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### Health Care Risks to Canadian Troops in Africa

Africa is a vast continent, with 55 countries, over 2,100 languages and 1.03 billion people (14.95% of the world's population). Yet, in history, Africa is often treated as a single entity—while you take Russian, Canadian or American history, you rarely hear of someone studying Nigerian or Somali history. Rather, those people study “African” history. The greatest challenge of this project has been to disengage from this frame of thinking, while still maintaining a common thread throughout the interviews upon which this paper is based. This paper features the commentary of five veterans who served in Africa between 1975 and 2002. Each veteran served in a different African country, and each had a very different impression of the continent, the challenges and the successes of their efforts there. Despite their differences, however, the common theme that surfaced in each interview was the health care risks that Canadian troops faced in Africa, including malaria, snakes, parasites, and gastrointestinal distress, and the impact these had on the troops. Each veteran, it seemed, had a story to tell about the threats to their personal health and that of the men and women with whom they served. Therefore, this paper seeks to discuss in depth the healthcare challenges of serving in Africa, allowing the words of the veterans who were interviewed to tell their stories.

Throughout this paper, the most significant contribution from these interviews has been the addition of information that cannot be found anywhere else. A detailed narrative of the nature of each conflict, including troop movements and mission statements, is almost always available, but oral history has contributed the material that does not necessarily make it into the history books, like the fact that certain venereal diseases that have been long eradicated in

developed countries can still be found in Africa, or that African soldiers often suffer from improperly set fractures and broken bones from childhood.<sup>1</sup> Much like a contributor to Paul Fussell's article "The Real War Will Never Get in the Books" commented: "we shall never know half of the history...of these times."<sup>2</sup> This is an absolute truth, especially when it comes to more contemporary history, where the details, such as healthcare risks in Africa, cannot be explored until evidence of the larger picture has been collected and examined by historians.

Despite the challenges that using oral history presented, such as fact that much of the information required explanation and background knowledge that the average person and the average historian does not necessarily have, or asking questions knowing that are difficult for the veterans to answer, the contributions these veterans made to this paper undoubtedly could not have been found any other way. Throughout the paper, I have attempted to provide background on the diseases, healthcare challenges, and medications that the veterans speak about, but I have allowed the veterans' words to tell their stories. As is apparent, each of these veterans had a very different experience during their time in Africa. This paper seeks to capture their stories, focussing on the healthcare challenges that they faced during their time there.

The veterans who contributed their voices to this paper are as follows (in chronological order of their deployment in Africa):

1. Major Joan Clement: Discussing her service as a pharmacist in Ismailia, Egypt, May-December 1975 in UNEF II.
2. Colonel Peter Green: discussing his service as a Major in the Canadian Forces Medical Corps in Uganda, 1982-1984 in CMTTU (Commonwealth Military Training Team Uganda).
3. Major General Cameron Ross: discussing his service as a Colonel in Angola, 1992-1993 in UNAVEM II (United Nations Angola Verification Mission II).

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<sup>1</sup> Peter Green, (Colonel, Canadian Forces) in interview with Meghan Stewart, March 7, 2012.

<sup>2</sup> Paul Fussell, "The Real War Will Never Get in the Books," in *Wartime: Understanding and Behaviour in the Second World War* (Oxford: Oxford University Press, 1990), 272.

4. Major Philip Lancaster: discussing his service in Rwanda, 1994-1995 in UNAMIR (United Nations Aid Mission Rwanda).
5. Lieutenant Colonel Stanley Willow: Discussing his service in Sierra Leone, 2001-2002 in UNAMSIL (United Nations Aid Mission in Sierra Leone).

The most common health care risk to Canadian troops deployed to Africa was malaria. Malaria is a disease caused by the plasmodium parasite and is transferred through the bite of a female anopheles mosquito.<sup>3</sup> Once a person is infected, the parasite will grow and multiply inside the liver before attacking and destroying red blood cells.<sup>4</sup> A human will begin to show symptoms 10-12 days after infection, including high fever, shakes, chills, profuse sweating, body aches and other flu-like symptoms.<sup>5</sup> There is no vaccine against malaria, but it is usually preventable or treatable through the use of drugs such as chloroquine, mefloquine, atovaquone and proguanil. Malaria will become drug resistant, however, as Colonel Peter Green points out:

