treatments circulate within the framework of the informal drug market. Their symbolic construction as it occurs in the North is hardly relevant in understanding the meaning attributed to them locally. It is understood that the same object can be the support for varied social interpretations depending on whether it is in line with Chinese, western or African local therapeutic supply (Hsu, 2002).

Circuits for diffusion of these treatments and context of emergence

The appearance of alternative AIDS treatments is relatively recent and coincides with their local arrival whatever the indications. Numerous undertakings specialized in manufactured herbal products have occurred since 2003: Forever Living Products⁶ (FLP) (USA) in 2003, Mariandina (provenance unknown) in 2005, Bio-Citrus (France) in 2006, etc. During this same period, the Tianshi Corporation, specializing in traditional Chinese medicines, was established in 2004.

All of these companies function using a direct sales network: the products are sold by distributors who purchase a batch of products at a preferential rate and/or receive a percentage on every new distributor's signed contract. Reaching a specific rank

⁶ About FLP see Desclaux, 2008.

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as distributor authorizes the opening of a shop. Tianshi shops have flourished over the last few years in Cotonou. The various companies have large product catalogues, including these that have an AIDS indication: “Aloe vera” from FLP and “Spirulina” from Tianshi, etc.

The “bio,” “natural health” and “health food” shops that arrived in Cotonou early in the 21st century also offered alternative AIDS treatments. These shops stock French medicinal plants in sachets, imported phytotherapy products, health food products, local food products presented as “healthy” (*gari*, flour, biscuits and even *sodabi*⁷!) and sometimes a few improved traditional treatments and specialized literature. One of these shops continuously advertised several herbal preparations, imported or not, with an AIDS indication (“Sutherlandia”, “Noni”, “Antilaleka”).

Medical practices or clinics offering manufactured herbals appear here and there, practicing homoeopathy, reflexology, Chinese medicine, phytotherapy, etc. In Cotonou, at least one clinic (Nesto-Pharma) offers AIDS treatment (prescribed by healer, a trained pharmacist): “Virusinest”, “Virusinest Duo” and “Virusinest Complex”. The products are made in the Czech Republic by the Nesto-Pharma Company and imported into Benin.

⁷ Alcohol made from distilled palm wine.

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Finally, various pharmacies in Cotonou have been selling manufactured herbals for several years. These products are usually placed next to African traditional treatments and to a few food products (honey, olive oil). Included among these products are a few that circulate in the therapeutic space of AIDS, including those from FLP (bottles of Aloe vera and other products) and Bio-Citrus (bottles of fermented papaya, sachets of spirulina).

Products also circulate in the biomedical healthcare system through various members of the medical profession, who receive visits from medical representatives and distributors from the companies involved in the direct sales network. Physicians prescribing ARTs have thus recently begun to prescribe manufactured herbals or vitamin complexes such as “Immunicomplex”, “Immunoboost”, “Viralgic”.

Therefore, these products mainly circulate over the counter. It is advisable to first consider the arrival of these products and examine this in connection with the permeability of the health markets in the South, which have no or few regulations concerning food supplements (products previously absent from the local healthcare market) and herbal products. Certainly, in industrialized countries, regulatory guidelines for herbal medicine might vary from one country to another (Dobos, et al., 2005). Yet, the fact remains that the lack of regulation and legislation contributes to this sector’s economic attraction with

the countries of the South thus becoming potential economic avenues for all kinds of products coming from the North and/or East. For example, in Benin, the registration of food supplements, which has only been implemented since 2006, is recommended but not obligatory. Registration is conducted at the *Direction des Pharmacies* and the cost of this step (compared to the cost for the AMM, French acronym for pharmaceuticals marketing authorization) is more than modest (25,000 FCFA). It is merely a formality because little information concerning the product's manufacture and stability is required. In addition, no definition of "food supplements" has been adopted. The Director of Pharmacies, when asked about this, considered that this was simply a question of dosage (cf. the vitamins classified as food supplements or medicines).

