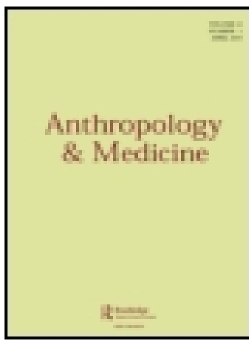

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Networking health: multi-level marketing of health products in Ghana

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Multi-level marketing (MLM0), a business model in which product distributors are compensated for enrolling further distributors as well as for selling products, has experienced dramatic growth in recent decades, especially in the so-called global South. This paper argues that the global success of MLM is due to its involvement in local health markets. While MLM has been subject to a number of critiques, few have analyzed the explicit health claims of MLM distributors. The majority of the products distributed through MLM are health products, which are presented as offering transformative health benefits. Based on interviews with MLM distributors in Ghana, but focusing on the experiences of one woman, this paper shows that MLM companies become intimately entwined with Ghanaian quests for health by providing their distributors with the materials to become informal health experts, allowing their distributors to present their products as medicines, and presenting MLM as an avenue to middle class cosmopolitanism. Ghanaian distributors promote MLM products as medically powerful, and the distribution of these products as an avenue to status and profit. As a result, individuals seeking health become a part of ethically questionable forms of medical provision based on the exploitation of personal relationships. The success of MLM therefore suggests that the health industry is at the forefront of transnational corporations' extraction of value from informal economies, drawing on features of health markets to monetize personal relationships.

Keywords: multi-level marketing; neoliberalism; global South; informal economy; casual health expertise

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Introduction

Passing through the courtyard of the residence where the author rented a flat, Juliana, the landlord, stopped him to recommend a new food supplement.[1] In her 60s, tall and commanding in contrast to her short and soft-spoken husband, Juliana enjoyed commenting on others' health, especially telling them what they should do about it. This time, Juliana skipped the casual patter and concerned advice and quickly got to the point. She produced a bottle of pills labeled 'CellMax' that she had purchased from an acquaintance for GHC 110 (over US $70 at the time), as well as a folder of sales materials. She was taking this medicine, Juliana said, as was her husband, and if she managed to make some extra money selling this product she would buy into the program and become a distributor. This would cost hundreds of Ghana cedis and she would then be obliged to enroll further distributors if she was to recoup her expenses.

Juliana was engaging in a form of marketing called multi-level marketing (also referred to as network marketing, direct selling, or simply 'networking,' hereafter MLM),

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a business model in which product distributors are compensated for enrolling further distributors as well as for selling products. In an MLM business structure, an individual must pay a fee to become a distributor for the company, and they must pay out of pocket for the products that they then resell. They are encouraged to recruit further distributors who are then 'downline' from them in their network. The original distributor is paid a bonus for recruiting further distributors, and also earns a percentage of those distributors' sales. Critics point out that MLM operates similarly to pyramid schemes. While, unlike in pyramid selling, MLM distributors sell material products, this is often a secondary source of income compared with the more profitable practice of recruiting further distributors. The cost of MLM products means that consumers are almost always *de facto* prospective distributors. MLM is associated with Avon, Amway, and Tupperware products in North America, but these companies do not operate in Ghana. Instead, a number of MLM companies sell food supplements in the form of teas, capsules, and shake powders.

This paper provides an ethnographic glimpse into the vast global success of MLM companies. It makes clearer the ways in which casual forms of sociality become available for transnational corporate profit, especially when they have to do with health. Anthropologists have studied the expansion of MLM, but have overlooked the health dimensions of the industry. MLM is successful because of its ability to intersect with or create local health networks, and MLM companies in Ghana depend on exaggerated health claims made by their distributors. This paper first surveys the scope of MLM distribution and the current literature on the phenomenon. It then describes how MLM distributors join already existing informal exchanges of health products and expertise, drawing on company marketing materials to position themselves as local health experts. It shows that these distributors make dramatic claims about the health benefits of their products, persuading others to join MLM distribution networks for the apparent income and social status that they offer. Through MLM, health industries are able to join in the dynamics of popular health markets, pioneering strategies for extracting profit from informal economic exchange in the so-called global South.

