Canadian Human Rights Tribunal Tribunal canadien des droits de la personne

Between:

Bronwyn Cruden

Complainant

- and -

Canadian Human Rights Commission

Commission

- and -

Canadian International Development Agency

- and -

Health Canada

Respondents

Decision

Member: Sophie Marchildon
Date: September 23, 2011
Citation: 2011 CHRT 13

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I. Summary

[1] Health Canada conducts medical assessments of Canadian International Development Agency employees seeking postings in other countries. Health Canada has developed medical evaluation guidelines specific to the assessment of employees seeking a posting in Afghanistan. Pursuant to these *Afghanistan Guidelines*, under the heading “Absolute medical requirements”, employees do not meet the medical requirements for posting if they have a medical condition that would likely lead to a life-threatening medical emergency if access to prescribed medication and/or other treatment is interrupted for a short period of time. On this basis, the complainant alleges that her employer, the Canadian International Development Agency, engaged in a discriminatory practice when it decided that she was not suitable for a job posting in Afghanistan due to the fact that she had a condition of type 1 diabetes mellitus. The complainant also alleges that Health Canada engaged in a discriminatory practice when it recommended to her employer, Canadian International Development Agency that she not be posted to Afghanistan because of her diabetic condition. She also alleges that her employer did not use its discretionary power to decide not to follow Health Canada’s recommendation.

[2] The *Afghanistan Guidelines* do not reflect equality between all members of society. Although the guidelines are meant to be instructive and informative, their wording suggests mandatory medical requirements without consideration of the individualized circumstances of each person. The process by which Health Canada assessed and arrived at its recommendation, influenced as it was by the *Afghanistan Guidelines*, failed to consider the inherent worth and dignity of the complainant. The application of these guidelines to the complainant resulted in her being discriminated against in the course of her medical assessment. Health Canada did not provide sufficient evidence that its conduct was non-discriminatory. Therefore, the complainant suffered adverse differentiation on the basis of her disability by the wording and application of the *Afghanistan Guidelines* by Health Canada.

[3] The evidence indicates that it would pose an undue hardship for the Canadian International Development Agency to accommodate the complainant in Afghanistan. There are

serious health and safety risks present for Canadians working in Afghanistan and these risks frequently materialize. It is not only the complainant who bears these risks, but also members of the Canadian Forces and other foreign military personnel. Evidence was lead that the recommendations made by the third independent endocrinologist who assessed the complainant, to accommodate her in Afghanistan could not be enforced at all times and could likely result in putting herself and other CIDA employees in danger. Medical services and facilities are limited including bed space, and therefore, must be preserved for the treatment of troops, injured Afghani civilians and unpredictable emergencies that impact all civilians posted in Afghanistan. In the requirements to accomplish the mission in Afghanistan, pre-deployment screening and medical assessments of employees is warranted and the high standard for safety reasons is justifiable but, should be made in accordance with human rights principles and, on a case by case, individualized approach. Furthermore, Canadian International Development Agency has breached its duty to explore all reasonable accommodation measures for the complainant. It had a duty to obtain all relevant information about its employee's disability and seriously consider how the complainant could be accommodated. It did not lead sufficient evidence that had explored all reasonable accommodation measures.

[4] Therefore, both complaints are substantiated under section 7 (b) of the *CHRA* against Health Canada and under sections 7 and 10 of the *CHRA* against CIDA; and the Tribunal orders appropriate remedial action to eliminate these discriminatory practices.

II. Background and Complaints

[5] There is a war in Afghanistan. Combat is continuous, complex and dangerous. At the time of these complaints, Canada was one of 41 countries participating in the International Security Assistance Force (ISAF), a North Atlantic Treaty Organization (NATO) led formation

that operates in Afghanistan under the authority of the United Nations (UN).[1] The UN also operates the United Nations Assistance Mission in Afghanistan (UNAMA), a political mission established at the request of the Government of Afghanistan to assist it and the people of Afghanistan in laying the foundations for sustainable peace and development[2]. The Political Affairs Division at UNAMA supports political outreach, conflict resolution, disarmament and regional cooperation. The political mandate of UNAMA supported the implementation of the institutional and political objectives of the Bonn Agreement, signed in November 2001, as well as a range of peace-building tasks[3].

[6] Canada has maintained a presence in Afghanistan since 2001. Canada has participated at many levels in the peacekeeping, security and reconstruction efforts within the country. The situation in Afghanistan calls for strong international cooperation. This international cooperation comes from both military personnel and civilian personnel as reconstruction efforts are often overseen by both military and civilian organizations. At the time of these complaints, all Canadian civilians serving in Kandahar performed their duties under the direction of the Representative of Canada in Kandahar (RoCk), who works under the leadership of the Canadian Ambassador in Kabul.[4] In Canada, the Canadian International Development Agency (CIDA) is the principal organization responsible for providing aid to developing countries. CIDA's mandate is to manage Canada's support, aid and resources to developing countries such as Afghanistan.

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[1] Government of Canada, *Canadian Forces Operations*, online: Canada's Engagement in Afghanistan <http://www.afghanistan.gc.ca/canada-afghanistan/approach-approche/cfo-ofc.aspx?lang=eng>.
[2] United Nations, *Mandate*, online: The United Nations Assistance Mission in Afghanistan <http://unama.unmissions.org/Default.aspx?tabid=1742>.
[3] United Nations, *Political Affairs*, online: The United Nations Assistance Mission in Afghanistan <http://unama.unmissions.org/Default.aspx?tabid=1752>.
[4] Government of Canada, *Representative of Canada in Kandahar*, online: Canada's Engagement in Afghanistan<http://www.afghanistan.gc.ca/canada-afghanistan/kandahar/represent.aspx?lang=eng>.

[7] This is part of the context in which the events giving rise to the present complaints occurred. The complainant, Ms. Bronwyn Cruden, filed two complaints with the Canadian Human Rights Commission (the Commission) on November 8, 2008. First, the complaint alleges that her employer, CIDA, engaged in a discriminatory practice within the meaning of sections 7 and 10 of the *Canadian Human Rights Act*, R.S.C., 1985, c. H-6 (the *CHRA*) when it decided that she was not suitable for a job posting in Afghanistan due to her condition of type 1 diabetes. The second complaint alleged that Health Canada (HC) engaged in a discriminatory practice within the meaning of s. 5 of the *CHRA* when it recommended to CIDA that she not be posted to Afghanistan because of her diabetic condition. The complaint against HC was subsequently amended at the hearing, by consent of the parties, to include sections 7 and 10 of the *CHRA*. On March 18, 2010, pursuant to paragraph 44(3)(a) of the *CHRA*, the Commission requested that the Canadian Human Rights Tribunal (the Tribunal) inquire into both complaints. The complaints were consolidated as they involve substantially the same issues of fact and law. The Commission participated at the hearing that took place from January 26 to February 4, 2011, representing the public interest in the proceedings.

III. Facts

[8] After carefully reviewing all the evidence provided by the parties including the Agreed Statement of facts my findings of fact are the following:

> The complainant is a CIDA employee who currently works at their Gatineau headquarters. From approximately August 6, 2007 to September 7, 2007 the complainant was on temporary duty assignment at the Canadian Embassy in Kabul, Afghanistan. She was not subjected to a pre-deployment medical assessment prior to departure, as at that time, CIDA's policy did not require a medical assessment of employees being posted for less than one year.

[9] In January 2008, the complainant applied for a number of one year postings in Afghanistan that CIDA was to make available in the near future. She applied for the position of "Director of Kandahar" and for other development officer positions.

[10] On January 20, 2008, the complainant was deployed a second time to Afghanistan, this time in Kandahar, as part of the Provincial Reconstruction Team (PRT). This deployment was to last until February 25, 2008.

[11] During the early morning of February 11, 2008, the complainant had a hypoglycaemic “incident” while she was sleeping. A co-worker in the adjoining room overheard her making noises and movements in her sleep, tried to wake her up and when she wasn’t successful, called a Canadian Forces Medical Officer, who administrated intravenous glucose to the complainant. The complainant was subsequently released after treatment. Later on that day, the complainant was referred to an internal medicine consultant at the Kandahar Airfield (KAF) who strongly recommended that the complainant be repatriated to Canada. The complainant disagreed with the internal medicine consultant’s recommendation and wished to stay on in Afghanistan to complete her temporary duty assignment. CIDA chose to end the complainant’s temporary duty assignment and promptly returned her to Canada.

[12] On February 13, 2008, Michael Collins (Director, Management Services CIDA) sent an email to the complainant and some of her colleagues within the Afghanistan Task Force (ATF) to seek if they were interested in field postings in Afghanistan. Everyone who received this email has since been posted to Afghanistan except the complainant.

[13] Upon her return to Canada, the complainant obtained a letter of support from her treating endocrinologist, Dr. Amel Arnaout. The letter dated February 21, 2008, supports the complainant’s efforts to return to work in Afghanistan. Dr. Arnaout explains that the complainant was assessed on February 18 2008, and that she "is mentally and physically capable of continuing her work in Afghanistan...’’. By e-mail dated February 22, 2008, Marion Parry (Manager, Mobility and Career Programs, CIDA) requested that the complainant be medically assessed in order to ascertain whether or not she could continue her temporary duty assignment and to determine her fitness for posting due to her expressed interest in a formal one-year posting.

[14] In an email dated February 26, 2008 to CIDA, Major Robin Thurlow (Canadian Expeditionary Force Command, JHSS) stated that he was concerned with the fact that no pre-deployment medical screening was conducted for persons deploying to Afghanistan for less than one year. He went on to request support in ensuring that screening be conducted for all personnel being sent to Afghanistan. CIDA subsequently changed its practices to require that all employees being sent to Afghanistan for any period of time undergo a pre-deployment medical screening.

[15] Pursuant to *Foreign Service Directive 9 Medical and Dental Examinations* (*FSD9*) (see *FSD9* at Appendix #1), which is published by the National Joint Council, HC conducts medical assessments of CIDA employees seeking postings in other countries. *FSD9* also provides a process by which these assessments are to take place. Both HC and CIDA have to consider *FSD9*. In performing medical assessments, HC has developed and publishes the *Occupational Health Assessment Guide* (*OHAG*), which is intended to help guide the medical examiner in making an assessment (see section 1 of the *OHAG* at Appendix #2). Shortly after Major Thurlow's February 2008 email indicating that medical assessments should be done for all postings to Afghanistan, HC developed the *Medical Evaluation Guidelines for Posting, Temporary Duty or Travel to Afghanistan (Hardship Post level 5 with Hostility Bonus)* (the *Afghanistan Guidelines*) (see *Afghanistan Guidelines* at Appendix #3). Under the heading "Absolute medical requirements", the *Afghanistan Guidelines* state:

> Employees do not meet the medical requirements for assignment or posting: [..] If they have a medical condition that would likely lead to a life-threatening medical emergency if access to prescribed medication and/or other treatment is interrupted for a short period of time.