At the same time, there are no specific regulatory laws (simplified marketing authorization as in France; inclusion in food supplement classifications as in the USA, etc.) for plant-based manufactured preparations. Local products circulate outside any regulatory framework while imported products are subjected to pharmaceutical drug regulation. It is therefore not surprising to observe in the field that the majority of alternative therapeutic products, circulating in the South are presented as food supplements, while not abstaining from unsubstantiated claims regarding their ability to prevent, care for or cure this or that pathology.

The advertising booklets circulating with some products include a number of circuitous statements that attempt to make the reader forget that, despite their legal status, these products claim to have properties normally ascribed to medicines. “Viralgic” is a case in point. This product from France has an AIDS indication and is only marketed in Africa and Asia. The pharmacist who “invented” it explained that this is not a matter of choice, but rather the result “of administration.” “The French regulations pertaining to phytotherapy are too stringent.” He also added that it is impossible to conduct research in phytotherapy in the North, where he “received a demurrer.” Prohibited in France because it is classified as a medicine, this product was tested in Burkina Faso, Togo, Côte d’Ivoire and Guinea, and presented as a “psychotherapeutic formula,” an “officinal formula of phytotherapy,” a “preparation” or an “*alicament*” (functional food). The company moved to Hutt River and was able to obtain marketing authorization for its product as a “phytotherapeutic pharmaceutical,” and positions itself as such today.

How to become a local medicine of AIDS?

Among the collected treatments, some internationally known panaceas such as Aloe, Ginseng, Morinda and some minerals or vitamin complexes have been noted in the literature as being used by people living with AIDS who reside in the treatment’s country of origin (Cho et al., 2006; Eurin, 1997). On the contrary, the majority of products marketed in the South for AIDS were marketed in the North (when they were marketed) for other

indications (even in the case of the panaceas cited above). The Nesto-Pharma Company did not have a single product in its catalogue with an AIDS indication before establishing itself in Benin (one should note that at the same time it developed a product for malaria). By the same token, the Web sites for the FLP Company, Bio-Citrus or Tianshi make no reference to treating AIDS. The product brochures that position themselves as treatment for AIDS usually do not mention this indication; instead they list: skin diseases, digestive disorders, haemorrhoids, allergies, high cholesterol levels, depression, etc. in the case of “Aloe vera” from FLP; cancer prevention, inflammation, mental disturbances, blood-clots in the case of “Anti-Oxydant/Omega3” from NL France.

On the other hand, the promotional leaflets from medical representatives, distributors or even in the delivered-locally documentation presenting tables at the end of the booklet that associate the pathologies and the recommended products, systematically refer to AIDS. Product distributors with direct sales network structures regularly visit members of the medical profession dispensing treatments as well as patient associations, just as they visit general practitioners, government officials, shopkeepers, etc. The sale of treatments takes into account the demand and the needs of potential clients. And AIDS, with its high prevalence in the South (and also malaria), provides an economic market for the companies that set up locally.

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However, unlike the locally improved products, for which the AIDS disease played a catalytic role (Dozon, 2001), the strategy used by the promoters of imported manufactured products is not necessarily centered on the disease AIDS. In the particular case of Chinese import products, in 2004 traditional Chinese medicines was officially integrated in the Chinese national program of fight against AIDS. But, the qualitative analysis of collected data show that there is no mention for Tangcao either, which was the only product approved by the Chinese State Food Drug Administration in 2006 or the Chuankezhi injection that has been tested for AIDS in Yunnan Province since 2006 (Micollier, 2007).⁸ And, like in China, part of AIDS products is composed of common plants of popular Chinese medicine (e.g. the Astragalus used in “Immuboot”). Yet, no reference is made to its use in China for an AIDS indication. As is true for treatments from the West, marketing around these products further targets the following indications: well-being (weight loss, skin beauty, anti-aging, balance, renewed energy), diabetes, arterial hypertension, cardiovascular diseases and high cholesterol with a predilection for cancer. All the sectors in which alternative treatments are usually positioned in the North are found here. Moreover, this concerns just some of the chronic or acute pathologies appearing in the South that continue to receive only limited care in the local

⁸ In other African countries, Chinese medicines are invested in the field of AIDS and are controversial objects portrayed by the press as being the same as traditional African treatments. This is the case, for example, in Congo-Kinshasa (Cf. “Controverse autour de la médecine chinoise,” *La conscience*, 21/01/07).

biomedical healthcare system. This positioning thus corresponds to new emerging health needs, especially among the “middle” or well-off class.