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Perspectives on multi-level marketing

The MLM industry is vast and profitable, incorporating millions of entrepreneurs into its global operations. One company alone claims 9.5 million distributors,[2] while another claims over three million independent distributors in more than 80 countries.[3] MLM corporations depend on growth in the so-called developing world, and are aggressively pursuing those markets. The MLM company Herbalife reports that 79.3% of their net sales come from outside of their North America market, with the majority of their profits coming from Latin America and Asia.[4] It is therefore no surprise that in 2010, as what the WHO called the 'decade of traditional medicine' in Africa was coming to a close, Herbalife chose a convention in South Africa from which to declare that the next decade would be 'the decade of Herbalife.'

Many marketing scholars have explained MLM companies' interest in 'emerging markets' by arguing that they are qualitatively different than those in Europe or America, and that MLM is particularly well suited to exploit them. Croft and Woodruffe (1996, 212) go so far as to suggest that MLM may be 'the ultimate in international distribution' that can 'offer companies rapid and highly profitable penetration of apparently impenetrable markets'. Some marketing scholars argue that MLM is more 'embedded' in social relations than more formal marketing (Grayson 1996), which makes it able to build on traditional trading arrangements (Dolan and Scott 2009). The authors of these studies

therefore suggest that MLM is more suited to markets where personal relationships are central, and argue that this can be mapped geographically.

Rather than rely on overdetermined North-South dichotomies, economic anthropologists have stressed the relation of MLM to neoliberalism in both its economic and imaginative dimensions, arguing that MLM is attractive because it allows entrepreneurs to 'replace or subvert conventional social geographies' (Jeffery 2001, 23). In doing so, it encourages the 'tenets of neoliberalism (Cahn 2008) through an 'overt religiosity' similar to Christian evangelical networks characterized by individual, born-again experiences (Cahn 2006). Anthropologists suggest that the success of MLM may therefore have to do with the growing prevalence of the logic of finance in everyday life (Krige 2012, 70). Similarly, it intersects with current business-led approaches to governance and development. Elyachar (2005, 5), for example, has argued that contemporary statecraft aims at 'reconstituting the social networks and cultural practices of the poor as part of the free market', and therefore sees the poor as 'a resource for reproducing global markets, maintaining global stability, and achieving economic growth' (Elyachar 2005, 9). As James Ferguson (2007, 84) puts it, 'Having recognized the charismatic power of the dynamic, bustling netherworld of the shanty, reformers now envisage harnessing it, and bringing it into a new relation both with the national economy and with the project of government'. The popularity of MLM suggests that consumer marketing has also come to value the economic activity of the poor as a lucrative, 'emerging' market.

The anthropological literature on MLM has largely downplayed the perceived health benefits of its products. However, the health aspects of MLM are critical to its success. For Juliana – and for Ghanaian MLM distributors more broadly – the perceived health benefits of MLM products are just as vital as the personal and economic transformations they promise. No MLM company in Ghana sells kitchenware, stationary, clothing, media, insurance, or anything else that is not in the field of health and wellness. Prominent MLM companies that do not sell health products such as Avon, Amway, and Tupperware do not operate in Ghana. Furthermore, MLM companies are deeply a part of financial investment in health industries (the MLM company Medifast claims the New York Stock Exchange abbreviation 'MED'). Even if they present their products as food supplements, MLM companies are highly associated with herbal medicines. Forever Living, for example, is by far the world's largest producer of aloe vera products, itself a newly popular medicinal plant in Ghana. Other companies (such as 'CellMax,' discussed below) make explicit health claims, tempered however by legal restrictions. The impressive growth of MLM distribution worldwide is therefore important for understanding new popular forms of distributing health products and knowledge.

