

ELEPHANTIASIS AND MUSIC

by

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Just over a year ago I received a letter from someone I had never heard of – Dr. B. R. Laurence, Reader in Entomology at the London School of Hygiene and Tropical Medicine, University of London – saying he would like to meet me to discuss his findings arising out of his recent research. The present essay is the result of our meeting.

For some years Dr. Laurence has been studying the world distribution of Elephantiasis (Filariasis) and its history, and trying to assess its probable geographical point of origin and its mode of dispersal. He has written up his work in *Nature* and elsewhere¹. The essence of the matter is this. Early European voyagers to South-west India found elephantiasis there – or ‘St. Thomas’ Arm’ as they sometimes called it. In 1643 Tasman observed it in the Tonga Islands, and so did Captain Cook in New Caledonia in 1774. Later travellers and missionaries found it and suffered from it in the Polynesian islands. “Thus”, says Dr. Laurence, “we have a picture of a widespread infection in both Western and Eastern Polynesia during the period of discovery and settlement by Europeans, with the endemicity of the disease so great that the settlers quickly became infected.”

He goes on, “It is now common knowledge in tropical medicine that the *filaria nocturna* of Manson (which occurs in China, and he worked in around 1894 – A.M.J.), now known as *Wuchereria bancrofti* (Cobbold) is a parasite of man throughout the tropics and that the parasite in Polynesia . . . is semi-periodic with many microfilariae in the blood by day in contrast to the nocturnal periodicity shown by the microfilariae in most other parts of the world.”

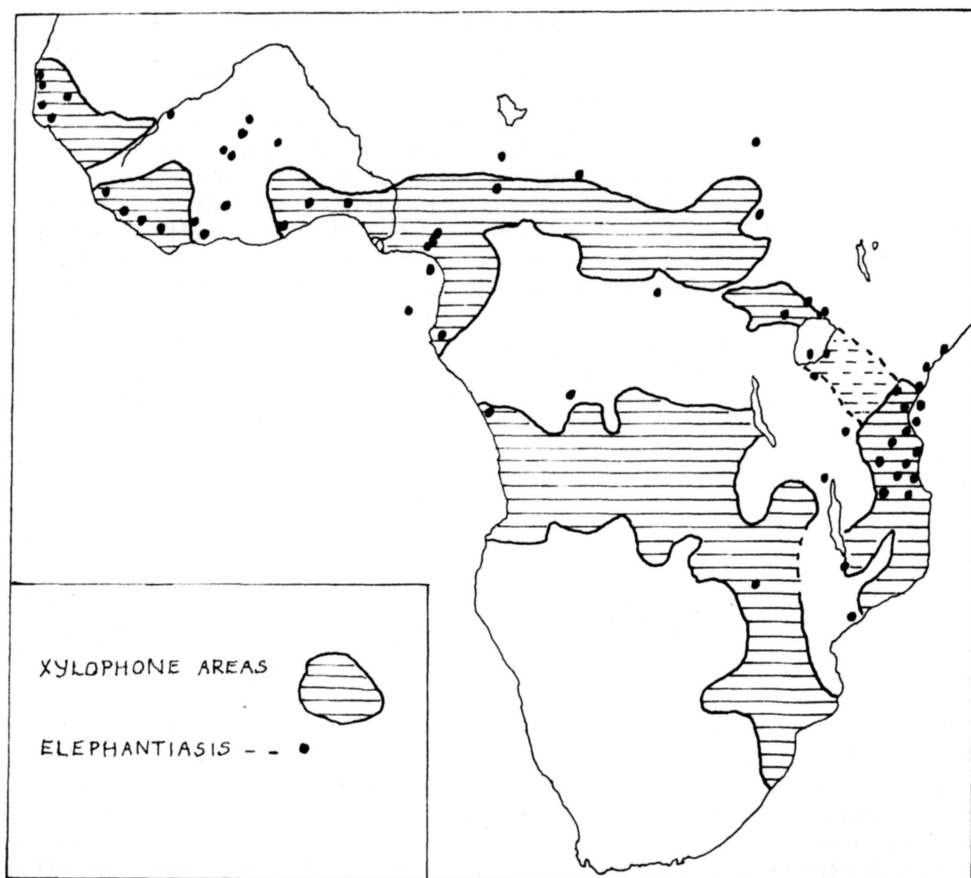
The two variant forms of *Wuchereria bancrofti* arise from the two types of mosquito carriers – the nocturnal form being spread by the night-biting *Culex pipiens fatigans*, *Aedes* and *Anopheles* mosquitoes, and the semi-periodic type by day-biting mosquitoes of the *Aedes* group. But both forms of infection present clinically the same characteristic elephantiasis as we know it.

Now the important point to grasp is that the mosquitoes are not responsible for the breeding of the parasite. “Unlike other vector-borne diseases”, says Dr. Laurence, “such as malaria, plague and yellow fever, there is no replication of the parasite in the mosquito host and in man the worm is bisexual.” In other words, the parasites breed in man, and for the disease to spread, there must be a sufficient number of infected humans for the mosquitoes to bite, and then to bite other non-infected people. “Casual exposure to the bites of infected mosquitoes”, he says, “rarely produces patent infection of filariasis. To move a disease of this kind one would have to suppose that a number of individuals in the migrant population were infected . . .”

“Today”, says Dr. Laurence, “Bancroftian filariasis is found as a disease of rural communities in Africa and in South-east Asia.” “The present information of this parasite of man points to the origin of this disease in the islands of South-east Asia.” “This infection is placed in the area of evolution of the Malay-Polynesian-Malagasy language group and it is conceivable that the disease was introduced to Africa by movements of people belonging to the same linguistic group.”