The biggest problem...Every day on sick parade with the Ugandan soldiers we would see malaria. Malaria was as common as the common cold...When I was there, it was still chloroquine sensitive. There were stories, just as I was leaving, that chloroquine resistant falsiparum malaria had arrived. It arrived from Mombasa, and, as I said, we were on the Trans-African Highway, and the trucks that provide fuel to the Eastern Congo would come from Mombasa and travel through Jinja and on through Kampala and over the border into Congo. The truckers were the ones who were gradually bringing the chloroquine resistant falsiparum malaria into Uganda. But when I was there, if a Ugandan soldier had Malaria, you give them chloroquine and you could cure him and it was really satisfying because it worked so well.<sup>6</sup>

Many of these drugs, however, have very unpleasant side effects, such as mefloquine, which can cause mild neuropsychiatric symptoms such as vivid dreams, nightmares, and an inability to concentrate.<sup>7</sup> If sociocultural complications are also present, mefloquine can aggravate psychiatric symptoms and it has been linked to more severe mental changes and

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<sup>3</sup> Olga S. Tomkins, "Malaria," *AAOHN Journal* 57, no. 9 (September 2009): 396.

<sup>4</sup> *Ibid.*, 396.

<sup>5</sup> *Ibid.*, 396.

<sup>6</sup> Peter Green, (Colonel, Canadian Forces) in interview with Meghan Stewart, March 7, 2012. (29:30-30:26)

<sup>7</sup> Oladipo Kukoyi, and Caroline P. Carney, "Curses, Madness and Mefloquine," *Psychosomatics* 44, no. 4 (July/August 2003): 339, <http://www.sciencedirect.com.ezproxy.library.uvic.ca>.

psychosis.<sup>8</sup> Due to its once-a-week dosing schedule and ability to fight chloroquine-resistant malaria, however, mefloquine was favoured as a prophylaxis for Canadian troops serving in Rwanda. The side effects of mefloquine, however, presented a massive problem for troops serving in Rwanda during the genocide, as Major Lancaster explains:

Of the ten of us [the ten soldiers with whom Major Lancaster arrived in Rwanda]...the major health concern was malaria. Now, it turned out that that was a misplaced concern for anyone in Kigali, because Kigali had a very low malaria infection rate, particularly if you're living up on the hills...we were given a prophylaxis called mefloquine, which has been linked to the Somali problems, the Somali killings. We had a horrible experience with it. Of the ten of us, the ten people I knew best, five of us had to be taken off the drug a few months into our time there because of psychological issues. Difficulty controlling emotions, dreams—very disturbing dreams...but it's difficult to sort out whether that was a result of the experience or a result of the mefloquine. In my own case, I got taken off the mefloquine and put on doxycycline, with the warning that I should stay out of the sun.<sup>9</sup>

The south-eastern corner of Angola, where Major General Cameron Ross served for a year on a UN peacekeeping mission, UNAVEM II, is one of the few places in the world where cerebral malaria is found. Cerebral malaria differs from regular strains of malaria because it progresses in a matter of hours from the flu-like symptoms of ordinary malaria into an encephalitic syndrome that includes ataxia, seizures, hemiplegia, coma and death.<sup>10</sup> Even with immediate and successful treatment, 10-20% of victims will suffer lasting neurological complications. Major General Ross spoke about the threat of malaria in Angola:

Malaria was a problem in Luanda, but not nearly as bad as it was out in the bush, and I was very conscious of spraying—we had lots of spray, lots of mosquito repellent, no shortage of that—sleeves always rolled down, and never went out early mornings, dawn or dusk, because that's when the mosquitoes are particularly active. But I would see guys, no shirts, whatever...as I found out, the mosquitoes in Luanda were nothing. In that south-east corner of Angola...there's only a couple of areas in the world that have cerebral malaria...Once you get the symptoms, you die in forty-eight hours...the rest of

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<sup>8</sup> Ibid., 339

<sup>9</sup> Philip Lancaster, (Major, Canadian Forces) in interview with Meghan Stewart, March 14, 2012: (16:34-18:54).

<sup>10</sup> Mahalia S. Desruisseaux, et al. "Cerebral Malaria: A Vasculopathy," *American Journal of Pathology: Cellular and Molecular Biology of Disease* 176, no. 3 (March 2010): 1075-1078, <http://www.ncbi.nlm.nih.gov.ezproxy.library.uvic.ca/pmc/articles/PMC2832128/?tool=pmcentrez> .