Critics often unflatteringly compare MLM to pyramid schemes, and point out that it is 'almost inevitable' (Krige 2012, 71) that they will disappoint participants, even when they adhere to legal restrictions. Indeed, only one of the MLM distributors in this study clearly made a profit (Tina), and she already had a well-paying job and a middle class lifestyle. These ethical concerns put MLM at risk of state regulatory action, which poses the greatest threat to sustained profit. The profitability of MLM therefore depends on the ability to be seen as ethically and legally legitimate, something about which marketing scholars have been largely ambivalent (see Albaum and Peterson 2011). Of course, MLM shares many features with familiar capitalist modes of production and distribution. The Fordist social contract similarly offered an opportunity to work in exchange for social and material care. However, MLM offers this contract in a face-to-face transaction contingent upon the distributor turning a profit. Many scholars of MLM frame these issues in terms of the difference between a legitimate MLM company and an illegitimate pyramid

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scheme (Grayson 1996; Woker 2003; Muncy 2004). However, all MLM operations involve difficult ethical issues. As Koehn (2001, 160) points out, 'It is hard to see how MLMs could exist if recruits did not market to friends, relatives, and clients. Yet such marketing is fraught with ethical peril.' The problem in general, says Bloch (1996, 18), 'is that the activity of recruiting people into MLM schemes is socially and psychologically unacceptable to most people in our society.'

Medical anthropologists have long observed the personal and affective qualities of private medical markets, especially pharmaceutical markets (van der Geest, Whyte, and Hardon 1996, 153; Petryna, Lakoff, and Kleinman 2006; Biehl 2007; Martin 2009). In this light, MLM seems like a particularly profitable industry that shares much terrain with the private medical industries to which it is ambiguously related, but with added issues of controversial economic practices and overstated health benefits. Evidence from Ghana suggests that MLM does indeed become ensnared in complicated and unpredictable ethical tangles, but that the entanglement of the personal and the economic is not considered an inherent moral problem for those involved. As Viviana Zelizer (2005) has shown, based on research in North America, the mingling of the intimate and the economic is a basic and constitutive part of human social life. However, she notes a common moral discourse that tends to understand them as a clash between two separate and opposed spheres.

Bloch and Parry's (1989) claim holds largely true for Ghana. While many societies conceptualize transactions as either short-term and concerned with individual competition or long-term and dealing with the reproduction of the cosmic order (Bloch and Parry 1989), money is not necessarily seen as opposed to socially productive transactions as it is in the West. In fact, Catie Coe (2014) has shown that geographically distributed Ghanaian families take material gifts, including gifts of money or medical fees, to 'express love and care' (Coe 2014, 40). Money can be part of a 'debt-care relationship' that is productive of social bonds. On the other hand, material accumulation can be associated with elite power and covert or even immoral activity, and comes with expectations of redistribution. The literature on medical transactions in Ghana shows a similar symbolic variability in the moral life of money. Among the rural Dagomba of Northern Ghana, money can be seen to corrupt some spiritually inflected healing and protecting processes (Bierlich 2007, 164–168), but Western pharmaceuticals and herbal medicines are often bought and sold without endangering their capacity to heal (Bierlich 2007, 72). In other words, Ghana has as variable a symbolization of money as any other place in the world. Economic relationships are morally charged but are not necessarily seen as morally corrupting.

Furthermore, the success of MLM is set against a background of material scarcity and inconsistent regulation. Ghanaian medical systems are characterized by high levels of sub-standard and counterfeit pharmaceuticals and long waits at public clinics. They also have a diverse array of informal and 'traditional' healers and health experts, some of whom make claims to cure diseases such as diabetes and HIV/AIDS. In this context, MLM distributors can appear to be trustworthy sources of health information and health products, and MLM companies can also appear to offer reliable employment in a context with relatively few opportunities for formal employment. At the same time, MLM companies are not necessarily an affordable option when compared with other sources of health goods or services. The cost to become a distributor is greater than that of joining the National Health Insurance Scheme, for example. Rather, MLM products are usually purchased in addition to other sources of treatment. Juliana for one was insured and frequently visited medical specialists. However, this involved travel across traffic-jammed Accra and long waits at the hospital for short visits with a doctor. Furthermore, MLM

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products are more expensive than other options in Ghanaian health markets, selling for more than generic pharmaceuticals, herbal medicines, bitters, or comparable nutritional supplements. Still, the strain on public health services and uncertainty in the formal economy are part of what makes MLM attractive is. In this context, MLM distributors could be trusted sources of health advice.