[16] On March 18, 2008, the complainant met with Dr. Maureen Peggy Baxter (Occupational Health Medical Officer (OHMO) with HC's Workplace Health and Public Safety Program WHPSP) Health Clinic (Clinic) to determine if the complainant was a suitable candidate for a position in Afghanistan. The complainant provided Dr. Baxter with past health records and a copy of Dr. Arnaout's letter dated February 21, 2008. Following this medical assessment, on April 9, 2008, Dr. Baxter consulted with some of her fellow OHMO at the Clinic. They

unanimously agreed on a recommendation that the complainant was not medically fit to be posted to Kabul. Dr. Eva Callary and Dr. Lloyd-Jones were part of the discussion and did not seek an independent third opinion under s. 9.05(a) of *FSD9* before reaching this decision. That same day, Dr. Baxter indicated by letter to Clement Bedard (Program Assistant, Assignments Management Centre, CIDA) that in light of the fact that the complainant's medical condition is chronic in nature and there was a risk of destabilization, she could not be recommended for deployment to Afghanistan because she required sophisticated care and treatment not available at this post. Dr. Baxter reported however, that Dr. Arnaout had submitted information indicating the complainant's current condition is stable. Dr. Baxter's letter was not sent to the complainant at that moment nor did HC advise her of their recommendation they made to CIDA.

[17] Upon receipt of this recommendation from HC, CIDA decided that it would not send the complainant to Afghanistan and did not make further inquiries of Dr. Baxter or Dr. Arnaout or pursuant to s. 9.05 (b) of *FSD9* to seek out an independent third medical opinion.

[18] On April 10, 2008, the complainant received a letter from Ms. Parry informing her that she had not been selected for the position of "Director Kandahar". Ms. Parry did not inform the complainant on the outcome of the other applications for development officers' postings to which she had also applied.

[19] Around April 15 or 16, 2008, the complainant had a conversation with Michael Collins who told her that HC had recommended against returning or posting her to Afghanistan.

[20] The complainant attempted to gather information from HC. The complainant and Dr. Baxter exchanged emails and had a telephone conversation. On April 17, 2008, the complainant learned from Dr. Baxter that while HC had the responsibility to provide recommendations based on health assessments, all decisions concerning the deployment of employees rested with CIDA. The complainant forwarded Dr. Baxter's email to Michael Collins (Director, Management Services, CIDA) and asked if it would exercise its discretion to allow her

to go to Afghanistan. No one from CIDA replied to this email. On April 21, 2008, the complainant wrote to Dr. Baxter to ask if HC would provide a list of countries to which it would not recommend for posting. On April 23, 2008, Dr. Baxter wrote back to say that such a list did not exist and that in general, higher hardship levels are less likely to have suitable medical services available and suggested the complainant short list some of the countries she was interested in, and ask her department to send a fitness request.

[21] On June 2, 2008, the complainant wrote and questioned Danica Shimbashi (Director General, Human Resources, CIDA) in order to find out if there had ever been a situation where CIDA did not follow a HC recommendation in the past. The complainant also asked if CIDA would ask for an advance fitness assessment for its postings.

[22] On June 20, 2008, as a response, Ms. Parry who had received the request forwarded from Ms. Shimbashi to her, replied to the complainant directly and advised her that HC is the only occupational health body responsible for medical assessments. Ms. Parry said she must advise management to be guided at all times by HC's determination since CIDA's human resources staff and managers are not in any position to re-evaluate a medical opinion. Furthermore, CIDA informed the complainant that HC's medical assessments were only valid for a period of six months being post-specific and that CIDA could not authorize evaluations now for possible future postings. Ms. Parry suggested to the complainant to follow-up with Dr. Baxter to see which levels of hardship could reasonably be expected to have the necessary medical capacity to respond to her health condition.

[23] On August 26, 2008, Mr. Wallace, from CIDA, wrote a letter to the complainant saying that HC had indicated a willingness to review countries where posting may be possible with her condition and that she could contact Dr. Eva Callary (Medical officer in charge, Occupational Health Clinic, WHPSP, HC) in this regard.

[24] On September 25, 2008, the complainant met with Dr. Eva Callary and she provided a list of 19 countries that were expected to have postings for 2009 to the complainant. During this meeting, Dr. Callary informed the complainant that it was possible to request an internal review of her circumstances with HC's Medical Advisory Committee (HC-MAC) this was the first time the complainant was made aware of such a possibility.

[25] On October 3, 2008, Dr. Callary, via email, assured the complainant that HC would respect the decision of the HC-MAC whatever it may be.

[26] On November 28, 2008, Dr. Baxter responded to the complainant concerning the list of 19 countries that Dr. Callary provided previously. HC found that of the 19 countries, 5 were considered suitable, 5 were considered unsuitable, and 3 were listed as "missions with concerns" which would require individual assessment. For the remaining six missions, Dr. Baxter said that insufficient information had been received from the responsible regional medical officers and that an addendum would follow when it received further information. No further addendum was delivered.

[27] The same day, Dr. Arnaout wrote a letter of assessment for the complainant and stated she considered the complainant being optimally managed in her diabetes and hoped this letter would help in her appeal process concerning postings in Afghanistan. The complainant sent a written submission to the HC-MAC to review her medical situation.

[28] On January 16, 2009 the HC-MAC rendered its recommendation and sent a letter to Dr. Baxter to this effect. It asked the complainant to undergo a medical examination with an independent medical endocrinologist, including a review of her history, clinical status and detailed reports on medical conditions in Afghanistan. The HC-MAC further said that if the independent medical endocrinologist was of the opinion that a posting to Afghanistan was not at risk to her or others that it would sign off on her case as meeting the medical requirements for this posting. However, if the independent medical endocrinologist was of the opinion that the

posting was medically inadvisable, the original recommendation would stand. Dr. Baxter sent a copy of the HC-MAC decision to the complainant on January 30, 2009.

[29] On February 15, 2009, the complainant informed HC that she would be willing to go through the medical exam towards midsummer 2009.

[30] On September 22, 2009 the complainant was examined by Dr. Hugues Beauregard, an independent endocrinologist in Montreal selected by an outside company (Compremed Canada Inc.). Dr. Joanne Lloyd-Jones (OHMO, HC) had sent Dr. Beauregard the complainant's history, described the available medical facilities in Afghanistan, and identified the questions that HC wanted Dr. Beauregard to answer. In his preliminary report dated September 23, 2009, Dr. Beauregard considered the complainant capable to adapt to harsh working conditions and considering her knowledge in the management of her diabetes, she should be given permission to accept a posting to Afghanistan. In his report dated September 29, 2009, Dr. Beauregard, classified the complainant as a well informed, organized and a motivated patient. According to Dr. Beauregard, the complainant faced exposure to health risks slightly more elevated than non-diabetics even though she effectively managed her condition of type 1 diabetes. Dr. Beauregard was of the opinion that the complainant was fit for deployment to Afghanistan due to the fact that the health risks could be reduced to, what he termed as, an 'acceptable level' so long as she could bring the equipment she needed, she was fit to work without restrictions at Kabul, KAF, PRT. Pursuant to Dr. Beauregard's suggestion, the complainant underwent a cardiac stress test and a psychological assessment, to examine her capacity to handle stress associated with conflict zones. She was deemed psychologically fit for full-time work and eventual Afghanistan posting. The complainant gave copies of Dr. Beauregard's report to various CIDA officials in October 2009, including her immediate supervisor Dave Metcalfe and Amy Baker (Chief of Staff, President's Office, CIDA) and Joanne Marquis (Human Resources, CIDA).

[31] On November 5, 2009, HC asked Dr. Beauregard to clarify the content of his medical report taking into consideration the current *Afghanistan Guidelines*. Dr. Lloyd-Jones, wrote to

Clement Bedard letting him know she had received information from Dr. Beauregard but was seeking clarification.

[32] On November 19, 2009, Dr. Beauregard responded to Dr. Lloyd-Jones's request for clarification. He wrote that the complainant would be deemed unfit by HC's "absolute medical requirement" that no employee "...have a medical condition that would likely lead to a life-threatening medical emergency if access to prescribed medication and/or other treatment is interrupted for a short period of time" (see *Afghanistan Guidelines* at Appendix #3). However, Dr. Beauregard remained of the view that the complainant could still be deployed since she could manage her diabetes in the prevailing conditions in order to bring any risk within acceptable levels.

[33] The same day, Dr. Lloyd-Jones wrote again to Mr. Bedard. In her letter, she stated that Dr. Beauregard had concluded that the complainant should be allowed to go to Kabul, the KAF or PRT in Kandahar. Dr. Lloyd-Jones indicated that his recommendation would change if he were to follow the wording contained in the Current HC Afghanistan guidelines.

[34] Dr. Lloyd-Jones also asked Dr. Beauregard for clarification concerning implications for travel to remote areas. On November 24, 2009, Dr. Beauregard clarified that the risk of traveling was acceptable, so long as the complainant could have extra food and insulin to carry with her. Dr. Beauregard concluded saying he could not comment on the risks inherent to the political instability in the area. Dr. Lloyd-Jones passed this information on to Mr. Bedard in a letter dated December 7, 2009.

[35] On December 9, 2009, France Genest (Director, Human Ressources Operations, CIDA) wrote a letter to Dr. Lloyd-Jones in which she asked her to confirm CIDA's understanding that HC's initial recommendation remained unchanged and if a further medical assessment would be required in connection with the complainant's application to be posted to Afghanistan as part of the 2010 assignment exercise.

[36] On December 16, 2009, Dr. Lloyd-Jones informed Ms. Genest that Dr. Beauregard concluded that the complainant did not meet the absolute medical requirements of the *Afghanistan Guidelines*. Dr. Lloyd-Jones added that Dr. Beauregard was of the view that the complainant could work and travel in Afghanistan, if she (i) has access to medication, testing equipment and backup supplies at all times, (ii) lives and sleep in a room with a person aware of her condition, and (iii) has extra food and medication for travel. She concluded in saying that the final decision whether or not to post the complainant was CIDA's decision so as the decision to seek another medical assessment in the absence of any compelling new medical factors.

[37] On January 11, 2010 the complainant was informed by Bob Johnston (Director General of the Afghanistan Task Force CIDA) that, in light of the information it received from HC, no further consideration would be given to posting her to Afghanistan unless there was a change to her medical condition.

IV. Type I Diabetes

[38] The Complainant was diagnosed with type 1 diabetes mellitus at age 10 and has undergone different treatments over the course of her life. Type 1 diabetes is a condition whereby the pancreas no longer produces insulin; as a result, the complainant is insulin-dependent. She must monitor her glucose levels and is on insulin therapy. The complainant often uses an insulin pump and a sensor to assist her in maintaining her blood sugar levels at normal range.

[39] Insulin therapy is required for the survival of persons with type 1 diabetes. There are different kinds of insulin and also different methods for insulin intake. One option is to take insulin with a syringe or pen as required. Another option is to use an insulin pump, which is a portable, battery-operated, device that is programmed to deliver insulin 24 hours per day through a small catheter under the skin.

[40] Regular monitoring of blood sugars is also required for persons with type 1 diabetes. The level of sugar in the blood can be affected by a number of factors, including the administration of insulin, food intake, physical exercise; stress levels and inter current illness. Persons with type 1 diabetes are at risk of short and long term complications, which can include kidney or renal disease (diabetic nephropathy), eye disease (diabetic retinopathy), nerve damage (diabetic neuropathy) or other end organ disease.