Angola has the normal kind of malaria, where you can die from it, but it is a recurring malaria, and the malaria that was in my area didn't recur, for the most part, or doesn't, but you normally die from it.<sup>11</sup>

While the challenges associated with malaria mostly involved preventative medicine, an estimated 60% of people visiting Africa experience diarrhea and gastrointestinal upset when they arrive, the continent as a whole being consistently rated as a high-risk area for gastrointestinal issues for travellers.<sup>12</sup> These issues are brought about most commonly by parasites, followed by bacteria and viruses.<sup>13</sup> As Major Clement points out, these issues are most often caused by changes in food and water, including the prevalence of bacterial water-borne illnesses, such as typhoid, shigellosis, and E. Coli in Africa. Although treatable, each of these illnesses cause great discomfort for their victims.<sup>14</sup> Following Major Clement's commentary, Colonel Green discussed his treatment of these problems.

There's always the 'Jippo guts'. This is the stomach upset that you get when you go into that sort of area. It's like going to Mexico...luckily enough, I was never bothered by that. But that was the number one, probably, complaint because when people arrive from this country and they go to someplace that has different water, different hygiene, different diet, I think that's bound to happen. So that was the number one complaint.<sup>15</sup>

Everybody gets diarrhea when they go to Africa. Probably about seven days after arriving, you will have the worst diarrhea you have ever had in your life. You'll feel you're going to die—you wish you were going to die—but usually, with the magic pills I had, which had a lot of opium and various other illegal things which you would never get now a-days, worked really well.<sup>16</sup>

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<sup>11</sup> Cameron Ross, (Major General, Canadian Forces) in interview with Meghan Stewart, February 28, 2012: (18:40-19:28) (28:50-29:29).

<sup>12</sup> Zoe Greenwood, et al., "Gastrointestinal Infection Among International Travelers Globally," *Journal of Travel Medicine* 15, no. 4 (July/August 2008): 221, <http://onlinelibrary.wiley.com.ezproxy.library.uvic.ca/doi/10.1111/j.1708-8305.2008.00203.x/full>.

<sup>13</sup> Ibid, 222.

<sup>14</sup> G.J. Bonde, "Salmonella and Other Pathogenic Bacteria," *Science of the Total Environment* 18 (April 1981): 9, <http://www.sciencedirect.com/science/article/pii/S0048969781800459>.

<sup>15</sup> Joan Clement, (Major, Canadian Forces) in interview with Meghan Stewart, March 7, 2012: (12:06-12:35).

<sup>16</sup> Peter Green, (Colonel, Canadian Forces) in interview with Meghan Stewart, March 7, 2012: (34:53-35:22).

For those who were accommodated by military contingents during their time in Africa, the food and water was far less of an issue than it may otherwise have been. For those living on a per-diem UN budget as peacekeepers, however, such as Lieutenant Colonel Stanley Willow, finding provisions, especially food and water safe to consume, sometimes proved to be a challenge while in Sierra Leone:

Food was a risk, always, because of contamination...The British had a very large medical contingent, because they had a large contingent of troops, and they would send out a weekly list of hotels that were authorized, or considered safe to eat at. So, out of the whole city, you'd maybe go to four places to eat. And we lived on the economy, so the military soldiers—the armed soldiers—where they were issued rations, and they had kitchens and cooks and everything else...we were given a per-diem, we had to find the place to live, we had to buy the furniture. We looked after everything ourselves, based on this UN per-diem, so there was no rations for us, we had to go and buy food. So we'd cook our own breakfasts, we'd cook our own dinners, sometimes. Generally at work we'd just go to the local restaurant at the hotel and eat there. Everything, you had to buy it. And sometimes in these places, it's hard to find food, because it's just not there, and if it is there, it's hugely expensive. But, the UN, in the basement of the headquarters, had a small grocery store...a lot of the imported stuff was there: fruits, vegetables, etcetera. You had big risks with vegetables in Sierra Leone, because of the fecal count in their fertilizer—they used human waste as fertilizer, so we spent a lot of time trying to find a clean area to buy vegetables from. We found one area up in the Kingston Heights area, on the way out of Sierra Leone, a climb up a hill, and up at the top of the hill was very clean farming and we used to buy our vegetables there.<sup>17</sup>

While Lieutenant Colonel Willow experienced difficulty finding goods on a personal level, the material challenges facing these missions extended to all kinds of supplies, including food and medical supplies. Major Clement discusses how she began ordering medical equipment through the Canadian Forces, rather than UN channels, and Major Lancaster discusses the struggle to work within the confines of the UN supply system:

The medical supplies...we were supposed to order our medical supplies through the United Nations, but having looked at some of the medical supplies that we received...these were very suspect. I really didn't trust some of the supplies that much. For example, there was a certain eye drop and I took two bottles—it was the same lot—