Multi-level marketing connects with casual health knowledge

Back in her courtyard, Juliana continued with her previously prepared sales pitch. She explained that CellMax is produced by an American company that had discovered the medical benefits of a species of blue-green algae. Showing glossy graphics from the binder provided by CellMax, Juliana explained how the product worked. Citing an article in a cardiovascular medicine journal, Juliana claimed that CellMax, which contains *Aphanizomenon flos-aquae*, otherwise known as AFA or blue-green algae, releases stem cells from the bone marrow to rejuvenate the body, fighting the effects of aging and leading to a long and healthy life. Although the details of the article do not suggest a scientific consensus on blue-green algae, the ability to cite scientific articles provided Juliana with the means to present information from a position of expertise.

Juliana was uniquely well equipped to draw on the marketing materials provided to her by CellMax. Although not exactly a healer or a member of a recognized medical profession, she was respected for her knowledge of health and healing. Her father had been a physician's assistant, first in the West African Medical Service and then in the Ghana Health Services after independence. Juliana's friends recognized her knowledge of the Ghanaian medical system after her own struggles with infirmities throughout her adult life. As a neighborhood health expert she sometimes took neighbors' blood pressures and dispensed advice. When Juliana borrowed the CellMax marketing materials from a business associate she acquired a persuasive means of wielding formal scientific research findings about human health. Glossy pages of graphs, bullet points, and citations made Juliana even more convincing than she had been with a stethoscope and a blood pressure cuff.

MLM intersects with common ways of accessing health products and knowledge in Ghana. Medical provision in Accra comes from a range of sources, including pharmacists, medical doctors and diverse traditional medicine practitioners, but also vendors, hawkers, and other less formalized professions (Obuobi et al. 1999). Medical anthropologists have long noted the pluralism of medical systems in Southern Ghana in particular (Appiah-Kubi 1981; Anyinam 1991; Mullings 1984; Twumasi 2005; Ventevogel 1996). MLM distributors often used the term 'food supplement' to describe their products, but in Ghana this does not necessarily imply that they do not have medical uses. Many Ghanaians are aware that herbal medicines, clearly medicinal, are considered food supplements in the United States. Research on West African plant utilization has shown the multidimensional character of plant usage (e.g. Etkin and Ross 1982). Many plants are part of local diet and herbal pharmacopeia such that their strictly nutritional and therapeutic uses are often indistinguishable from each other. In the neighborhood where Juliana lived, for example, bitter leaf (*Vernonia amygdalina*), garlic (*Allium sativum*), and *Moringa oleifera* are regarded for both their nutritional and therapeutic qualities. Furthermore, locally manufactured and imported herbal medicines and alcoholic bitters are often described as bestowing 'power' (*tumi*) in a wide range of senses, such that even energy drinks are sometimes considered medicinal. The Ghana Food and Drug Administration has ramped up regulation of locally manufactured products in recent years, but these products still

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carried the reputation for making misleading health claims. It is a matter of opinion whom to trust; respondents to a qualitative survey in Juliana's neighborhood were split on whether herbal medicines were more trustworthy than pharmaceuticals.

Accra is characterized by a 'double burden' of chronic and 'lifestyle' diseases alongside infectious diseases such as malaria, tuberculosis, cholera, and typhoid. As the death rate has decreased, the relative burden of circulatory diseases in particular has increased (Agyei-Mensah and De Graft Aikins 2010). A recent increase in focus on chronic conditions has put lifestyle management at the center of discourse about health. Health advice regarding nutrition and lifestyle is incorporated into radio and television programs, newspaper columns, video compact discs, and pamphlets distributed at local health food restaurants. Many Ghanaians express dissatisfaction with mainstream biomedicine's ability to treat chronic conditions, and patients frequently seek treatment and advice on these ailments from a range of sources in addition to hospital care.