[41] Individuals with type 1 diabetes are also at risk of suffering from hypoglycaemia and hyperglycaemia. Hypoglycaemia occurs when the blood sugar is too low. This occurs when the person with diabetes does not consume enough nourishment in a timely fashion or takes too much insulin, causing the sugar in the blood to be consumed more rapidly than anticipated. The symptoms of hypoglycaemia range from hunger, anxiety, shakiness, sweating, and irritability. If left untreated, symptoms may progress to confusion, loss of consciousness, seizures and possibly death. A person that experiences a severe hypoglycaemic reaction resulting in cognitive function deterioration, convulsion and coma would need help from a third party to help them ingest sugars, to provide an injection of glucagon (a hormone that increases the blood sugar level) or to administer intravenous glucose. Intravenous glucose cannot be administered by a person with no medical qualifications, for example, a qualified person to administer intravenous glucose would be a medical technician, a nurse or a doctor. However, anyone can receive training to give a glucagon injection. In certain instances, hypoglycaemic unawareness occurs whereby the early signs of hypoglycaemia go unnoticed or are absent. Severe hypoglycaemic events increase with age. Also, the more a person experiences them, the more vulnerable that person is to experiencing another severe hypoglycaemic event in the future.

[42] Hyperglycaemia is another complication that can result from type 1 diabetes. It occurs when a person’s blood sugar level becomes too high. Hyperglycaemia can be caused by numerous factors, including excessive consumption of food or sugar, infection, trauma, increased stress, and failing to take enough insulin in a timely fashion. Symptoms of hyperglycaemia can include hunger, excessive thirst, frequent urination, blurred vision or fatigue. Most of the time a

person will detect early symptoms of hyperglycaemia and correct the problem, for example, by taking insulin. If left untreated, hyperglycaemia can lead to an acute complication called diabetic ketoacidosis ("DKA''). DKA occurs when high blood sugar levels cause the body to break down fat cells for fuel, rather than convert sugar in the blood. This process releases waste products called ketones that can accumulate in the blood and affect the body's metabolism. Signs and symptoms of DKA can include fruity odour on the breath, confusion, nausea, vomiting and weight loss. DKA is life-threatening and requires emergency treatment, which includes administration of fluids and insulin and can require hospitalisation.

[43] A severe hyperglycaemic or hypoglycaemic event can often be prevented by many means and by the use of an insulin pump and a sensor. The complainant has been outfitted with a system called the Continuous Glucose Monitoring System (CGMS). The CGMS automatically checks blood glucose levels every few minutes using a sensor inserted under the skin. It can sound an alarm if levels are too high or too low. The CGMS is designed to interact with an insulin pump. An insulin pump replaces insulin injection therapy. The pump can administer insulin in two ways: (1) it injects a basal rate of insulin (a regular series of small doses); or, (2) it injects a bolus rate (an increased dose of insulin programmed when carbohydrates are to be consumed). It is possible to suspend or adjust the basal rate when needed. In the event the CGMS is not working, the person with type 1 diabetes will switch to needles and insulin. The CGMS is not a foolproof tool: it only helps with the surveillance and management of diabetic symptoms. While this tool may help diminish the risk of a hypoglycaemic event occurring, the use of it cannot guarantee that such an incident will not reoccur. In the event of such an incident, the complainant would need a glucagon injection. I find, the CGMS' use is not very well documented because no significant study has been performed on the subject.

[44] The complainant has extensive knowledge of her condition and how to cope with it, even during her pregnancy (at the time of the hearing). She also possesses a good knowledge of her insulin pump and sensor and explained their functioning very clearly at the hearing. There are ways to prevent water, heat and sand, all current conditions in Afghanistan, from damaging the

insulin pump. The complainant takes 12 readings a day of her blood sugar levels and notes them in a notepad. She is able to skip meals even with her condition because of the way she controls her blood sugar levels. The complainant keeps sugar tablets with her in case of a low blood sugar reaction. She also gave examples of other food intake she may use in the same situation. She lives alone and copes with the dangers of hypoglycaemia by herself. She has never had a severe hypoglycaemic event in her sleep while living in Ottawa. Since 2009, the complainant uses a sensor to sound an alarm that can wake her up if her blood sugar levels are too low. Whenever the complainant travels or works overseas, she keeps her insulin, needles and other materials with her in case she needs it.

V. Facts in Dispute & Positions of the Parties

A. Position of the Complainant

[45] According to the complainant, CIDA and HC discriminated against her on the basis of her diabetic condition. As far as the complainant is concerned, her medical condition is in no way an obstacle to her career. During her stay in Afghanistan, the complainant travelled in an armoured vehicle and had her medical supplies with her at all times. The day following her hypoglycaemic event in Afghanistan, the complainant was well and did not need additional care. She reported for duty as usual. Prior to, and since her hypoglycaemic incident in Afghanistan she never required hospitalisation for her diabetes. Since this incident, the complainant affirms that she has taken preventative steps in order to ensure that such an incident does not reoccur in the future.

[46] The complainant argues that the *Afghanistan Guidelines* place a blanket ban on all type 1 diabetics. This general prohibition does not take into account one diabetic's particular characteristics over another. The complainant argues that she manages her diabetes in a way that permits her to accomplish her tasks without putting her or third parties in danger. She is of the view that she requires only the same level of security available to all other CIDA employees

deployed to Afghanistan and that a medical evacuation for complications related to her diabetes is very unlikely. Furthermore, the complainant asserts that no personnel from CIDA have ever been taken hostage while in Afghanistan.

[47] The complainant contends that CIDA did not inform her of her rights and obligations when seeking accommodation. In this regard, CIDA's communications with her were not prompt and were often given after lengthy intervals. She claims that she was never provided with a copy of *FSD9* or informed about HC's medical assessment process.

[48] According to the complainant, CIDA must attempt to find ways to accommodate the complainant that would minimize any risk she may pose, to a reasonable level and, that CIDA only made a minimal attempt to remedy the situation. The complainant claims she attempted to work with CIDA to eliminate any perceived risks she may have posed by being posted to Afghanistan. The possibility of limiting all the complainants' functions to "inside the wire" which means Protective perimeter at Kandahar airfield was advanced, as was the recommendation that the complainant share a room with an individual cognizant of her condition and the treatment of it. Furthermore, the complainant argues that CIDA could have chosen to instruct its employees on how to administer glucagon injections. She was also willing to sign a waiver of liability in order to be able to be posted to Afghanistan.

[49] The complainant claims that the impact of not being posted to Afghanistan was that she did not gain the field experience necessary for her career plan. Had the complainant received the posting in Afghanistan she feels confident that she would have received experience in managing programs, projects or issues in the area of international development. The complainant has applied for other competitions in CIDA in order to gain the field experience she feels she lost.

B. Position of the Respondents

[50] CIDA and HC filed a joint response to these complaints.

[51] According to the respondents, accommodating the complainant in Afghanistan would cause undue hardship to the employer. Canada is at war in Afghanistan. Danger is everywhere and it is not possible for the complainant to be in control of her environment at all times. The medical facilities available in Afghanistan are ill equipped and overburdened. Medical evacuations are expensive and dangerous, as the helicopters used for these evacuations are often the target of enemy forces. Accommodating the complainant in Afghanistan poses an unacceptable level of risk to the complainant, to CIDA's operations and to the operations of the Canadian Armed Forces. Since the complainant has already suffered a hypoglycaemic incident in Afghanistan, the respondents consider their position to be reasonable.

[52] CIDA contends that it attempted to accommodate the complainant by eliminating the travel requirement of her position. Moreover, a detailed list of appropriate countries for deployment based on the complainant's medical conditions was created and given to the complainant to help her with her career plans.

[53] The respondents contend that medical screenings are necessary before deploying employees to foreign countries. In this case, the rationale for not sending individuals with chronic diseases to Afghanistan is risk minimization in an already unstable and risky environment. CIDA maintains that it does not have the expertise needed to pronounce themselves on health matters, which is why they rely on HC's recommendations. CIDA is not the only department that requires medical screening and recommendations from HC in order to deploy its employees. The Department of Foreign Affairs and International Trade (DFAIT) also relies on HC for recommendations before deployment. CIDA officials inquired to DFAIT if they had ever deployed an employee against a HC recommendation. DFAIT's response was that it was uncommon, and likely only occurred on two separate occasions.

C. Position of the Commission

[54] The Commission is of the view that HC's *Afghanistan Guidelines* can be interpreted as imposing a blanket ban on sending any person with type 1 diabetes to Afghanistan. The

Commission also submits that CIDA may have interpreted the guidelines as imposing a blanket ban as it cited HC's recommendation and guidelines in deciding that it would not allow the complainant to work in Afghanistan.

[55] The Commission argues that CIDA has not shown that it turned its minds to the possibility of finding ways, short of undue hardship, to bring any risks of accommodating the complainant in Afghanistan within tolerable levels. According to the Commission, since accommodative options in Afghanistan were not explored, the *Afghanistan Guidelines* cannot be justified.

[56] The Commission submits that CIDA breached its procedural obligation to accommodate the complainant by failing to take active steps to obtain all the relevant medical information necessary to make a fair, individualized and comprehensive decision. In this regard, the respondents did not treat the complainant in a fair and transparent manner, or respect her needs for information and support.

VI. Law & Analysis

A. The Complaint against HC

i. A complaint can be filed under section 7 of the *CHRA* in the circumstances of this case

[57] The complaint against HC was originally filed pursuant to section 5 of the *CHRA*. By consent of the parties, the complaint was amended to include sections 7 and 10 of the *CHRA* as well. Given the unique relationship between the complainant and HC in this case, a question arises as to which of sections 5(b), 7(b) and/or 10(a) of the *CHRA* provide jurisdiction for the Tribunal to consider a claim against HC in this case. Each of these sections will be examined in turn.

[58] Section 5(b)

Section 5(b) of the *CHRA* provides:

> **5.** It is a discriminatory practice in the provision of goods, services, facilities or accommodation customarily available to the general public
>
> ...
>
> (b) to differentiate adversely in relation to any individual.
>
> on a prohibited ground of discrimination.

[59] In this section, the term "services" has been interpreted as something of benefit, being "held out" as a service (see *Canada (Attorney General) v. Watkin*, 2008 FCA 170 at para. 31). The term "customarily available to the general public" contemplates that the service being offered creates a public relationship between the service provider and the service user (*Dreaver v. Pankiw*, 2009 CHRT 8 at para. 30; and, *Gould v. Yukon Order of Pioneers*, [1996] 1 S.C.R. 571 at para. 69).

[60] In this case, HC is not providing a service for the benefit of the complainant but, rather, is providing a service for the benefit of CIDA. CIDA does not have medical expertise and relies on HC's assessment to make its own decision. It is CIDA who requests the assessment from HC, not the employee. HC is not offering a service that is generally available to other members of the Canadian public.

[61] In *Panacci v. Canada (Attorney General)*, 2010 FC 114 [*Panacci*], the complainant was a Canada Border Services Agency mail inspector who suffered a number of ailments. The Treasury Board instituted its accommodations policy and HC was responsible for carrying out health capacity and limitations evaluations. The complainant made her complaints following an evaluation in which the doctors attributed her complaints to job satisfaction and recommended transfer to another division. On judicial review, one of the questions that the Federal Court had to deal with was which of sections 5, 7 or 10 of the *CHRA* could form the basis for the grant of

jurisdiction for a discrimination claim against HC. With regards to section 5 of the *CHRA*, the Court stated:

> While public servants with disabilities may fall within a sector of the general public, it stretches the normal meaning of "general public" to include persons such as the Applicant, a public servant who is subject to a Health Canada review in relation to her employment needs -- a service not available to most other members of the Canadian public.
>
> (*Panacci* at para. 52)

[62] Based on the above, I do not believe that a complaint can be made out against Health Canada on the basis of section 5 of the *CHRA*.