The inventory of properties of manufactured herbals intended for AIDS (packaging, brochures) or the documentation circulating with them (advertisements, product catalogues, brochures distributed by medical representatives) casts light on the position of these products as food supplements that “restore” the organism, such as immunostimulants and antioxidants. References to cancer are recurrent in these products’ booklets and are usually linked to the notion of antioxidant; for example: “prevention: cancer, inflammation, mental disturbances, blood clots” (NL France); “antioxidant used in cancers” (“A-Beta-Care” from FLP). The same arguments are found for Chinese neo-traditional products: “revitalizes the activity of the lymphocytes that can eliminate cancerous cells” (“Chitosan” from Tianshi). In an equally significant manner, the Nesto-Pharma products intended for AIDS have been developed based on a formula for the treatment of cancer, “Anticar.” The promoter explained that he initially prescribed “Anticar” for seropositive patients, but the lack of response led him to modify the composition resulting in “Virusinest.” Since the connections between the two pathologies are very strong, the therapist

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explained during our last interview that he was in the process of treating several patients with prostate cancer with “Virusinest”.⁹

In fact, the action of “reducing the oxidative stress” in the “battle against free radicals” was initially described in the sector of cancer care. And this inflation of discourses around the notion of antioxidants is related to the link between AIDS and cancer characteristic of the nosological representations conveyed in Western alternative therapeutic models. This transference of cancer towards AIDS was quite topical in the 1990s (since AZT also comes from the therapeutic space of cancer, a parallel was perhaps drawn and then transposed to another paradigm). For example, the French Beljanski Company, which is currently based in the USA, (and was accused of charlatanry in France¹⁰) comes to mind. After having developed products for cancer, which are still marketed today in the USA and available via the Internet in France, the company marketed a product for AIDS in the 1990s (there is no sign of this product today for this indication).

The idea of food supplements enabling the restoration of the organism brings us back to the notion of food supplement, not as

⁹ Concerning the circulation of treatments, therapeutic theories also follow the southern route with the same shift from cancer towards AIDS; this is the case of “biological decoding” of Claude Sabbah (personal communication from A. Sarradon).

¹⁰ In 2002, Act Up, AIDES and the League against Cancer filed a civil suit against the Beljanski products:
<http://www.actupparis.org/article500.html>

understood in its legal status but as a property attributed to a product. This can take two forms: (1) purging: “detoxification of the body” (“Tianshi detoxifying tea”), “favouring the process of natural elimination” (“Energy Pure”, NL France) and (2) tonification: “revitalization, invigoration” (“Spirulina”, Evans Carter) and a “roborant, nutritive substance displaying a rapid regeneration of the convalescent organism” (“Virusinest Complex”).

The idea that good nutritional balance makes it possible to avoid “clogging up” the body and supplies it with elements necessary for proper functioning is widely shared in the North and is a matter of common sense. This representation of diet is meaningful in societies with growing medicalization (or over-medicalization) where health involves the sectors of beauty, sports, diet, etc. It is also characteristic of societies where there is overconsumption. This type of representation is spreading in the South among the middle class. An advertisement for a product that is currently aired on Beninese television channels (Jago milk is presented by a man dressed like a chemist or doctor as a product containing 35 vitamins and minerals necessary for a child’s healthy development) and the numerous radio programs on nutrition bear witness to this preoccupation. It should be noted, not without cynicism, that the arrival of food supplements in the therapeutic space of AIDS was undoubtedly also favored by international recommendations pertaining to nutritional support for people living with AIDS. It is known that

recommendations were formulated subsequent to research conducted mainly in Africa, which showed that the consequences of AIDS were all the more serious when the sick person is malnourished or undernourished. Let us remember that a food supplement is not intended to offset malnutrition, but to supplement a normal diet.