In this landscape, professional identities are often unclear. Scientific expertise is sought in casual exchanges, from contacts both intimate and unfamiliar, but almost always face to face and usually for sale. Medical advice is often taken from advertisements of course, but in personal interactions with those doing the advertising. There is a bustling market in African cities for both the materials and facts that will make an ailing body well, and these are often personally tailored to the consumer's wants and needs. As Das and Das (2006) illustrate, 'self-treatment' with health products occurs in local worlds where health-seekers have limited resources, amidst diverse and overlapping networks of health expertise that can be activated to access products and information. MLM is able to join these networks by providing materials that distributors need to become informal health experts.

Juliana's involvement in MLM was part of a series of entrepreneurial efforts to make ends meet. After retiring from hairdressing, Juliana began to grow, process, and sell moringa, a newly popular medicinal plant cum food supplement in Accra. As a casual health expert and entrepreneur, Juliana was able to position herself as an intermediary for what she saw as the latest international health science regarding moringa. It was therefore easy for Juliana, after the moringa market became so oversaturated with product that it became unprofitable, to turn to CellMax and other MLM companies, selling their products through the same informal networks. Soon enough, her energies were focused on MLM, and she cut down several of her moringa trees to build extra rooms to rent.

It was unclear if MLM ever offered Juliana much income, but she looked to these products for more than just their marketing value. Juliana was sick. She suffered from largely uncontrolled diabetes, hypertension, and osteoarthritis. Some years earlier she had spent so much time in the hospital with recurrent bouts of malaria that many close to her feared she would never come home. Moringa and CellMax were business opportunities for Juliana, but health science was a passion. When she described her fellow 'networkers,' she was most impressed with how much they knew about health. Juliana had a powerful sense that if she had any chance of living long enough to meet her grandchildren, it lay in her knowledge of medical science. As far as Juliana was concerned, what was important was that CellMax provided apparently dependable health benefits. She sold moringa, but even when it became unprofitable, she kept producing it for herself. She hoped that CellMax would provide some much needed pocket change, but she also spent the little she had to buy the product. She sold CellMax for the reason she sold moringa: so that she could afford to take it.

MLM companies give their distributors materials that help establish them as trusted sources of health expertise, building their reputations as legitimate sources of health

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products. People such as Juliana could gain the authority of a sort of informal health expert. By mobilizing social networks to make profit, MLM becomes a part of healing relationships, relying on health experts such as Juliana to sell their products through their own networks. In this way, MLM companies are able to participate in popular dynamics of medical exchange and caregiving. MLM became a part of both Juliana's entrepreneurial work and her attempts to live a long and healthy life. This enhanced authority is used to promote MLM products.

Food supplements as medicine

Part of the way that MLM companies are able to participate in the popular dynamics of health and expertise is that distributors present their products as medicines. Tina, a middle-aged distributor for Vitabotane who worked at a food research institute, clearly suggested that her products had benefits that extended beyond mere good nutrition. During her sales pitch, Tina first said that although Vitabotane is not curative it could help someone to 'grow out of disease.' She explained the benefits of each of the four Vitabotane products she sold, which she said helped you 'shape your lifestyle' and avoid junk food. She served a tea ('a gym in a bottle') that she said provided the same effects as exercise 'while you sit at your desk.' Later, she relayed a well-rehearsed anecdote of how her uncle was nursed back to health following a stroke, eating nothing but Vitabotane products. Tina suggested to the doctor that she feed Vitabotane to her uncle. 'Apparently, the doctor has been traveling to the US, he knows the product,' she explained. According to Tina, her uncle began to improve within 45 minutes, and after two weeks of eating only Vitabotane products he made a full recovery. Such stories clearly suggested that Vitabotane products provided spectacular health benefits. Tina further discussed Vitabone's benefits for diabetics, saying, 'If you are diabetic, Vitabotane is the best food you need to take, because it kind of controls your sugar intake.' According to Tina, Vitabotane 'stabilizes the blood flow' and allows for regular bowel movements. Tina continued: 'With the little training I went through, I'm convinced that it helps in stabilizing the blood sugar. It wouldn't cure you, but it aids in stabilizing it.' Using a slideshow provided by Vitabotane, Tina displayed a chart of the blood sugar of someone who eats poorly, which had the high peaks and low troughs associated with diabetes. Then she showed a chart 'with Vitabotane.' The blood sugar level was safely within the happy green zone on the chart. In no uncertain terms, Tina presented Vitabotane as a way to manage diabetes.