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<sup>17</sup> Stanley Willow, (Lieutenant Colonel, Canadian Forces) in interview with Meghan Stewart, March 12, 2012: (14:33-16:10).

the liquid inside one bottle was red, and the liquid inside the other bottle was yellow. And I thought, ‘This is not very good.’ So, I had made arrangements to order from our central medical equipment depot in Petawawa [Ontario]. And Petawawa used to ship all of our medical supplies. We used to keep them in these big containers outside the pharmacy walls, and, as long as we ordered from Petawawa, we had good supplies...we had to be so careful with the storage, you know, the excessive heat and the night time humidity and this sort of thing. I was always on watch to make sure we had the optimum conditions for our medical supplies.<sup>18</sup>

The only way in and out of Rwanda at the time was by air. So, that meant we had to fly things in from the UN base in Nairobi, and for some reason or other, we just couldn’t get the logistics system to respond to need. There was procedure, and the papers passed back and forth, and requests were made and so on, and money was put aside to buy it, but we just couldn’t get [the system] to perform. I’ve since worked several times inside the UN as a civilian, and have come to understand that their system is set up to favour following rules. The system is completely disconnected from the operational outpost of whatever outputs being deployed—they don’t care. They have no interest in actual delivery. The fact that things tend to work more often than not goes back to basic human qualities of the people involved. You get these little teams of people who just say ‘Nevermind the rules, let’s get this done, because it matters.’ But, in that case, we didn’t have a team like that. We had people who were just following rules, and really, you know, if we didn’t get fed, well, it didn’t really matter, because no one had broken a rule.<sup>19</sup>

Another prevalent medical challenge that came up several times in these interviews was snake bites. Angola is home to both the black and green mamba, two of the most poisonous snakes in the world. Black mambas can grow to be 4.3 metres in length, and their neurotoxic bites will cause paralysis that can lead to death in under twenty minutes.<sup>20</sup> Sierra Leone is home to both the forest and black-necked spitting cobra, the former being a fairly timid snake and the latter being an aggressive snake which spits venom into the eyes of its victim and will chase a human being down the road if they approach too closely.<sup>21</sup> An added complication to the treatment of snake bites is that even if medical assistance can be reached within twenty minutes

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<sup>18</sup> Joan Clement, (Major, Canadian Forces) in interview with Meghan Stewart, March 7, 2012: (4:28-5:51).

<sup>19</sup> Philip Lancaster, (Major, Canadian Forces) in interview with Meghan Stewart, March 14, 2012: (39:40-41:02).

<sup>20</sup> Lee Douglas, “Meet the African Species that One Expert Calls ‘Death Incarnate’,” *International Wildlife* 26, no. 6 (November/December 1996): 48, <http://web.ebscohost.com.ezproxy.library.uvic.ca>.

<sup>21</sup> Department of the Navy: Bureau of Medicine and Surgery. *Poisonous Snakes of the World: A Manual for Use by U.S. Amphibious Forces*. Washington D.C.: Government Printing Office, 1965: 81.

for a mamba bite, an estimated ten percent of the human population will have a severe, anaphylactic reaction to the antivenin, requiring immediate dosage of cortisone and epinephrine.<sup>22</sup> Major General Ross spoke about the black and green mambas in Angola, followed by Lieutenant Colonel Willow's commentary on the black cobras in Sierra Leone:

So, after the storm would go, you've got humidity, you've got water, you've got animals coming out to feed on it, and then you've got the snakes going after the animals and people. During the night you would hear in the little village behind us bloodcurdling screams of people being bitten by snakes...You went outside the tent, and the snakes were everything you could imagine: Cobras, pythons...but the two worst by far were the green and black mambas, and of all snakes, those are the ones that are aggressive. They will chase you, and the other thing is that most snakes, like a rattlesnake, bites and releases. Mambas chew...the green is in the trees, and the black is on the ground.<sup>23</sup>

Snakes were always a big problem, they used to have black cobras that would chase you. Because it was hot and dry, and in the mornings, the dew was underneath the trees, and the cobras would live underneath those trees. So if you went walking down the road, you always had to watch for trees where there was dew, 'cause these big, honking black snakes would come screaming out of the woods and want you out of the way.<sup>24</sup>

Along with snakes, there were other bugs and parasites that threatened Canadian troops, such as scorpions in Angola and Tumbu flies in Uganda. Although scorpion stings are usually not life threatening in adults, they can cause a human to go into anaphylactic shock (unlike snake venom, which targets the central nervous system), and they do require immediate medical attention.<sup>25</sup> Tumbu flies lay eggs in the seams of clothes and the larva will crawl beneath the skin of a person, where it will grow into a worm.<sup>26</sup> The wounds left by Tumbu flies, however

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<sup>22</sup> Douglas, "Meet the African Species that One Expert Calls 'Death Incarnate'," 48.