How does supply meet demand?

These treatments carry therapeutic ideas and models with them that come from Western societies, but how do they fit into the local healthcare supply? To respond to this question, the discourses of actors from two moments in the “biography of pharmaceuticals” (Geest, Whyte, Hardon, 1996) will be emphasized: prescription and consumption.

If an inventory equivalent to that described above¹¹ is drawn up for the improved traditional treatments circulating in Benin, it has been observed that these products do not *a priori* occupy the same therapeutic territories and that they develop distinct nosological categories. The development of neo-traditional treatments for AIDS is usually based on previous treatments for viral or bacterial pathologies (herpes and hepatitis are the most frequently cited), treatments for local nosological categories considered to be precursors of AIDS (such as Goxuxu: weight loss) and on treatments for pathologies termed “black” or

¹¹ The packaging standards of the products are often more rudimentary, and the critical apparatus circulating with these treatments are often insufficient or even lacking.

“African,” such as drepanocytosis. The majority of these products are presented either as local alternatives (in the situation of limited accessibility to ARTs and/or without the secondary effects of ARTs) or as treatments capable of curing AIDS (Simon et al., 2007).

Returning to manufactured herbals, we have said that they are mainly positioned as immunostimulants. The antiviral property is, however, not absent. For some twenty imported products circulating in Benin and Togo, eight professed antiviral properties in addition to immunostimulation.

The antiviral dimension sometimes only refers to the opportunistic diseases associated with AIDS: anti “herpes buccalis or genitalis, mycoses, shingles” (packaging for the gel form of “Immunicomplex”), anti “herpes, antiviral” (“Immuboot”) and “herpes, shingles, Karposi’s sarcoma” (“Herbpower”). And, it often remains secondary. The treatment proposed by Tianshi is, for example, composed of immunostimulants and tonics (for which “Spirulina” is also presented as being antiviral), and the definition given for AIDS in their catalogue puts the least emphasis on the immunodepressive dimension: “disease that destroys the immune system of the body and exposes it to all kinds of diseases. AIDS is characterized by the loss of appetite, weight loss, constant headaches, faeces, etc.”.

Finally, it has been observed that two products initially professing an anti-HIV activity are placed differently today. “Virusinest”, whose promoter withdrew it from the market (he distributed it to local physicians), today affirms that analyses conducted among patients do not allow for maintaining the anti-HIV assertion. By the same token, an attentive reading of the successive brochures for “Viralgic” reveals a change in the product’s position from an antiretroviral promising to render the virus undetectable (brochure 1) to an immunostimulant (result of trials published on the Web site), by way of an antiviral, anti “herpes, influenza, chickenpox for healthy persons” (application for registration in Benin). Upon questioning, the product’s “inventor” reaffirmed the antiviral quality of the product but noted that it is locally perceived as an immunostimulant. The interviews conducted with the prescribers of ARTs using these manufactured herbal products show that, in fact, these products are recognized for the quality of immunostimulation or the capacity to treat opportunistic diseases (dermatoses, herpes, Kaposi’s sarcoma). Conversely, prescribers involved in the use of improved traditional medicines mention an anti-HIV activity instead (“Tobakoaks”, “Api-Sida”, “Medoleme”, etc.).