[63] Section 7(b)

> Sections 7(b) of the *CHRA* provides:
>
> **7.** It is a discriminatory practice, directly or indirectly,
>
> ...
>
> (b) in the course of employment, to differentiate adversely in relation to an employee,
>
> on a prohibited ground of discrimination.

[64] Under section 7(b) of the *CHRA*, the focus of the inquiry is on adverse differential treatment that is work or job-related (see *Robichaud v. Canada (Treasury Board)*, [1987] 2 S.C.R. 84 at para. 12). There is authority to suggest that a broad and liberal interpretation of section 7 of the *CHRA*, consistent with the nature of human rights legislation (see *CNR v. Canada (Human Rights Commission) (Action Travail des Femmes)*, [1987] 1 S.C.R. 1114 at para. 24), leads to a conclusion that this section encompasses employment situations beyond the direct employer-employee relationship. In *Fontaine v. Canadian Pacific Ltd.* (1989), 11 C.H.R.R. 288 (CHRT) [*Fontaine*], the Tribunal interpreted section 7 of the *CHRA* as follows:

> There need not be an actual contract or a direct relationship between the two parties in question. In any event, the word "indirectly" in the Canadian Human

> Rights Act provision must be given some meaning and thus provides a further basis for the conclusion that there need not be a contractual nexus between C.P. and Mr. Fontaine so long as there exists a significant element of control over his employment.
>
> In our view the nature of the inquiry should not be whether C.P. is actually Mr. Fontaine's employer as that would not end the matter. To come within the purview of Section 7, one merely has to show that the impugned conduct was by someone who had a considerable degree of control or influence over the actual employer and indirectly upon its employee.
>
> (*Fontaine* at paras. 30-31)

[65] The *Fontaine* decision was upheld by the Federal Court on judicial review (*Canadian Pacific Ltd. v. Canada (Human Rights Commission)*, [1991] 1 F.C. 571 [*Canadian Pacific*]); however, in relation to the Tribunal's interpretation of section 7, the Federal Court stated that "...the language used by the Tribunal may not be apt in all respects" (*Canadian Pacific* at para. 11). Rather, the Federal Court preferred to interpret "employ", and its derivatives (employer, employment), to mean "utilize" and arrived at the same conclusion as the Tribunal. Although *Canadian Pacific* seems to narrow the interpretation of section 7 set out in *Fontaine*, the recent decision of the Federal Court in *Panacci* provides a fresh perspective on the interpretation of section 7 of the *CHRA*. As mentioned above, in the *Panacci* decision, the question on judicial review was whether a discrimination complaint could properly be made out under sections 7 and 10 of the *CHRA* against HC on the basis of its health capacity and limitations evaluations, even though Canada Border Services Agency was the employer of the complainant. In this regard, the Court stated:

> While s. 10 raises the very issue of who is the "employee", the section could be read to encompass situations beyond the "direct" employer-employee relationship, e.g. *Canadian Pacific Ltd. v. Canada (Human Rights Commission)*, [1991] 1 F.C. 571 (C.A.), [1990] F.C.J. No. 1028. This is particularly the case where the Court is required to take a "large and liberal" approach in respect of a remedial statute.
>
> Therefore, it is not "plain and obvious" (as that test is described in *Canada Post Corp. v. Canada (Canadian Human Rights Commission) (re Canadian*

> *Postmasters and Assistants Assn.)* [1997] F.C.J. No. 578 (T.D.), aff'd [1999] F.C.J. No. 705 (C.A.)) that ss. 7 and 10 could not apply to the Applicant's complaint. This would be a matter which should have been left to the Tribunal to determine assuming there had been some factual basis upon which to ground the operation of these sections.
>
> (*Panacci* at paras. 54-55)

[66] Ultimately, the Court seems to indicate that the determination of which section applies involves the following analysis:

> The real search is which department committed the discriminatory acts and which should be a "party" in order that remedial action can be ordered and be effective. It must be remembered that because the Act is directed at remedial action, the focus of the inquiry is what happened "in the course of the complainant's employment". (See *Robichaud v. Canada (Treasury Board)*, [1987] 2 S.C.R. 84.). There was no question raised as to the Commission's true jurisdiction to deal with the Applicant's complaint. The question was which of at least three provisions form the basis for the grant of jurisdiction.
>
> (*Panacci* at para. 51)

[67] Using the broad and liberal interpretation of section 7 as described by the Federal Court in *Panacci*, I find that this section finds application in this case. HC established a guideline and medical assessment practice that applied to the complainant “in the course of her employment”. The complainant claims that the guideline and medical assessment process adversely differentiated against her on the basis of her disability, a prohibited ground of discrimination. On this basis, there is a factual foundation upon which to ground the operation of section 7(b) of *CHRA* in a complaint against HC in this case.

[68] Section 10(a)

> Section 10(a) of the *CHRA* provides:
>
> **10.** It is a discriminatory practice for an employer, employee organization or employer organization

> to establish or pursue a policy or practice, or
>
> ...
>
> that deprives or tends to deprive an individual or class of individuals of any employment opportunities on a prohibited ground of discrimination.

[69] Unlike section 7, in section 10 of the *CHRA* Parliament has specified that only employers, employee organizations or employer organizations can be held liable for discriminatory policies or practices. In *Bell Canada v. Communications, Energy and Paperworkers Union of Canada*, [1999] 1 F.C. 113 (F.C.A.) [*Bell Canada*], the Court found that the operating words of section 11(1) of the *CHRA* ("It is a discriminatory practice for an employer...") made "...the employer alone liable for differences in wages with respect to work of equal value" (*Bell Canada* at para. 56). The Court added:

> It would fly in the face of the clear wording of the Act and the obvious intent of Parliament to find the unions equally liable either implicitly under section 11 or indirectly through sections such as section 10 for having participated in the establishment of different wages with respect to work of equal value.
>
> (*Bell Canada* at para. 56)

[70] The interpretation of section 11(1) of the *CHRA* by the Court in *Bell Canada* is equally applicable to the interpretation of section 10 of the *CHRA* in this case. Only employers, employee organizations and employer organizations can be held liable under section 10 of the *CHRA*. Given that HC is not the complainant's employer in this case, there is no basis to found a complaint against HC under section 10(a) of the *CHRA* in the circumstances of this case.

ii. The complainant has established a *prima facie* case of discrimination

[71] The complainant in a proceeding before the Tribunal must establish a *prima facie* case of discrimination. A *prima facie* case is "...one which covers the allegations made and which, if they are believed, is complete and sufficient to justify a verdict in the complainant's favour in the absence of an answer from the respondent" (*Ontario (Human Rights Commission) v. Simpsons*

Sears Ltd., [1985] 2 S.C.R. 536 at para. 28). It is not necessary that discriminatory considerations be the sole reason for the actions in issue for a complainant to succeed. It is sufficient that the discrimination be but one basis for the employer's actions or decisions. (See *Holden v. Canadian National Railway Co.* (1990), 112 N.R. 395 (F.C.A.); and, *Canada (Attorney General) v. Uzoaba*, [1995] 2 F.C. 569). However, allegations made by a complainant have to be credible in order to support a conclusion that a *prima facie* case exists (see *Dhanjal v. Canada (Human Rights Commission)* (1997), 139 FTR 37 (FC)). Once a *prima facie* case is established, the onus then shifts to the respondent to provide a reasonable explanation that demonstrates either that the conduct did not occur as alleged or was non-discriminatory.

[72] On February 11, 2008 when the "incident" occurred, the complainant was sent back home because the internal medical doctor recommended it was safer for her and for others that she not stayed in Afghanistan. Following this incident, the military was displeased by the fact that no medical screening was done before sending any civilians to Afghanistan on assignments of up to a one year period. This displeasure was communicated to CIDA in an email from Major Thurlow questioning why employees were not medically screened before being sent to a war zone if their posting was under a year. CIDA usually retains the services of HC to assess if employees are medically fit before sending them on a posting in Afghanistan or in other countries. HC modified the *Afghanistan Guidelines*, an annex to the *OHAG*, to include "Absolute medical requirements", referred to by the complainant and the Commission as the "blanket ban". According to the *Afghanistan Guidelines*, no one with a chronic medical condition is allowed to be posted to Afghanistan. The complainant lives with a condition, type 1 diabetes mellitus. Disability is included amongst the prohibited grounds of discrimination set out in section 3 of the *CHRA*, and is defined in section 25 as "any previous or existing mental or physical disability". Being a physical disability, diabetes is encompassed by the definition of disability in the *CHRA*. When the complainant requested to go back to Afghanistan and started applying for postings and ultimately underwent the medical assessment process for posting, she was found to not meet the requirement for posting to Afghanistan by all HC doctors and the independent medical endocrinologist retained in the process. Although the independent medical specialist originally

found that she could meet the requirements for posting with conditions, when confronted with HC's inquiry about the "Absolute medical requirements", he declared that the complainant did not meet the requirements. I find, on a *prima facie* basis, the complainant was adversely differentiated by HC's assessment process and guidelines on the ground of her disability according to section 7(b) of the *CHRA*.

iii. HC has not established that the conduct did not occur as alleged or was non-discriminatory

[73] In the present case, the respondents' responsibilities in assessing the complainant are intertwined. CIDA requests that employees be medically "fit for posting" before an assignment for posting is confirmed and materialized. HC's recommendation plays a crucial role in the medical assessment process. Unless CIDA exercises its discretion not to follow HC's recommendation, CIDA's decision to post or not rests on the assessment and reasoning of HC. In this case, I find HC's medical recommendation was a determining factor in CIDA's decision not to post the complainant in Afghanistan.

[74] After HC-MAC reviewed Dr. Baxter's assessment, it rendered its decision that a third medical opinion should be performed and that the opinion of this third independent endocrinologist would be accepted. HC informed the complainant of the HC-MAC's decision. When the opinion came back from the independent endocrinologist, Dr. Beauregard, that the complainant was deemed fit and, after receiving a positive result on her stress and psychological assessments, based on the assurances from HC that the independent medical examiner's opinion would be accepted; the complainant expected that she would be posted to Afghanistan. Rather than accepting the opinion, HC asked Dr. Beauregard twice for clarification insisting that he look at the *Afghanistan Guidelines* in his clarification process. In response to HC, Dr. Beauregard stated that if the requirements were to be interpreted as "absolutely no medical conditions'' that had the potential to constitute a danger of death, then in that case, the complainant was not an ideal candidate for deployment. HC then recommended to CIDA that the complainant not be posted in Afghanistan.

[75] The absolute medical requirements in the *Afghanistan Guidelines* were the determining factor in swaying the endocrinologist's opinion. He interpreted them as instituting a "blanket ban", a description of the guidelines that I do not think came from the doctor himself (term used by the complainant and the commission), however, I do believe he understood the medical requirements as being absolute. The evidence showed that the interpretation of the "absolute medical requirements" by Dr. Beauregard was not contested nor clarified by HC. In this regard, I find that there is a problem with the manner in which the "Absolute medical requirements'' of the *Afghanistan Guidelines,* are worded and therefore are open to more than one interpretation.