<sup>23</sup> Cameron Ross, (Major General, Canadian Forces) in interview with Meghan Stewart, February 28, 2012: (29:55-32:00).

<sup>24</sup> Stanley Willow, (Lieutenant Colonel, Canadian Forces) in interview with Meghan Stewart, March 12, 2012: (20:12-20:30).

<sup>25</sup> , Charles Todd, "Scorpion Venom and Anti-Venom," *JAMA: Journal of the American Medical Association* 103, no. 16 (1973): 1294, <http://jama.ama-assn.org.ezproxy.library.uvic.ca>.

<sup>26</sup> Ruthven Mitchell, "Tumbu Fly," *British Medical Journal* (May, 1972): 351, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1788171/pdf/brmedj02202-0065a.pdf>.

unpleasant, generally heal well once the worm has been removed.<sup>27</sup> Troops also fell victim to other parasites, such as the world's third ever case of owl fly infestation of a human rectum in Uganda.<sup>28</sup> In the section below, Lieutenant Colonel Willow discusses parasites in Sierra Leone, Major General Ross comments on scorpions in Angola, and Colonel Green explains how he solved the Tumbu fly problem in Uganda:

Anything that flew, swam, walked or crawled could bite you and hurt you, so you always had to be careful of that. I ended up with a parasite, two of my other guys ended up with parasites. We had a twenty-five percent malaria rate, or twenty percent, one out of five would contract malaria, despite having the pills—we were taking Lariam (a brand-name form of mefloquine) on a weekly basis.<sup>29</sup>

We also had scorpions, too. So, in our compound...we had wooden pallets to walk on because of the scorpions that were around, although you always had to shake your boots out, and they would rarely go into a tent if it was air conditioned, because they didn't like the air conditioning, so we kept the air conditioning on almost all the time.<sup>30</sup>

The [Tumbu] fly...it's the fly that lays its eggs on clothing as the clothing's drying, and then, when you put on your vest, pants, whatever, it crawls out, it hatches, crawls under the skin, and forms a big, nasty boil and then, when you finally get to lancing the boil, the worm will come out. I actually solved that problem—really simple—the way the Ugandan houseboys would do the washing for us, they'd wash it and then they'd put it on the bushes to dry and then they would iron the seams to kill the eggs—that was the theory. It worked most of the time, but it didn't work all the time. We put a clothesline up, and the wind—the flies didn't sit on the clothes anymore. As long as the clothes were flapping, the flies wouldn't settle on them, and they wouldn't lay their eggs in the seams. We reduced the incidents of abscesses from the flies by ninety-five percent.<sup>31</sup>

While Canadians were at risk for all of the previously mentioned health concerns, other troops and civilians serving in the region were at risk for other health concerns. Diseases that have long been eradicated in developed countries, such as syphilis and tuberculosis (TB), were

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<sup>27</sup> Ibid., 351.

<sup>28</sup> Peter Green, (Colonel, Canadian Forces) in interview with Meghan Stewart, March 12, 2012.

<sup>29</sup> Stanley Willow, (Lieutenant Colonel, Canadian Forces) in interview with Meghan Stewart, March 12, 2012: (19:40-20:12).

<sup>30</sup> Cameron Ross, (Major General, Canadian Forces) in interview with Meghan Stewart, February 28, 2012: (30:15-31:08).

<sup>31</sup> Peter Green, (Colonel, Canadian Forces) in interview with Meghan Stewart, March 7, 2012. (33:18-34:40)

rampant, and people in Africa were dying from them.<sup>32</sup> Often, troops from less developed nations suffered from poorly set fractures and broken bones.<sup>33</sup> High refugee populations and rampant poverty in Sierra Leone and Uganda made for poor living conditions and provided the perfect place for diseases like typhoid (a waterborne illness caused by salmonella typhi bacteria fecal contamination of drinking water)<sup>34</sup> and cholera (an acute, quick spreading, waterborne intestinal infection with pandemic potential, caused by vibrio cholera bacteria contamination in water)<sup>35</sup> to flourish. Here, Colonel Green comments on the multitude of venereal diseases, orthopaedic disorders and tuberculosis he saw in Uganda, followed by Lieutenant Colonel Willow's assessment of refugees in Sierra Leone and Colonel Green's discussion of typhoid and cholera in Uganda:

The second commonest thing we would see [following malaria] was venereal disease, usually gonorrhoea, although I did see syphilis—I hadn't seen syphilis outside a special clinic since I was a medical student. It is not common, but I would see it there. Not often, once a week maybe, something like that...A lot of orthopedic disorders. People as kids would fall and break their arm, and it wouldn't be properly set, it wouldn't be properly treated, and so you'd see these really unpleasant results of badly treated fractures. You just don't see them here in Canada—you think somebody breaks an arm, you go to the hospital, you get it set and it's done properly the first time, usually. There it wouldn't be, and so you'd have these people with really bad orthopedic disorders. Not the NCOs, I don't remember the officers having it to the same extent—they probably came from a different background. Maybe they could have afforded to go to a decent hospital...You'd see TB. I saw people dying from TB. I'd never seen anybody dying from TB. I saw a man so weak that he couldn't move off the bed, his ribs, the space between the ribs, caved in and blood stained spittle lying in the gaps there. I mean, the absolute classic picture of somebody dying from TB. Never seen it before, never seen it again, but you would see TB.<sup>36</sup>

Disease was rampant. Lots and lots of sick people everywhere. There was no medical—you go into the hospitals there, it's like going into the middle ages. So, you just had to be

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<sup>32</sup> Peter Green, (Colonel, Canadian Forces) in interview with Meghan Stewart, March 7, 2012.

<sup>33</sup> Ibid.

<sup>34</sup> Ali Shaukat, "Typhoid Perforation," *The Professional Medical Journal* 13, no. 2 (August 2006): 269.

<sup>35</sup> Michael Fournier, and Marie-Laure Quilici. "Cholera," *La Presse Medicale* 36, no. 4 (April 2007): 727, <http://www.sciencedirect.com.ezproxy.library.uvic.ca/science/article/pii/S0755498207001133>.

<sup>36</sup> Peter Green, (Colonel, Canadian Forces) in interview with Meghan Stewart, March 7, 2012:(30:32-30:55), (30:55-31:30), (32:36-33:04).

careful with everything. You know, you shook hands, you lived with a bottle of Purell in your pocket, when you were dealing with the locals you didn't eat anything local...The refugees were screaming across the border. So, we'd have five, six, seven hundred refugees at a time, and they were a sorry bunch...Jindema, just east of the Zimmi bridge, this is the refugee processing centre. This blue tarp...with five hundred people under there, four hundred people. And the smell in that little hovel is just amazing. And in there, there's six UN HCR people, trying to process these Liberians, and this is ten miles into Sierra Leone.<sup>37</sup>

Quite a bit of unexplained diarrhea—I say unexplained, I think some of it was typhoid. I don't think we saw any cholera. I was asked once to go...to a district hospital outside Jinja because there were rumours that cholera had been seen there. I remember writing a report when I got back that said 'No, I don't think it's cholera, it's just typhoid.'—as if that was okay. But it was okay, because typhoid was a much more treatable and local thing than cholera, which would spread very quickly in Africa... I think we had one Australian NCO who I think may have probably got a typhoid-like illness. He had quite a high fever with his diarrhea. Most of the time it was just the diarrhea.<sup>38</sup>

With the exception of the end of the Sierra Leonean mission and Colonel Green's time in Uganda, all of the missions discussed in this paper were Chapter Six UN missions, meaning that although these veterans had direct encounters with combat situations, they were not permitted to respond with force, as per the UN rules of engagement. In addition to all the health risks they encountered, many also experienced being shot at, and most took safety precautions, such as wearing flak vests and ensuring they were back in the UN compound by nightfall. In the following section, Major Lancaster discusses safety precautions in Rwanda, and Lieutenant Colonel Willow discusses the perils of driving in Sierra Leone:

There's just no safety, period. There couldn't be. Every time we went out our door, we were at the mercy of fate, of which way a stray bullet or a stray explosion went, we had flak jackets, but other than that, our most significant safety device was our own instinct. And that seemed to work.<sup>39</sup>

You never went anywhere alone...you always go in pairs, at least. You only go to safe areas...Driving was a super-hazard, because the roads were so bad, vehicles were poorly

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<sup>37</sup> Stanley Willow, (Lieutenant Colonel, Canadian Forces) in interview with Meghan Stewart, March 12, 2012: (23:45-24:10) (31:00-31:45).

<sup>38</sup> Peter Green, (Colonel, Canadian Forces) in interview with Meghan Stewart, March 7, 2012: (32:00-32:36) (35:24-35:33).