The corollary to the immunostimulant dimension is the fact that these products are presented as complements to ARTs. In the case of companies specializing in alternative products, they claim there is a link to biomedical care for all their products (“there is no medicinal interaction,” FLP catalogue; “does not replace

treatment with ARTs” *and* “this treatment can also be administered to patients under ARTs,” “Viralgic brochure”). Among prescribing physicians who have chosen these products, this is the determining dimension: “if this is something that requires stopping ARTs; that’s just not true” (physician prescribing ARTs, Lomé). Otherwise, their singularity is that they divide the complementary qualities into two phases: pre-inclusion with ARTs to delay the administration of ARTs and post-inclusion to curb the development of opportunistic diseases: “from contamination and seroconversion from 1,000 to a 600 CD4 count. To prevent decreases in the CD4/CD8 ratio and the level of CD4 lymphocytes to maintain a sound immune system; treatment for life; after contamination dating several years, having a lymphocyte level somewhere between 600 and 200 to improve the immune system by increasing or stabilizing the CD4/CD8 ratio to prevent opportunistic diseases and the rapid appearance of declared AIDS; with declared AIDS, below 200 CD4 count. Complementing the treatment with ARTs to stimulate the production of lymphocytes to check viral opportunistic diseases” (“Viralgic brochure”).

The fact that one must await eligibility for ARTs continues to be frequently misunderstood element. A televised debate in Benin organized on 1 December 2005 for World AIDS Day invited two opponents—the head of the PNLIS (national program to fight AIDS) and a tradipractitioner who asserted that he cured AIDS—and came to an abrupt end around this question. The journalist as

well as the tradipractitioner accused the PNLS director of not providing convincing arguments. Patients' concern about waiting for eligibility for "*amisin daho*" (translation from Fon: "the great medicine") is also understandable. The possibility for a prescribing physician to dispense an original (or even newly introduced, cf. below) pre-inclusion therapeutic treatment with ARTs weighs heavily on patients' decisions (Simon et al. 2008).

Very little information is available about the consumption of these products among people living with AIDS. However, the few interviews conducted with persons consuming manufactured herbals indicate that they are used for different reasons: to cure, to alleviate secondary effects of ARTs (lipodystrophy, nausea), to strengthen the organism and for skin problems (blemishes). Thus treatments are mostly used in combination with ARTs. Regarding the hope to be cured (although certainly no product has put forth such an allegation), it must be remembered that there is an intermediary link between the brochure and the consumer of products diffused in the framework of a direct sales network: the distributor. And in the case of FLP or the Thianshi group, the differences between the direct sales network and a pyramid business (prohibited for several years in Europe given its excesses) are not always clear. For example, as with the case for pyramid businesses, the distributor purchased a minimal stock that cannot be returned to launch activity. This promotes far-fetched allegations. The sick consumers whom we interviewed referred to the testimonies reported by these distributors: "There

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are people who have experienced it.” “When they did follow-up tests some time later, they found nothing, they were negative. That’s what motivates me, I want to get rid of the virus” (woman living with HIV, age 27).

For all our interlocutors (consumers and prescribers), the professed arguments for the AIDS indication are in line with the discourses pertaining to the safety and efficacy of these products. While the arrival of these treatments is due to the lack of local regulation in the pharmaceutical sector and that a non-negligible percentage of them are sold within the framework of direct sales companies with questionable operations, it seemed that the consumers and prescribers place these objects on the side of safety and efficacy. One recurrent element is the asserted absence of aggressiveness or toxicity. For the AIDS indication, one can read: “no secondary effects” and “no resistances” unlike the ARTs... More generally, the documentation circulating with these products develops the problematic of iatrogenic pathologies, secondary effects, the high economic stakes around the medicine, the by-products of clinical tests in the South, etc. It is a prominent element in the decisions made by prescribers or consumers: “It’s natural. I like everything that is based on plants. Allopathy has its benefits, but also its limits. Since Hippocrates, there have been two schools of medicine, allopathy and the medicine of opposites, which led to homoeopathy. Our parents treated that way” (a midwife).