[76] In *Meiorin*, the Supreme Court of Canada stated:

> Yet the standard, if it is to be justified under the human rights legislation, must accommodate factors relating to the unique capabilities and inherent worth and dignity of every individual, up to the point of undue hardship.
>
> [...]
>
> Employers designing workplace standards owe an obligation to be aware of both the differences between individuals, and differences that characterize groups of individuals. They must build conceptions of equality into workplace standards. By enacting human rights statutes and providing that they are applicable to the workplace, the legislatures have determined that the standards governing the performance of work should be designed to reflect all members of society, in so far as this is reasonably possible. Courts and tribunals must bear this in mind when confronted with a claim of employment-related discrimination. To the extent that a standard unnecessarily fails to reflect the differences among individuals, it runs afoul of the prohibitions contained in the various human rights statutes and must be replaced. The standard itself is required to provide for individual accommodation, if reasonably possible. A standard that allows for such accommodation may be only slightly different from the existing standard but it is a different standard nonetheless.
>
> (*Meiorin* at paras. 62, 68)

[77] Although the guidelines are meant to be instructive and informative, their wording suggests mandatory medical requirements without consideration of the individualized

circumstances of each person. While HC doctors might understand the informative nature of the guidelines, an independent doctor, as in this case, might interpret the *Afghanistan Guidelines* as mandatory or absolute. In fact, on cross-examination, one of the authors of the *Afghanistan Guidelines* established that it is more than probable that someone reading the guidelines will interpret the medical requirements contained therein as being absolutely necessary. The terminology used in the guideline suggests that no person with a chronic condition will be qualified for a posting in Afghanistan. As was the interpretation of Dr. Beauregard, the *Afghanistan Guidelines* do not indicate a consideration of what exactly the restrictions of the person's condition are and whether these restrictions can still fulfill the medical requirements for posting to Afghanistan. In order to advance human rights, human rights principles need to be considered in the process of developing policies and guidelines. Organizations need to insure that in writing policies or guidelines that they are written in accordance with human rights principles.

[78] The process by which HC assessed and arrived at its recommendation, influenced as it was by the *Afghanistan Guidelines*, also failed to consider the inherent worth and dignity of the complainant. Section 2 of the *CHRA* provides that the purpose of the Act is to give effect to the equality rights of all individuals. The notion of equality means "...a respect for the inherent dignity of all human beings whatever their colour, race, language, sex or religion" (*Warman v. Tremaine*, 2007 CHRT 2 at para. 97). The inherent worth and dignity of every individual is also recognized in the Preamble to the *Universal Declaration of Human Rights*, G.A. Res. 217 A (III), U.N. Doc. A/810 (1948) 71:

> Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

[79] Also, Article 1 of the *Universal Declaration of Human Rights* provides:

> All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

[80] Furthermore, the Preamble to the *International Covenant on Civil and Political Rights*, 19 December 1966, 999 U.N.T.S. 171, arts. 9-14, Can. T.S. 1976 No. 47, 6 I.L.M. 368 (entered into force 23 March 1976, accession by Canada 19 May 1976), states:

> The States Parties to the present Covenant,
>
> Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,
>
> Recognizing that these rights derive from the inherent dignity of the human person,

[81] Also the *Covenant on the Rights of Persons with Disabilities* adopted on 13 December 2006 during the sixty-first session of the General Assembly by resolution A/RES/61/106 signed by Canada on March 30th, 2007 and ratified by Canada on March 11, 2010, in its Preamble section h mentions:

> *"Recognizing also that discrimination against any person on the basis of disability is a violation of the inherent dignity and worth of the human person,"*

[82] Human dignity is harmed when "...individuals and groups are marginalized, ignored, or devalued..." (*Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497 at para. 53). HC's witness admitted at the hearing that it was an error to tell the complainant that they would respect the independent endocrinologist's opinion "whatever it may be". HC's witness testified that they found Dr. Beauregard biased because he did not consider all the information first handed to him and that he was influenced by the personal motivation of the patient to go to Afghanistan. Under oath, Dr. Beauregard testified that the complainant appeared to be a very competent employee and that he would certainly hire her if he was in the employers' position. He also presumed that if a kidnapping were to occur, the kidnappers would want to keep their hostage alive. Although I redirected Dr. Beauregard to testify on his area of expertise,

these comments demonstrate that HC's concerns that Dr. Beauregard was biased were justified. I find what happened is that when the HC-MAC recommended a third opinion and made the statement that they would accept that opinion, this placed them in a difficult position when they considered the third opinion to be bias. Having said they would accept the third opinion, whatever it may be, the HC-MAC created expectations for the complainant. Although they chose to seek clarification when the opinion deemed her fit, they did not seek further clarification when the opinion was changed. As it was not part of their practice, HC did not call or attempt to meet with Dr. Beauregard to determine the basis of his opinion that the complainant was fit for posting or to explain the instructional nature of the *Afghanistan Guidelines*.

[83] Furthermore, section 1 of the *OHAG* indicates:

> The intention of the OHAG is to guide the examiner to reach decisions and **not to provide a set of rigid standards**. No manual or set of standards can replace judgment based on the examiner's knowledge of the individual, the job, and the circumstances under which the job will be carried out.
>
> The standards contained in this guide are deliberately worded in such a way to require the exercise of sound medical expertise, considering the requirements of the job and current occupational health practice.
>
> When an individual is unable to meet the occupational health medical requirements of a given position as outlined in this guide, **the employing department, to the point of undue hardship, undertake further medical testing and/or other accommodation. As part of its duty to make every effort up to the point of undue hardship to make every effort up to the point of undue hardship to accommodate the individual. Consideration will be done in consultation with the regional HC OHMO.**
>
> (**Emphasis added**)

[84] The evidence indicates that although HC takes an active role in the updating of the medical assessment guidelines of the *OHAG* and, that they remain available for any consultation with the employer concerning the *OHAG*, accommodation measures or further medical testing,

HC never clarified with CIDA that Dr. Beauregard's opinion was swayed when he interpreted the medical requirements found in the "*Afghanistan Guidelines* to be "absolute". HC never explained to Dr. Beauregard that the intention of the *OHAG* is not to provide a set of rigid standards. HC simply accepted Dr. Beauregard's conclusion in the light of the "Absolute medical requirements" and gave the information to CIDA. Even if Dr. Lloyd-Jones from HC gave Clement Bedard (Program Assistant Assignments management Center CIDA) both of Dr. Beauregard's opinions in its letter dated November 19, 2009, that the complainant could be posted if certain conditions are met and, the other opinion, that she might not be the ideal candidate in light of the absolute medical requirements; this does not suffice to show that HC acted in a non-discriminatory way. Context and information were missing in the transmission and communication of the medical assessments. On December 9, 2009, France Genest (Director, Human Resources, Operations, CIDA) writes a letter to Dr. Lloyd-Jones, to ask if her conclusions are correct that Dr. Baxter and Dr. Beauregard are of the same opinion, HC does nothing to clarify the nuance between the two. Dr. Baxter's assessment of the complainant did not include a consideration of the *Afghanistan Guidelines*. At the time of Dr. Baxter's assessment, the guidelines were in draft form and had not been implemented yet. Dr. Baxter's assessment led her to the conclusion that the complainant was not an ideal candidate for posting in Afghanistan. The respondents contend that Dr. Beauregard arrived at this same conclusion. However, only one assessment considered the "Absolute medical requirements'' in the Afghanistan guidelines. Dr. Beauregard originally found the complainant fit for posting in Afghanistan with conditions. It was only in light of the absolute medical requirements of the *Afghanistan Guidelines* that Dr. Beauregard changed his recommendation and said that the complainant might not be the ideal candidate. Without the application of the *Afghanistan Guidelines*, Dr. Baxter's assessment is that the complainant should not be posted and Dr. Beauregard's assessment is that the complainant can be posted to Afghanistan with conditions. Knowing the fact that the final decision rests with CIDA, HC had to ensure the information was as accurate and complete as possible.

[85] I find, the problem lies, in part, with the manner HC chose to deal with the doctor's perceived bias. Even though HC found Dr. Beauregard to be biased, they followed through on his recommendation that additional tests be performed. On one hand, they followed Dr. Beauregard's recommendation to test the complainant and, on the other hand, they questioned his judgement because they did not find him independent. When the test results ultimately were positive, HC was faced with a challenge because then again, it raised the complainant's expectations for posting.

[86] Throughout the whole process the complainant's dignity was not preserved: false expectations were raised and the process was not timely on HC's end. Overall, it took over a year and a half from the point when the complainant asked CIDA to exercise its discretion and allow her to work in Afghanistan, through HC's medical assessment process, to CIDA's final determination that she could not be posted to Afghanistan. Although HC's doctors are busy, this does not explain the significant delay bearing in mind that these medical assessments are only valid for six months. The evidence also shows that a posting process usually starts in September of a certain year and that after the application period is closed, the next opportunity to apply for postings is in September of the following year. With the process being designed this way, it is unreasonable to require an individual to wait for months at a time to obtain medical information thus losing the opportunity to participate in a posting process.

[87] Given the above, it is clear that the wording and application of the *Afghanistan Guidelines* is producing results that do not fit with its intent. It is important that human rights be reflected, not only in the contents of a policy or guideline, but in its communication and end result as well. The intention of a guideline or policy may be legitimate, but the manner in which it is expressed or applied may be deficient. With that in mind, monitoring the effects of that policy or guideline is important. Communicating a message and a direction through a policy or a guideline will have a better impact if it is not only well communicated, but also well monitored.

Monitoring guidelines and policies and their effects is necessary, especially in the human rights context:

> ***"Monitoring"*** *is the active collection, verification and immediate use of information to improve human rights protection.*
>
> (Office of the High Commissioner for Human Rights, *Training Manual on Human Rights Monitoring*, UN Doc. E.01.X1V.2 (2001) at pp. 3, 9)

[88] It is important that once a guideline or policy is adopted that appropriate risk management processes are put in place to prevent other human rights violations and injustices. With the use of surveys and reports, a good risk management system will frequently assess the effect of a guideline or policy to ensure that the intent of the guideline or the policy is being fulfilled without violating any rights and/or obligations. This monitoring and system to correct irregularities can help to correct any negative effects and can help improve the policy or guideline to better reflect its intent. In order to implement an effective guideline or policy, an organization should consult with experts in various fields, including human rights specialists. It is imperative in every process affecting an individual's rights, such as work related matters, to inform them of their rights and recourses. It is also important to maintain a transparent dialogue with the individual in a timely, complete and up to date manner. The goal is to respect human dignity in these work related matters, such as in this case, when a medical assessment needs to be performed for a job posting. Considering all these factors contributes to elevating justice standards in our society, in conformity with the human rights enshrined in our Constitution and, in accordance with the quasi-constitutional character of the *CHRA*.

[89] The standard of proof in discrimination cases is on a balance of probabilities. Therefore, discrimination may be inferred where the evidence offered in support of the discrimination renders such an inference more probable than the other possible inferences or hypotheses (see *Premakumar v. Air Canada* (2002), 42 C.H.R.R. D/63 (C.H.R.T.) at para. 81). In this case, I find the *Afghanistan Guidelines* do not reflect equality between all members of society. The application of these guidelines to the complainant resulted in her being discriminated against in

the course of her medical assessment. HC has not provided evidence that its conduct was non-discriminatory. Therefore, it has been established that in the course of employment, the complainant suffered adverse differentiation on the basis of her disability by the wording and application of the *Afghanistan Guidelines*. On the basis of the reasoning above, HC has violated section 7(b) of the *CHRA*.