MLM companies themselves may not make explicit medical claims, but their success is based upon the fact that their distributors do. In effect, the obligations of companies are 'devolved' (Dolan and Johnstone-Louis 2011) to the distributor. Dramatic health claims are by no means unusual in Ghana, where many traditional medical practitioners, Muslim and Christian faith healers, along with herbalists, regularly claim to have cures for a range of apparently incurable diseases. In most instances, dramatic health claims about MLM products were made by distributors based on ambiguous or merely suggestive materials provided by the companies. However, one video by a Chinese MLM company – which will be called Tansi here – and shared on Facebook by Ghanaian MLM distributors, showed a representative of the company claiming that their product offered protection from the Ebola virus. Although the location of the video is unclear, it depicts a Chinese representative of the company speaking in English to an audience of MLM distributors. As he dramatically throws away a facemask, he says that he does not need this sort of protection from Ebola. 'Why? Why? Because we are Tansi people! We have enhanced immunity product! We are very, very strong… We are unbeaten for Ebola!' This is

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evidence of an MLM company making an unsupported health claim, in this case benefiting from the panic over the Ebola epidemic.

One MLM distributor, James, similarly presented his product as bequeathing spectacular health benefits. James, a recent secondary school graduate, explained that he recruits distributors by identifying people who are sick, asking what is ailing them, and suggesting LiveWell products as a cure. 'These are the sicknesses it cures,' James said as he handed the author a small business card. The card appeared to have been produced by another MLM distributor, and James had added his name and phone number in pen. On the card were listed over 20 illnesses: diabetes, ulcer, fibroid, arthritis, and others. James explained that he recruited customers by identifying sick people and telling them that he had a product that can cure them. He concluded that, if the customer found the product helpful, 'he will like to join the company.' These sorts of wide-ranging health claims are striking, but not unusual (see Cahn 2011, 79). If a customer was convinced by James' claims, he or she would likely need to invest in the company and become a distributor in order to afford the product.

MLM distributors, like Juliana, considered it normal practice to use the products that they sell. These companies suggest that they promote a healthy lifestyle through providing a healthy regimen and their distributors are expected to be models of that lifestyle. For that reason, several product distributors stated they are expected to be regular customers. James explained that it is important to use the company's products in order to be able to recommend it to others, 'Because if you do not use the product, you don't know how well they do. You yourself have to use the products… That is the way you introduce someone to join the company.' Distributors therefore become patients, business partners, and potential care providers at the same time. The author raised his own concerns about MLM with each person in the study, but they each dismissed them as exaggerated or based on a misunderstanding of MLM. Juliana, James, and Tina each argued that this form of marketing was a normal part of business. In any case, the fact that MLM products were presented as medicine by apparently reputable local health experts who themselves used the product was central to the successful expansion of MLM networks.