Anthropological literature pertaining to medicines has already described how, in the context of globalization, one sees both growing popularity and skepticism towards medicines that promote the appearance of other therapeutic models (Geest, Whyte, 2003). Thus, as Nichter underscores, a double movement can be observed favoring, on the one hand, pharmaceutical medicines and, on the other hand, a new relationship to the body, which together favor products dependent on traditional/neo-traditional and alternative therapeutic models (Nichter, 1994). This contributes to the local incorporation of imported products. This can be seen, for example, in the fact that they are arranged beside each other in the pharmacies and “bio” shops, or in the fact that a few improved traditional treatments are included on the list of food supplements for the *Direction des Pharmacies*, with the comment “phytotherapy.” This shared platform masks the fractures that exist between imported manufactured herbals and improved traditional treatments.

Nevertheless, manufactured herbals also advance technology enlisted in the production of their products. The “tradition” that characterizes the “improved traditional medicines” takes on a negative value for whatever is deemed “obsolete” and “ineffective” (Tan, 1999). It is contrary to the notion of “industrial technology” considered to be the gauge of effective know-how (precise calibration, repeated gestures, rapid innovations, etc.) and product safety. Hence, these products’ efficacy is related to their innovative capacity: “the active

principles are extracted, notably by solubilization in different solvents, maceration, distillation, etc. (...) according to the know-how specific to the inventor: new technology in the area of phytotherapy” (Viralgic documentation). The galenic nature of Chinese neo-traditional treatments also includes them in modernity. In Asia, industrial production of products based on traditional knowledge began at the end of the 19th century (Afdhal F., Welsch R., 1998, Bode, 2002). This is much less frequent in the case of traditional African treatments except for a few products in particular from South Africa (such as “Sutherlandia” or “African Poteteos). Production is usually artisanal, and capsules and gels are still rare among local neo-traditional treatments. Thus, traditional Chinese products that are strengthened by their success even within the pharmaceutical drug industry (e.g. arthemisine) are perceived as being particularly effective. The ease with which they are taken combined with the lack of the pronounced taste that is characteristic of a number of Beninese neo-traditional or traditional treatments (the bitterness gauging their efficacy) is another prevalent argument among consumers: “I also trust our tradition, but the Chinese treatment is easier to take” (man living with HIV, age 34). Emphasis is placed on the production processes that ensure proper preservation of the products. The FLP information gatherings begin with a film screening on the micro-industry, food safety, obtaining quality labels, etc. This type of argument is also found among the consumers, who explain their refusal to resort to improved traditional medicines:

“We know that the Americans have prepared the treatments in conditions that are possibly more hygienic, cleaner” (woman living with HIV, age 27).

The distant origin of the treatments is also an element contributing to the attractiveness of these products. It should be noted that, despite being financially inaccessible for a large number of patients, the FLP “flagship” product is one of the best known among people living with HIV with the local name: “yellow bottle.” However, the exoticism, in the sense of unfamiliarity, is potentially dangerous. A seller who regretted the fact that the FLP products were no longer made with a recipe explained this with: “They changed the composition; the product is no longer as pure; we’re not duped.” A man living with HIV, who produces his own aloe juice, explained that he recalls having read that the aloe content was only 70%; “and what’s the rest? I prefer to make my stuff myself; it’s more natural.” Based on its incorporation into the industrial production chain, this exoticism risks pushing some of these products across the “line of combat” in the battle against pharmaceutical medicines.

Conclusion

The arrival of these products in the therapeutic space of AIDS in Africa should be seen in relationship to globalization (accelerated exchange of goods and ideas and the increased movement of people). Although the impact of globalization on the population’s access to medical care has now become the subject of relevant

studies, few or no studies have been conducted on globalization understood as the diffusion of alternative therapeutic products (marketing, circulation of information and knowledge concerning these products, modality of choice regarding available products, etc.). This article presents a few descriptive contours of this transfer, knowing that the recent arrival of these products can only lead us to observe the positions and discourses that are still in the process of developing. In this informative article, I wanted to reconstitute the information while taking into consideration the depth of the situation. This was intended as preliminary work on the development of a social critique of the structured and dominating power relationship existing around these medicines.

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