B. The Complaint against CIDA

i. The complainant has established a *prima facie* case of discrimination

[90] The complainant worked and contributed to CIDA's development program in Afghanistan. She went on two different temporary missions to Afghanistan and all the members of her team were eventually posted to Afghanistan except her. The factual evidence established that she was always considered a competent employee and, if not for her disability and the application of the *Afghanistan Guidelines*, she would have been posted in Afghanistan like the rest of her team. CIDA cited HC's medical information and assessment and the fact that the absolute medical requirements of the *Afghanistan Guidelines* were not met, in its final decision not to post the complainant in Afghanistan. Therefore, CIDA pursued a medical assessment practice, pursuant to HC's policies and guidelines, which deprived the complainant of an employment opportunity on a prohibited ground of discrimination: her disability. Therefore, a *prima facie* case of discrimination has been established under section 10(a) of the *CHRA*.

[91] Under section 7(b) of the *CHRA*, "adverse differentiation" means a "distinction between persons or groups of persons that is harmful or hurtful to a person or a group of persons" (*Tahmourpour v. Canada (Royal Canadian Mounted Police)*, 2009 FC 1009 at para. 44; varied on other grounds in *Tahmourpour v. Canada (Royal Canadian Mounted Police)*, 2010 FCA 192). As stated in the previous paragraph, the complainant has established that a distinction was made between her and her co-workers on the basis of her disability by the application of the *Afghanistan Guidelines*. This distinction was harmful to the complainant's career because she

lost the opportunity to work and gain field experience in Afghanistan. Therefore, I find that a *prima facie* case has been established against CIDA under section 7(b) of the *CHRA*.

[92] Since a *prima facie* case has been established under sections 7(b) and 10 of the *CHRA*, the onus shifts to the respondent CIDA to prove that these *prima facie* discriminatory practices were based on a *bona fide* occupational requirement.

ii. CIDA's discriminatory practice was not based on a *bona fide* occupational requirement

[93] Sections 15(1)(a) and 15(2) of the *CHRA* provide:

> **15.** (1) It is not a discriminatory practice if
>
> any refusal, exclusion, expulsion, suspension, limitation, specification or preference in relation to any employment is established by an employer to be based on a *bona fide* occupational requirement;
>
> […]
>
> (2) For any practice mentioned in paragraph (1)(a) to be considered to be based on a bona fide occupational requirement and for any practice mentioned in paragraph (1)(g) to be considered to have a *bona fide* justification, it must be established that accommodation of the needs of an individual or a class of individuals affected would impose undue hardship on the person who would have to accommodate those needs, considering health, safety and cost.

[94] Under section 15(2) of the *CHRA*, Parliament has chosen to specifically identify the matters that may be taken into account by the Tribunal in an accommodation analysis: health, safety and cost. However, in *Air Canada Pilots Association v. Kelly*, 2011 FC 120 [*Kelly*], the Federal Court stated the following:

> That is not to say that matters such as employee morale and mobility, interference with other employees' rights, and disruption of a collective agreement could never be relevant in a claim under the CHRA. Rather, [...] in order to be taken into account in an accommodation analysis, these matters must be of a sufficient

> gravity as to have a demonstrable impact on the operations of an employers in a way that related to health, safety or cost.
>
> (*Kelly* at para. 402)

[95] In addition, although section 15(2) is subject to section 15(9) of the *CHRA*, which provides for the universality of service for members of the Canadian Forces, the complainant is not a member of the Canadian Forces and, therefore, section 15(9) is not applicable in the present case (See *Irvine v. Canada (Canadian Armed Forces),* 2004 CHRT 9 at paras. 30-32; upheld on judicial review in *Irvine v. Canada (Canadian Armed Forces),* 2005 FC 122; and, *Irvine v. Canada (Canadian Armed Forces)*, 2005 FCA 432).

[96] The analysis used to determine whether an employer's standard is a *bona fide* occupational requirement (BFOR) is that outlined by the Supreme Court of Canada in *British Columbia (Public Service Employee Relations Commission) v. British Columbia Government and Service Employees' Union*, [1999] 3 S.C.R. 3 [*Meiorin*], as follows:

> (1) that the employer adopted the standard for a purpose rationally connected to the performance of the job;
>
> (2) that the employer adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of that legitimate work-related purpose; and
>
> (3) that the standard is reasonably necessary to the accomplishment of that legitimate work-related purpose. To show that the standard is reasonably necessary, it must be demonstrated that it is impossible to accommodate individual employees sharing the characteristics of the claimant without imposing undue hardship upon the employer.
>
> (*Meorin* at para. 54)

Steps One & Two

[97] The first step of the *Meiorin* analysis examines the legitimacy of the standard's general purpose. The second step assesses the employer's intent in adopting the standard. These steps

ensure that "...when viewed both objectively and subjectively, the standard does not have a discriminatory foundation" (*Kelly* at para. 356; see also *McGill University Health Centre (Montreal General Hospital) v. Syndicat des employés de l'Hôpital general de Montréal*, 2007 SCC4 at para. 14 [*McGill University Health Centre*]). The parties agreed that the first and second steps of the *Meiorin* analysis have been met in the present case. Therefore, I will briefly address these elements as they apply in the present case.

[98] The *Afghanistan Guidelines* outline that employees must meet certain medical requirements to be posted in Afghanistan. They identify adverse climatic conditions that may affect the health of employees, including extreme heat, severe atmospheric pollution and exposure to infectious diseases. In this regard, the *Afghanistan Guidelines* state that access to medical treatment is very limited or may not even be available. The guidelines also identify that there is a significant risk of injury or death from travelling in Afghanistan and that employees live under the threat of physical attacks, even in secured zones. Therefore, the *Afghanistan Guidelines* are generally designed to determine whether an employee can withstand the stresses imposed by the war conditions in Afghanistan, and to minimize the requirement for medical care, which is in place primarily for the military to treat illnesses and injuries of troops, injured Afghani civilians and unpredictable emergencies that impact all civilians posted in Afghanistan.

[99] The evidence indicates that the health and safety concerns identified in the *Afghanistan Guidelines* are legitimate and that medical care is indeed limited in Afghanistan. A detailed outline of the evidence in this regard is provided below. Therefore, a medical fitness standard is rationally connected to the working conditions that CIDA employees must endure in Afghanistan.

[100] There is no indication in the evidence that the "...imposition of the guideline was not thought to be reasonably necessary or was motivated by discriminatory animus" (*Meiorin* at para. 60). Therefore, I find that the Afghanistan Guidelines were adopted in an honest and good

faith belief that it was necessary to the fulfilment of a legitimate work-related purpose and that the first two steps of the *Meiorin* analysis are satisfied.

Step Three

[101] The third step of the *Meiorin* analysis examines "...whether the standard is required to accomplish a legitimate purpose, and whether the employer can accommodate the complainant without suffering undue hardship" (*Kelly* at para. 356; see also *McGill University Health Centre* at para. 14). The use of the term "undue" infers that some hardship is acceptable. It is only "undue hardship" that satisfies this test (see *Central Okanagan School District No. 23 v. Renaud*, [1992] 2 S.C.R. 970, at page 984.). Generally, undue hardship means "disproportionate, improper, inordinate, excessive or oppressive" and is "...reached when reasonable measures of accommodation are exhausted and only unreasonable or impracticable options for accommodation remain" (*Council of Canadians with Disabilities v. Via Rail Canada Inc.*, 2007 SCC 15 at paras. 130, 140). The complainant must facilitate the search for meaningful accommodation by responding to reasonable employer requests for relevant medical information regarding his or her limitations, in order to allow the employer to initiate a proposal (*Tweten v. RTL Robinson Enterprises Ltd.*, 2005 CHRT 8; and, *Graham v. Canada Post Corporation*, 2007 CHRT 40) However, an employee cannot dictate to an employer the precise terms of an accommodation and cannot expect a perfect solution (see *McGill University Health Centre*; and, *Hutchinson v. Canada (Minister of the Environment)*, 2003 FCA 133).

[102] It may be ideal for an employer to adopt a practice or standard that is uncompromisingly stringent, but if it is to be justified it must accommodate factors relating to the unique capabilities and inherent worth and dignity of every individual, up to the point of undue hardship (*Meiorin* at para. 62.). Furthermore, when an employer is assessing whether it can accommodate an employee it must do an individualized assessment of the employee's situation. In this regard, in *McGill University Health Centre*, the Supreme Court of Canada stated: "The importance of the individualized nature of the accommodation process cannot be minimized".

[103] The analysis at this stage looks at "...first, the procedure [...] which was adopted to assess the issue of accommodation and, second, the substantive content of either a more accommodating standard which was offered or alternatively the employer's reasons for not offering any such standard" (*Meiorin* at para. 66). Therefore, I will examine, first, the procedure adopted by CIDA to assess the complainant's condition and possible accommodation and, second, whether accommodating the complainant in Afghanistan would cause CIDA undue hardship.

Procedure adopted to assess the complainant's condition and possible accommodation

[104] As mentioned above, CIDA does not possess medical expertise, and relied on HC's medical assessment and the *Afghanistan Guidelines* in determining that the complainant could not be posted to Afghanistan. In April 2008, based on HC's recommendation, CIDA informed the complainant that she was not selected for posting in Afghanistan. After finding out that CIDA ultimately had the discretion to determine whether she could be posted in Afghanistan, regardless of HC's recommendation, the complainant asked CIDA to exercise its discretion and allow her to work in Afghanistan: to accommodate her disability. From this point forward, CIDA had a duty to obtain all relevant information about the employee's disability and seriously consider how the complainant could be accommodated (see *ADGA Group Consultants Inc. v. Lane et al.*, 91 O.R. (3d) 649 at para. 107 [*Lane*]). CIDA did not respond to the complainant's initial request to exercise its discretion to allow her to go to Afghanistan. CIDA did not inform the complainant of, nor were the CIDA officials who testified familiar with, the procedures outlined in *FSD9*, HC's medical assessment process or the *OHAG*. The evidence before the Tribunal contains an email sent from Marion Parry, who works in the Chief mobility exercises and career programs, human resources branch at CIDA, to two other CIDA managers, Joanne Nolan and Michael Collins. She wrote:

> With regards to next steps...we need to undertake medical screening for any officer you anticipate sending to Afghanistan any duration of TD. This note refers to situation with DND in Kandahar...but we should just do it in a blanket way for

> Kabul too. I need to draft a response to Major Thurlow can you call me to discuss what process rigour we are now going to put in place.

[105] According to the evidence and this email, I find, CIDA was actively implicated in the changes that ultimately were seen in the *Afghanistan Guidelines* used to assess the complainant. I also find that the evidence demonstrated that even if CIDA contends that it only follows HC's recommendations and does not get involved in the medical assessment process and not having the expertise to do more than to follow their directions, they have much more influence in the whole assessment process than what they put forward.

[106] In order to establish that a standard is "reasonably necessary", an employer bears the burden of establishing that it considered every possible accommodative measure and determined that it cannot accommodate the employee without experiencing undue hardship (see *Meiorin* at para. 62; and *British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights)*, [1999] 3 S.C.R. 868 at para. 32 [*Grismer*]). CIDA did not lead evidence that it explored all reasonable accommodation measures at the time of the complainant's request. Although CIDA discussed removing the travel requirements of her job, this did not address the complainant's need for operational field experience to advance her career. When the complainant asked for a list of countries to which she could be posted, it took CIDA over two months to determine that HC would take charge of this determination. It took another two months for HC to determine that insufficient information had been received with respect to six of the 19 countries, and that an addendum would follow once the information was received. HC never provided the addendum and CIDA did not make efforts to insure that an answer to this inquiry was provided. CIDA was of the mindset that offering the abovementioned to the complainant was accommodation as they state it was not part of their standard practice. However, the duty to accommodate is not met by simply going beyond standard practice. It is met by exploring all reasonable accommodation measures up to the point of undue hardship as outlined in *Meorin* and *Grismer* above.