<sup>39</sup> Philip Lancaster, (Major, Canadian Forces) in interview with Meghan Stewart, March 14, 2012: (41:16-41:48).

maintained, and there was no tow truck service. So, when you broke down, you broke down. I broke down once, with a blown radiator, and it took us seven hours to drive back...The other thing we did, for safety, was we never did anything at night. If it got dark, you had to be back in your accommodation. [One day] we'd driven through a small village, and the women and everybody were working...when we came back, all of the women were on the side of the road, in their Sunday best—absolutely spotless, beautiful clothing, in wild colours, African colours—they were singing a cappella. So we stopped the cars for a while, and we were watching, but unfortunately, you look at your watch and it's four o'clock, and we had two hours to go, and at six o'clock it gets dark. We couldn't stay any longer. So we had to drive away...that's one of the few things I remember as a, I hate to say it, as a good moment in Sierra Leone.<sup>40</sup>

Understandably, the psychological trauma encountered during these missions was hard on those who served there. Estimated rates of post-traumatic stress disorder (PTSD) for Canadian peacekeepers are 11% for those deployed once, and as high as 15% for those who served in multiple peacekeeping missions (compared to 4% in those never deployed).<sup>41</sup> Estimated rates of clinical depression in returning peacekeepers ranged from 30-33%.<sup>42</sup> Being deployed overseas was stressful, but returning home was often the hardest part. In this section, Lieutenant Colonel Willow speaks about the stress of serving in Sierra Leone. Major Lancaster then addresses the challenges of returning home to Canada after serving in Rwanda.

The time and the weather, the environment was tough for all of us. We were all—I don't know if you noticed in that picture—but we're all in our forties, almost fifties. And that's a tough place to be at that age. It's tiring, hard work. I remember a few of the guys my age, there were three of us, and we were commiserating something fierce...it was tiring work.<sup>43</sup>

[The return to Canada] That's the hardest part. Always the hardest part. It's difficult to describe, but—have you seen the Narnia chronicles? Imagine there was one, I think the second one, where the oldest boy in the family...is having trouble because he'd been a king, and here he's a school boy. It's a little bit like that. When you're working in that kind of context, you have power and status just unimaginable in Canada. The Prime

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<sup>40</sup> Stanley Willow, (Lieutenant Colonel, Canadian Forces) in interview with Meghan Stewart, March 12, 2012: (22:54-23:34)(34:50-35:27) (14:23-14:32).

<sup>41</sup> David Hodges, "Screen Peacekeepers for PTSD," *Medical Post* 44, no. 25 (August 2008): 15, <http://search.proquest.com.ezproxy.library.uvic.ca/docview/228950813>.

<sup>42</sup> *Ibid.*, 15.

<sup>43</sup> Stanley Willow, (Lieutenant Colonel, Canadian Forces) in interview with Meghan Stewart, March 12, 2012: (29:53-30:15).

Minister of Rwanda used to come to use my phone...Home to Canada, and I'm holding on to the strap on the bus along with all the rest of the peasants. It's just a great deal of ego involved in, loss of ego, if you want, in coming back. Then there's the loss of the immediacy of that kind of life. I mean, just day to day, minute to minute, was so intense. There was kind of an emotional freedom, I suppose, that again, you had to give up coming home...And then, of course, the family issues. I think it was probably four or five years before I could sleep through a night without startle alerts waking me up, I would get violent in my sleep...a whole bunch of nasty little residual problems that come home with you that you don't get time to get rid of...every time is difficult coming home, but it gets easier. You get practiced, and you learn what to look for, what to do, how to cope.<sup>44</sup>

Many of the veterans commented on their pre-deployment training, stating that there were problems with it, including the idea that Canadians are good peacekeepers, and have been involved in peacekeeping for so long that they will automatically know what to do. In Colonel Green's case, he was trained in tropical medicine by the British army, but did not receive any additional training from the Canadian Forces before his deployment to Uganda. By 2001, however, training had improved incredibly. In the section below, Major General Ross and Colonel Green comment on their pre-deployment training, followed by Lieutenant Colonel Stanley Willow discussing the changes in training between his service in 1992 and 2002:

On Canada's side I would say complacency. That was a challenge. We'd been doing this forever, so don't worry about it, we're good at it, out you go. And when you [compare] the pre-deployment training that we undertake now, which is really good, and it is required on all aspects: cultural, health, everything else.<sup>45</sup>