This was the important conclusion that Dr. Laurence came to as a result of his studies – namely that elephantiasis was brought from South-east Asia and/or Polynesia to Africa by the migration to Africa of a fairly large number of people.

¹ Laurence, B. R. “Elephantiasis and Polynesian Origins.” *Nature*, Vol. 219, No. 5154, pp. 561-563, August 10th, 1968
Laurence, B. R., and Pester, F. R. N. *Journal of Helminthology* 41, 365, 1967.



It was at this point that he happened to come across my book *'Africa and Indonesia'*² which, starting with the evidence of the xylophone, adduces a good deal of other musical, linguistic and cultural evidence, and arrives at the conclusion that somewhere around the beginning of the Christian era, or more probably a few centuries before, people from South-east Asia and the Malay Archipelago sailed across the Indian Ocean, reached Madagascar – where they still are to this day – sailed round the Cape of Good Hope, and up the West coast of Africa, some of them going up the Congo River and settling in the Congo basin, and others going on to the Gulf of Guinea, up the Niger and colonising the Niger basin.

Dr. Laurence said in his letter to me, "I should say that I had already arrived at my conclusion about this disease before coming across your book."

Now Dr. Laurence makes no claim to being musical. Nevertheless having found my book he copied out Olga Boone's map³ of the distribution of the xylophone in Africa, and on that he plotted the known areas of the occurrence of elephantiasis in Africa. His map is reproduced here with some slight corrections to Olga Boone's xylophone areas based on information I have received since her book was published.

² Jones, A. M. *Africa and Indonesia*. Second enlarged edition. Leyden, 1971.

³ Boone, Olga. *Les Xylophones du Congo Belge*, plate XIII. Tervueren, Belgium, 1936.

Looking at the map we see that the elephantiasis areas fall almost entirely in or practically in the xylophone areas. There are two elephantiasis dots in the sea off the West coast; they are of course on the islands of Fernando Po and São Tomé. Similarly in the Indian Ocean the two dots are on the islands of Zanzibar and Pemba. Now the xylophone areas are my basic argument for Indonesian colonisation in parts of Africa, for the home of the xylophone is, *par excellence*, South-east Asia, Java, Bali and Celebes. Moreover, the xylophone areas in Africa, as I set out in my book, are the areas where a large number of other Indonesian cultural traits occur, particularly the singing in parallel thirds. So we find elephantiasis, a disease which Dr. Laurence claims originated and became endemic in lands on the other side of the Indian Ocean, present in the very areas of Africa which indicate on musical and cultural grounds the presence of Indonesians.

But one area in Africa worried Dr. Laurence – to wit, Ghana and the area just west of it. I mark no xylophones there but Dr. Laurence shows elephantiasis just to the north of Ghana. I did not show xylophones here as I had no evidence. However, I then wrote to Professor J. H. Nketia at the Institute of African Studies in the University of Ghana asking whether xylophones were found in Ghana. He replied, “Xylophones are made and played in north-western Ghana. This is the home of the instrument, although one may find it played here and there by migrant musicians from this area.” So Dr. Laurence was right, and his elephantiasis map enabled me to correct my xylophone map; which is one more indication that the two phenomena are closely linked.

There is a feature in some West African sculpture which bears upon the subject. Frank Willett, in his recent book⁴ draws attention to the portrayal of elephantiasis in this sculpture. He cites and illustrates two terracotta figurines which are patently intended by their sculptors to represent unfortunate victims of elephantiasis. Dr. Laurence, commenting on this, says, “It is very difficult to account for the figurines from West Africa portraying elephantiasis without supposing that the infection was introduced from Indonesia.”

Returning to the map, my own musical and cultural evidence strongly suggest that this Indonesian influence started on the coast and spread inland from four coastal areas: from opposite Madagascar in a north-westerly direction; from around Zanzibar also to the north-west; from the mouth of the Congo and inland; and from the coast of the Gulf of Guinea eastwards inland. Now Dr. Laurence’s elephantiasis dots for the most part definitely follow the same pattern. Look at the Gulf of Guinea; look at the East coast of Africa. Of course a critic could say the gaps in Dr. Laurence’s elephantiasis map arise simply because no one has investigated these areas. He is well aware of this: he writes, “The distribution of filariasis in Africa is very patchy and it is very difficult to account for this. Some of the patchiness is due to lack of knowledge but we are fairly sure of some areas where the disease is absent. The distribution of xylophones (and thirds) and the distribution of filariasis are not a bad fit.”

He sums up his conclusion in these words, “(Elephantiasis) was found in the Pacific by Tasman and Cook and it is also found today in both East and West Africa. Now it is very difficult to account for the spread of filariasis across the Indian Ocean without some considerable movement of the human population.”

The whole matter therefore, resolves itself now into two approaches to phenomena in Africa which lead to one and the same conclusion. But the two approaches are so very different in nature. I for my part started with music – xylophones, singing in thirds, the *mbira*, the *sese*, and metal bells; I then went on to ships, to the Board game, to *plangi* dyeing and to the similarities in vocabulary. Now all this is material culture and is open

⁴ Willett, F. *Life in the history of West African sculpture*. London, 1967. pp. 61-63, Fig. 7, and plate 40.

to the usual counter-explanations of spontaneous generation on the one hand, and of diffusion on the other – this diffusion entailing a spread of culture influence from one people to another and not a movement of people taking their culture with them from Indonesia to Africa.

Dr. Laurence's approach on the other hand is something which goes much deeper. His evidence cannot be accounted for by the above two explanations. If elephantiasis can only be carried from one place to another by the actual movement of 'a considerable number of people', surely it follows that the Indonesians *must* have come to these areas in Africa.

It seems to me that entomology has brought a new dimension into the question of Indonesia and Africa. I leave the reader to weigh the evidence for himself.

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