[107] CIDA's evaluation of accommodative measures was based, almost exclusively, on information provided by HC as CIDA does not possess the expertise to medically asses their employees. Although CIDA has the discretionary power not to follow a medical recommendation given by HC, the evidence has shown that CIDA rarely challenges a HC recommendation. In this regard, HC's medical recommendation is a determining factor in CIDA's decision for not posting the complainant to Afghanistan. In addition, HC's medical assessment process is directly linked to CIDA's accommodation analysis. However, HC did not provide CIDA with all the information it used in the assessment process, including information about the complainant's "...current medical condition, prognosis for recovery, ability to perform job duties and capabilities for alternate work" (*Lane* at para.107). As mentioned above, based on the wording and application of the *Afghanistan Guidelines*, the individualized nature of the complainant's condition, including her "...unique capabilities and inherent worth and dignity" were not taken into consideration (*Meiorin* at para. 62). CIDA did not seek another independent medical opinion and did not respond to the complainant's request to exercise its discretion not to follow HC's recommendation. On the other hand, if CIDA is not trained to evaluate the medical condition of an individual how will they establish when not to follow HC's recommendation? Will they need to create another Committee of experts to validate HC's recommendations? If they decide not to follow the recommendations, what are the consequences if another incident occurs bearing in mind the employer's duty of care towards its employees?

[108] Moreover, I find, CIDA tried to facilitate accommodation for the complainant by answering some of her questions on available postings and their requirements. When applying for a posting, evidence suggested that the employees rank countries by preference and, they often write a second and a third choice. CIDA did not attempt up to the point of undue hardship to ensure that the complainant would obtain her second or third choice for a posting overseas. While the employee cannot expect a perfect solution in the accommodation process (*See McGill Health Centre (Montreal general hospital) v. Syndicat des employés de l'Hôpital général de Montréal, 2007 SCC 4, 2007 1 S.C.R. 161, at para. 22);* CIDA had a practice of working with an

employee's career plan. Michael Collins, Manager in the Afghanistan Task Force at CIDA wrote in an undated email to the complainant and her team:

> This email is to acknowledge formally that we have either received, or are aware of, your application/interests in upcoming postings to Afghanistan. The intent is very much to consider this interest on a priority basis. At this juncture, the plan is to set up meetings (or follow up in writing for those overseas) with each of you individually (e.g. with Steve Hallihan) over the next few days by which explore your interest in terms of location, timing, etc. And to review this in the context of your overall career interests and direction within the ATF. Will follow up on this shortly.

[109] Although the evidence showed some meetings occurred and some efforts were made to help the complainant's career plan she suffered a different treatment from her peers because of her disability. She could not be posted to Afghanistan and was the only one in her group that was prevented from a posting over there. The reason was not that she was not qualified for the job but rather that she was not fit to go because of her disability and more importantly because of the way the standard in the medical assessment was interpreted. CIDA made attempts to accommodate the complainant but did not offer her any alternative other than applying for other postings and a position in the Afghanistan task force in Ottawa without travel requirements.

[110] The Complainant had a duty to cooperate in the accommodation process. At the hearing, CIDA argued that the complainant sent mixed messages and did not sufficiently cooperate in the accommodation process. In this regard, CIDA mentioned the fact that the complainant received a reprimand for some of the actions she took in addressing her situation with CIDA. I find the complainant did cooperate in the accommodation process even if some actions were found inappropriate.

[111] For the above mentioned reasons, CIDA has not met its procedural duty to accommodate the complainant. On this basis, CIDA has not provided a *bona fide* justification for its discriminatory practices under sections 7 and 10 of the *CHRA*. Therefore, on the basis of the complainant's disability, I find CIDA to have differentiated adversely in relation to the

complainant in the course of employment and to have pursued a practice that deprived the complainant of an employment opportunity.

iii. Accommodating the complainant in Afghanistan would constitute undue hardship

[112] The evidence clearly established the unique context in which the events leading to the complaints before the Tribunal took place. Does this unique context invalidate the duty to accommodate up to the point of undue hardship? The Commission argued that not conducting such an analysis would constitute an error of law. I concur. The duty to accommodate up to the point of undue hardship analysis needs to be done even in a war zone. It might not always be possible to accommodate in a war zone because of the unique conditions of war that could result in undue hardship; however, I reiterate that a case by case, individualized approach, is important because a generalized standard could create injustices if individual characteristics are not considered in the process.

[113] Although CIDA did not establish that it considered every possible accommodative measure up to the point of undue hardship, I will examine whether it would cause undue hardship to CIDA to accommodate the complainant in Afghanistan. I find it necessary to perform this analysis as the parties made substantial submissions on this point and this determination relates to some of the remedies sought by the complainant.

[114] Above, I found that the wording and effect of the *Afghanistan Guidelines* resulted in the complainant being discriminated against when she was being medically assessed for a job posting in Afghanistan. I also made a finding that HC relied upon the *Afghanistan Guidelines* to make their recommendation to CIDA concerning the complainant's medical fitness to be posted in Afghanistan and that CIDA relied upon HC's recommendation and the *Afghanistan Guidelines* to make their final decision not to post the complainant in Afghanistan. On January 11, 2010, Bob Johnston from CIDA wrote a letter to the complainant, which is contained in the agreed

statement of facts, informing her that, given HC's recommendation, no further consideration would be given for her posting. The letter states:

> *Hc confirmed that the independent medical specialist concluded that you "did not meet the absolute medical requirements of the OHAG". HC further stated that* ***the conclusion reached by the independent medical specialist was "consistent with those reached by the original assessing medical officer".***
>
> ***CIDA's position and conduct in this matter has been and remains consistent with the existing applicable policy, technical and procedural framework.*** *Furthermore, in response to CIDA's question regarding the necessity of conducting further medical assessments for 2010, HC confirmed that no new assessment was required.*

[115] Bob Johnston finishes his letter to the complainant emphasizing that CIDA's conduct was within the *current policy and procedural framework*. I find this confirmed the impact of the Afghanistan guidelines on the complainant's medical assessment and on CIDA's decision not to post her to Afghanistan. The letter also explained that Dr. Beauregard arrived to the same conclusion as the other doctors that assessed the complainant but only in the light of the "Absolute medical requirements".

[116] Thus being said, I have decided to base my analysis of whether there is undue hardship in accommodating the complainant in Afghanistan on the third medical opinion (Dr. Beauregard's assessment), leaving aside his conclusion regarding the "Absolute medical requirements". The HC-MAC was supposed to rely on the third medical opinion, but for reasons already outlined, the HC-MAC had difficulty doing so. Without the application of the *Afghanistan Guidelines*, Dr. Beauregard's conditions and recommendations are the accommodative measures that CIDA should have considered in deciding whether the complainant could be posted in Afghanistan. In order for the complainant to be posted in Afghanistan, Dr. Beauregard recommended the following conditions to arrive at an acceptable level of risk for the complainant in Afghanistan :

> Access to her medication, testing equipment and back-up supplies at all times so that she can monitor her own condition frequently throughout the day.

> Live and sleep in a room with another person aware of her condition" in order to "gain additional security.
>
> Manage to have extra food and insulin to carry with her during travelling.

[117] There is sufficient evidence before me to find that CIDA considered the possibility of implementing these conditions and arrived at the conclusion that it was not possible. The evidence indicates significant health and safety risks for the complainant in working in Afghanistan, as well as safety risks for those fighting the war in Afghanistan should they have to assist the complainant. For the following reasons, I find that it would pose an undue hardship on CIDA to have to accommodate the complainant in Afghanistan.

Health Risks

[118] Development Officers from CIDA posted to Afghanistan contribute to the economic and political development of Afghanistan by a variety of means. At the relevant times, Development Officers could be posted at the Canadian embassy in Kabul, at the KAF or with the PRT in Kandahar. Mr. Johnston described the duties of Development Officers working at these three locations. At the Canadian Embassy in Kabul, responsibilities included liaising closely with Afghan government departments, contributing resources for programs run by international organizations or non-governmental organizations, and travelling frequently in Kabul. With the PRT, where the majority of CIDA's officers were posted, Development Officers were responsible for managing a portfolio of projects and initiatives. Canada's aid totalled around 10 million dollars a year, spread over 20 projects, with each officer responsible for up to 4 or 5 projects. As is the case in Kabul, Development Officers were required to travel to meet partners and to visit and monitor project sites. CIDA did not post many officers at the KAF. Their duties there were principally related to coordination with the military. Bob Johnston testified at the hearing:

> Their role was to ensure that he [the commander] was taking into account the development dimension". Day to day activities at the KAF included meetings

> within the KAF, "but when the general or ROCK was invited to Shura, or site visit they would be expected to accompany, on occasion they would be sent out on their own, to accompany one group or another that was dealing with an issue that involved civilian or military assets.

[119] Dr. Callary and Dr. Baxter travelled to Afghanistan to visit the different locations where CIDA employees work except one, the PRT. Because of a sandstorm, they were not able to fly over at the PRT. In the event that the complainant suffered an injury and needed evacuation, she would be in greater risk than other employees because of her health condition and the risk would increase in cases such as a sandstorm that could limit the evacuation. The doctors considered that fact in their analysis. Dr. Callary and Dr. Baxter testified and submitted a written report on the possibilities of accommodating the complainant in Afghanistan. They reported that local stressors in Kabul, at the KAF, and at the PRT and wrote in the report that stressors included “general fatigue from working long hours, noise levels and sleep difficulties, small cramped quarters, and lack of freedom to travel and dangers of suicide bombers during travel”. In their view, and CIDA’s view as well, it was a challenge to have the complainant work inside the wire without any traveling requirement because that meant other employees had to travel more to compensate, which increased their exposure to the dangers in the area. When all factors were analysed together, the doctors concluded that it was not possible to accommodate the complainant in Afghanistan as the complainant would expose herself to increased stress, infections, and risks of injury that require more medical attention for a person with type 1 diabetes.

[120] The Tribunal also heard testimony from Dr. John Dupré, an endocrinologist expert on behalf of the Respondents. Dr. Dupré was of the opinion that the risk of hypoglycaemic event cannot be completely eliminated for the complainant. He testified that severe hypoglycaemic events, such as the incident involving the complainant in 2008, can reoccur and increase with age and with the frequency of hypoglycaemic events. After considering all available medical evidence regarding the complainant and the situation in Afghanistan, Dr. Dupré considered the complainant at risk for herself and for others and did not for see any possibility for

accommodation. He wrote in his report concerning the risk of severe hypoglycaemic event, that it was inevitable for the complainant.

[121] In his report Dr. Beauregard wrote: "I assumed that she could be posted to Afghanistan, provided that she had access to food, insulin and the necessary equipment for insulin administration and blood glucose monitoring. I did recognize, however, that if she were taken hostage, she would be at greater risk of dying if deprived of food and/or insulin. Although living and working in difficult conditions imposes an additional challenge to a person having to cope with type 1 diabetes, my assessment, based on the qualifications and the motivation of Ms. Cruden in the management of diabetes, was that she was qualified to be posted to Afghanistan, **but only provided that her necessary equipment were made available**''. **(Emphasis added).** Dr. Beauregard testified that the risk for the complainant of having a severe hypoglycaemic event was "real". Dr. Arnaout reported that the risk of a hypoglycaemic event is unavoidable. I find that the risks for the complainant of having another severe hypoglycaemic event are present and cannot be eliminated.