When you join the British Army, they spend at least three months trying to bring you up to speed on all the things they didn't teach you in medical school that they think you need to know to be a good army medical officer...so I had gone through, albeit a few years before, a fairly intense course...of tropical medicine...And so, I was sort of okay, I think. An awful lot of it was learning on the job. A lot of it was the big books that we brought with us...but could I have been better trained? Yes, I sure could. I mean, there were a lot of things that I didn't know. But I think the training I got, not from the Canadian Forces, but from the Royal Army Medical Corps before I joined as a regular officer there stood me in good stead, particularly in army health and particularly in tropical medicine.<sup>46</sup>

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<sup>44</sup> Philip Lancaster, (Major, Canadian Forces) in interview with Meghan Stewart, March 14, 2012: (49:49-53:02)

<sup>45</sup> Cameron Ross, (Major General, Canadian Forces) in interview with Meghan Stewart, February 28, 2012: (1:02:39-1:03:10).

<sup>46</sup> Peter Green, (Colonel, Canadian Forces) in interview with Meghan Stewart, March 7, 2012: (39:00-40:12).

Canada's really good...they've been recognizing over the years that you can't throw us into places with nothing. I went into the Sahara in 1992 and my first aid kit was six inches by six inches. That was it. When I went to Sierra Leone, I went with four casualty bags, four rucksacks full of medical gear. I could have done surgery for God's sakes...the only thing we didn't get was morphine...We did three weeks of pre-deployment training, and four days of that was, well, more than first aid. It was combat first aid, it was how to deal with bad things: everything from punctures to gunshots to amputations...you name it, the whole bit...it was much better than I had in my other tours.<sup>47</sup>

The health care concerns discussed in this paper inevitably impacted each mission in Africa, albeit in different ways. Due to the developmental state of these African countries, diseases that have long been eradicated in North America are prevalent, and they threaten the troops serving there. Because of the geographical location of these nations, there are problems caused by insects and wildlife that are not an issue in Canada. Because of the nature of conflict in the countries these veterans served in (almost exclusively civil wars brought about in post-colonial states), the levels of stress and the threats that faced troops differed drastically from anywhere else in the world.

It is difficult to imagine the threats that were posed to Canadian troops in Africa, both physically and mentally. However, perhaps the most frustrating thing about researching and learning about these African states has been the notion that continues to persist today that Africa is a country, rather than a continent, and that it can be treated as a single entity. Major Philip Lancaster summarized the frustration that this notion causes, speaking about his return to Canada in 1995:

I got home in May of 1995, and it was clear to me at that point that people had either forgotten or not noticed at all that there had been a genocide in Rwanda. People would ask me where I was, I would say Africa, and they would say, 'Oh, how was Africa?' I would say, 'Well, I was in Rwanda,' and they said, 'Oh. Where's that?' No memory of it. It just hadn't penetrated. And yet, when I turned the news on, boy—O.J. Simpson's gloves were the item of the day... And at the end of the day, you would find a brilliant

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<sup>47</sup> Stanley Willow, (Lieutenant Colonel, Canadian Forces) in interview with Meghan Stewart, March 12, 2012: (24:23-26:06).

spotlight being shone on one particular issue, and the all the rest of the world left in shadow.<sup>48</sup>

Despite the health care and personal safety risks to Canadian soldiers, and the frustration that came with the failings of peacekeeping during the 1990s, none of the veterans suggested that Canada should avoid becoming involved in peacekeeping missions. In fact, although many suggested that changes need to be made, they all agreed that Canada should continue to be a peacekeeping nation, and that when the UN needs peacekeeping troops, Canada should answer the call. This speaks to the reality that, despite its challenges, peacekeeping does create positive change in the countries where it is deployed. The veterans who contributed their voices to this project spoke at length regarding the risks involved with serving in Africa, but each one also offered a profound sense of respect and, in some cases, fondness for the countries in which they served and the people they met during their time in Africa.

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<sup>48</sup> Philip Lancaster, (Major, Canadian Forces) in interview with Meghan Stewart, March 14, 2012: (34:30-35:49).

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Friday 6th March 2010, was special for Laura, and me – our sleep over at the American Museum of Natural History (AMNH). I am guessing you've seen the movie? A22 in 2006 and called "A Night at the Museum" with Ben Stiller starring. It's a kicking comedy about a night guard who A23 an ancient curse that makes the animals on display come to life every night and trash the place. I am not sure if the night Laura and I spent at the museum was A24 by the film, but it was way cool. Fact, fact, fact! AMNH is one of the largest Museums in the world. There are 25 buildings and 46 A25