Multi-level marketers as distributors of transnational health expertise

MLM companies are further able to provide their distributors with the means of becoming successful informal health experts by constructing a wealthy, informed, and connected cosmopolitan identity (Jeffrey 2001; Wilson 1998). Certain aspects of how CellMax present their product and the science behind it maximize the ability of their materials to lend a sense of exclusive access to medical science. CellMax's claims rested primarily on a single publication in a peer-reviewed cardiovascular medicine journal, which CellMax suggests shows that *Aphanizomenon flos-aquae* (AFA) promotes the release of stem cells from human bone marrow. CellMax's own materials, and subsequently Juliana's sales pitch, promoted a sense of controversy surrounding this claim. The first of these was a relationship between stem cells and the funding of embryonic stem cell research in the United States. This sense of controversy made the science of CellMax's product seem less settled and yet full of potential, as if the controversial nature of the medical research made it only available through unorthodox avenues, such as MLM distributors. CellMax's own marketing materials suggests that the 'media frenzy' surrounding stem cell research is what might make their company especially profitable. Building on what Sunder Rajan (2006) calls the 'promissory discourse' surrounding stem cells, Juliana implied that this was an embattled science. That the science was unsettled made it appear

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as a potentially revolutionary object only available through informal networks. This is a classic strategy of MLM, where products are positioned as available only through exclusive means ('not available in stores') because of regulatory or trade-industry reasons that ironically signal their powerful potential. The result was that CellMax was associated with a world of arcane medical knowledge in which Juliana was uniquely versed.

MLM distributors leverage MLM's association with foreign wealth and expertise to promote a sense of exclusive access to scientific knowledge. Distributors saw participation in an MLM scheme as a means of becoming a part of an international professional milieu, which carried with it an expectation of high quality products and significant wealth. There are gender-appropriate models for entrepreneurship for both men and women of all ages in Ghana; becoming a pastor is a high-profile avenue for building legitimacy and income for young Ghanaian men (Lauterbach 2010), while the image of the 'Avon lady' (see Wilson 1998) provides a gender-appropriate entrepreneurial role for professional-class women. MLM also resembles market trading, which is a predominately female gendered activity in Southern Ghana. Historians and anthropologists have shown that market trading became an especially attractive venue for growing women's agency in Southern Ghana in the early twentieth century, when many Ghanaian men moved into cocoa farming (Clark 1994; Allman and Tashjian 2000; see also Hill 1963). The opportunity to consolidate market trading as women's work offered material and cultural resources for negotiating domestic and public female roles. MLM may similarly offer (or appear to offer) means of achieving upward mobility for those who feel otherwise blocked from social advancement to the middle classes.

In addition to Juliana, other MLM distributors interviewed were also recognized for their health expertise. Tina, for example, worked at a major research institution, which she agreed gave her a sense of medical authority in the eyes of her clients. Tina did not present herself as a medical professional, but rather a knowledgeable individual able to competently mobilize practical information and advice. Distributors for MLM companies therefore often present themselves as knowledgeable about the practical effects of the products in a way that sidesteps any specific questions about efficacy (see also Cahn 2011, 61).

As Tina prepared to pitch Vitabotane, she arranged her laptop computer facing herself, with another smaller computer on the edge of her desk facing the author. Together with her Bluetooth device, designer bag, and (admittedly aging) Mercedes, Tina projected an image of upper middle class social life that downline distributors could attain if they were successful in the company. She said that she made US$1000 in the previous month, even though MLM was something she did in her spare time (she said it was work she did in her 'back office'). Tina also displayed a cosmopolitan identity, presenting knowledge about MLM as part of her international connections. Tina spoke of Vitabotane as an American company, which she learned about because her sister lived in the US. When she talked about its medical benefits, these were also associated with American medical science and knowledge held by those who had been to the US (as in the story about her uncle's doctor). The international nature of MLM was also reflected in the public events held by these companies, especially rallies and product launches. Tina shared a video of a product launch she attended at the National Theater in Accra, where an executive from Vitabotane had appeared with a number of medical doctors. In the video a dancer runs onto the stage waving a Ghanaian flag. Soon a dozen other dancers surround him, each waving a flag of a different country, vigorously dancing as the audience cheers. Here are the members of Vitabotane, the event seemed to say, striding the globe alongside Western medical doctors and shaking national flags without reverence. This was a 'product

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launch,' but the global brand of Vitabotane was displayed far more than any particular product.

James' eyes lit up when he described the global scope of LiveWell. When asked if people wanted to join LiveWell because it was an American company he laughed and said, 'No! It's an *international* company!' James immediately pointed to pictures in the LiveWell catalogue about their latest global rally in South Africa. The next would be in Hawaii, he said, with another upcoming event in California. If he worked hard enough and found success in LiveWell, James could imagine himself travelling to these places. James also leveraged the global nature of LiveWell in marketing the program to others. He put up posters around Accra that read, 'Opportunity and success. An American company is looking for immediate employment. This can be done on full or part-time basis. More cash for you.' This form of advertising managed to recruit particularly vulnerable individuals. Charles, a young man diagnosed with schizophrenia responded to James' advertisement hoping to find steady employment with a reputable American company after he had lost his previous job with an international security company. It was only when an acquaintance of Charles' told him that she had failed to recoup her money after investing with James that he gave up hope.

MLM's association with upward mobility, international travel, and upper-middle class consumption habits were important factors in the successful expansion of MLM networks in Ghana. Along with its ability to give credentials to informal health experts and the willingness of those experts to present MLM products as medicine, the apparent cosmopolitanism of MLM was part of the allure of paying to join an MLM company. This was a powerful motivating factor for prospective distributors, but even this was inseparable from the promised health benefits of MLM. As a whole, becoming a distributor promised transformative benefits in a holistic package, where class status, professional credentials, and good health were inseparable.

Conclusion

MLM companies are able to join local networks of exchange in health expertise by providing materials that let someone such as Juliana extend her reputation as an informal health expert. With the materials provided by an MLM company, Juliana could convince others of her own health expertise. However, while MLM companies ostensibly sell food supplements, distributors make dramatic claims about the curative medical effects of MLM products. Finally, MLM companies present themselves as transnational companies offering access to upward mobility and a cosmopolitan identity. Part of this entails gaining access to apparently exclusive new medicines associated with wealthy nations. In effect, MLM companies appear to offer their distributors personal and economic transformation linked to elite social status and medical knowledge. These factors allow MLM to participate in local ecologies of care, joining or creating profitable networks of caregiving. In so doing, MLM fosters caregiving relationships that take shape through indebtedness and the promise of health and profit. This links everyday exchanges of health materials and information with metropolitan financial investment, while the trickier ethical conundrums of MLM are kept at arm's length from the corporations that benefit from them. In this way, they are able to extract economic profit from informal personal networks in the so-called global South.

MLM's frequent themes of self-improvement cannot be disentangled from the health claims made by MLM distributors. The dramatic growth of MLM in the global South should be understood in the context of global inequality writ large, including disparities

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in health and access to health care. This may offer indications about the future of global exchange and inventions. As transnational corporations are increasingly capable of profiting from casual and intimate relationships, informal health provision and expertise becomes a critical juncture of both medical care and profit. If the growth of MLM in the global South is indicative of emerging trends in transnational capitalism then medical anthropologists should pay special attention to the financialization of health care. Health industries are leading the drive to extract profits from those with the most precarious position in the global economy. When health care industries are driven by a financial logic, the quest for health can be another opportunity for the exploitation of those at the bottom of the pyramid.

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Notes

1. All personal names have been anonymized, as have the names of the companies that appear in ethnographic evidence. CellMax, Vitabotane, LiveWell, and Tansi are pseudonyms.
2. www.foreverliving.com/marketing/Page.do?name=about [accessed 20 October 2012];
3. http://company.herbalife.com/ [Accessed 20 October 2012]
4. Herbalife, Ltd., FY12-10-K for the Fiscal Year Ended 31 December 2012 [filed 19 February 2013], p. 10, from Morningstar website, http://quicktake.morningstar.com/stocknet/secdocuments.aspx?symbol=hlf, accessed 27 April 2013).

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