[122] The Tribunal also heard evidence from Colonel Ricard and Major Thurlow. They possessed a good knowledge and expertise of Afghanistan, the war zone context in that country and gave a detailed description of the functioning, locations and goals of the medical facilities in Afghanistan. The two witnesses that testified on these issues testified without contradictions and I found their testimony to be credible. Overall, the evidence of Colonel Ricard and Major Thurlow indicated that the medical facilities in Afghanistan are limited and are operating at full capacity.

[123] Medical facilities are classified in four categories by the military from Role 1 to Role 4, the Role 1 being the least capable and the Role 4 being the most capable. In Afghanistan, the most capable facility operated by Canadians, now taken over by the Americans, was the Role 3 facility at the KAF. There is no Role 4 facility in Afghanistan. If a person should require a

Role 4 facility, the person would be medically evacuated to Germany or Canada if the person is stable enough to travel.

[124] There are no Canadian medical facilities at the Canadian embassy in Kabul. Moreover, there is no ambulance or 911 services. In any emergency situation, a patient would require transportation by armoured car. The journey may also be delayed due to conflict. Afghan hospitals are considered too dangerous for western nationals. There are two NATO military bases in the vicinity of Kabul that have medical facilities. There is a Role 1 facility at Camp Souter, located 20 minutes away from the embassy. The only Role 3 facility is located at Camp Warehouse, a French NATO base, 10 km east of Kabul. The road to Warehouse from Camp Souter is said to be dangerous, requiring the full military support of 8 soldiers to move one ill person. Camp Warehouse will provide medical services "in extremis'' if it is not detrimental to the medical support of ISAF personnel. Finally, an ISAF pass is required for entry onto the base. Without an ISAF pass for vehicle access, entry may be refused or severely delayed.

[125] Both the KAF and the PRT have a Role 1 and a Role 3 facility. The Role 1 facility at the KAF and at the PRT are capable of providing for patients needing minor procedures. These facilities do not have a lab or an x-ray machine and the pharmacy does not carry a full stock of medications. The hours of operation are from 07:30 to 16:30. A Role 1 facility is staffed with a medical officer and a physician's assistant and was described as being similar to a family medicine office. The medical officer is like a family physician or a general physician. The physician's assistant was described as an extension of the medical officer, similar to a nurse practitioner with a trauma focus rather than an illness focus. Both the medical officer and the physician's assistant cover for each other when the other is away for "real life situations". A Role 1 facility is used for triage only and, as a result, they do not have beds.

[126] A Role 2 facility has a limited capacity as well. A patient may stay from a few hours to a couple of days. In a Role 2 facility only damage control surgery is provided to stabilize the patient. If further surgery is required the patient will have to be moved to a Role 3 facility.

[127] The Role 3 facility at the PRT was a Canadian run facility, but by nature it is a multinational facility. Although other nations are there at times, primarily it is Canadians and Americans stationed at the facility. It is a make shift facility with add-ons. One hundred and sixty people work at the facility. There are 6 Intensive Care Unit beds (ICU), 6 Triage beds, 12 holding beds and 3 Operating rooms. The bottle necks are the triage and the ICU beds.

[128] The Role 3 facility at the KAF is staffed with two surgical teams, an orthopaedic surgeon, a psychiatrist and one internal medicine specialist. There are 12 regular beds and 4 (ICU) beds, 16 beds in total and all in the same room. Colonel Ricard, (First Task Force Surgeon) serving at the KAF described the capacity of the facility as being "very very small''. He also testified the 16 beds are kept filled at 80%-90% capacity at all times. In the fall of 2009, the Americans took over command of the facility. KAF is now a modern structure, with a trauma focused hospital, but can take on illnesses if need be. KAF now has 12 ICU beds and 12 Triage beds, increasing its capacity.

[129] Colonel Ricard described the workload of military doctors at the KAF as extremely busy, with three major trauma surgeries per day on average. The doctors at the facility work at an intensive pace that is not sustainable for more than six months. In this regard, Colonel Ricard testified to the following:

> So you see as a commanding officer your staff which are all well trained and dedicated getting tired and tired and tired. And the way I saw it is that we squeeze them like a sponge for the 6 months they are there, there's only a 3 week vacation during that six months, we burn them completely out and then we send them home to recuperate, but we couldn't do that for one year, 2 years-3 years working at the Ottawa civic as my regular job with the intensitivity (sic) of what was happening over there.

[130] Major Thurlow was the Watchkeeper at the joint operations centre of KAF. As such, he was responsible for responding to calls for medical emergencies, and would help determine the means of evacuating a casualty. In that task, he had up to date current knowledge of bed states

within all of the hospital facilities in his area of operations. He testified as to the following with regards to the hospital codes that conveyed the level of occupancy of a facility:

> Color code determines the capacity to accept patients. And this is known at the joint operations centre as something monitored minute to minute. A facility at green means that is has a capacity to take casualties, no restrictions. A facility at yellow, means 75% capacity is reached. Could be ICU beds, triage, war beds. You get to red, 90% of the hospital has been met. Finally you get to black, Black is 100% so they are maxed out, the facility cannot take any more casualties'

[131] Major Thurlow testified that the Role 3 facility at the KAF frequently would encounter red or black color code scenarios. Major Thurlow added that hospital occupancy had an impact on both military operations and medical treatment. A commander may curtail military operations if he is made aware that a facility is in the red and would be unable to treat casualties. A red or black code also means that the military will prioritize who will get care. As such, NATO helicopters would prioritize evacuations depending on the casualty's role and nationality, giving priority to coalition forces, western nationals, etc.

[132] Patients are categorized according to their injury by type A, B or C. A patient in category A requires treatment within the hour, which is referred to as the golden hour. A category A patient will have priority over all others. Their situation is urgent and the most expedient methods are used to get them care. This patient is always moved by air. For a category B patient the window in which one must act goes up to 4 hours and they can be moved to a different location once stabilized. A category B patient is at risk from a life threatening injury but the risk is less elevated than a category A patient. A category C patient is a routine patient and can be moved within 24 hours.

[133] There is no ambulance or 911 service in Afghanistan. Rather, where a medical emergency arises there is a limitation on the health care that can be given on site, as is the case at the PRT for example. If the situation is an A or B category, a medical evacuation mission is required and care will not be provided on site, the person has to be moved to another location

which involves additional safety risks for the injured person and the caregivers and the military. Evidence showed that if a person with type 1 diabetes gets shot there are additional risks to their health. Risks of being injured or shot, even in the PRT, were said to be "real not slim''.

Safety Risks

[134] Apart from the health concerns, civilian employees working in Afghanistan are under constant threat of attack. CIDA employees posted in Afghanistan receive an additional remuneration called a "hostility bonus" in recognition of the dangers inherent with working in a war zone and the severe living conditions of the mission. At all three sites where CIDA officers operate, KAF, Kabul and the PRT compound, the security conditions were described as very dangerous.

[135] Major Thurlow testified that KAF gets shelled fairly regularly and consistently. Colonel Ricard was the Task Force Surgeon at the KAF for a period of nine months and he testified that during that time there were 70 rocket attacks on the KAF. At the time of the hearing of this case, Major Thurlow testified that the KAF had recently suffered a rocket attack that landed in the dining facilities, injuring several people and killing one person. In cross examination, Colonel Ricard disagreed with complainant counsel's suggestion that the risks of injury at the KAF were "quite low": "The chances of injury within KAF are real – not quite low. [...] There's a significant risk to life in KAF – all people have to have flak jackets and helmets accessible".

[136] Bob Johnston, described the escalation of dangerous conditions in Kabul during the summer of 2008. He testified that in 2008, security was breached at a hotel used by foreign nationals. This hotel was previously considered "secure". This security breach was followed by the first of the Indian embassy bombings, where fertilizer-loaded vehicles were blown up. Body parts were found in the Canadian embassy, located half a mile away. Mr. Johnston testified that the security measures at the Canadian embassy in Kabul are the most expensive when compared

to any other Canadian embassy in the world. After the events described above, the embassy hired a security firm that had both Afghan personnel and former members of the British Special Forces. CIDA officers attending meetings at the Canadian embassy were driven in armoured cars with an armed driver. In 2009, the embassy instituted "close protection" protocols, whereby employees were accompanied by these former members of the British Special Forces to meetings to help with extraction in the event of a suicide bombing, which was often followed by gun fire.

[137] The PRT compound is also under threat of attack. Drs. Callary and Baxter reported that "firefights occur 300 to 400m away from the walls of the PRT, requiring employees to stay in bunkers". Bob Johnston testified that in 2009, everyone at the PRT was evacuated because of a threat of major attack.

[138] The constant threat of attack also impacts on medical evacuations. Medical evacuations can be done either by armoured vehicle or by helicopter. Given the dangers of travelling by vehicle, most medical evacuations are done by helicopter. Major Thurlow, who was responsible for monitoring battles and dispatching helicopters to rescue casualties, testified that there were 15 helicopters, most if not all American, responsible for all the medical evacuations in the area of operations known as Regional Command South, which comprises 5 southern provinces of Afghanistan. In 2009, these 15 helicopters performed 5,300 medical evacuations, and transported 7,500 casualties. This number does not include patient transfers from one facility to another, which are done with the same 15 helicopters. There was an average of 16 medical evacuations a day, but this number could rise to as many as 32:

> one day, we had 32 medevacs missions flown – and that means that everyone is working to full capacity – they are flying from one mission to the next to the next – you have facilities filling up, and in that day, we denied care

[139] Major Thurlow also testified about the dangers of evacuating casualties in Afghanistan. Each mission requires two helicopters to be flown, with each helicopter carrying three people. One helicopter will land while the other provides protection. According to Major Thurlow :

> So 2 helicopters will go out, to pick up the casualty because of the security risk, the 2nd helicopter will either be a second medevac helicopter, or if the security risk is considered high in the area, the 2nd helicopter is an attack helicopter. But both helicopters have the capacity to defend themselves. Both helicopters will go out to pick up the casualty. One helicopter lands, the medical team, there's approximately 3 people per helicopter. They'll get off, assess the casualty bring the casualty in the helicopter. The other one stays in the air and provides protection to that helicopter, interdicts any enemy that may appear or try to involve themselves in the event. Interdiction is common – not unexpected. These helicopters are shot at – all helicopters are shot at. If they're flying around they are shot at. It's a dangerous job.

[140] Major Thurlow added that Improvised Explosive Devices (IED) constitute another danger faced by soldiers performing medical evacuations. On one occasion, while making their way back to the helicopter after placing a casualty on a stretcher, two stretcher bearers became amputees when they stepped on an IED.

Other Safety Considerations

[141] I also consider the following factors to be relevant to safety in evaluating undue hardship in the circumstances of this case.

1. *Accommodating the complainant in Afghanistan and the effect it may have on the success of the mission*

[142] The success of the Afghanistan mission, like for all other UN political or peace keeping missions, is optimal when good collaboration exists. The same principle applies for CIDA missions. Does accommodation in a war zone negatively impact the relationship between the different actors in place? We have to bear in mind that the success of UN and other international missions, such as the CIDA mission in Afghanistan, relies upon the effective partnerships and

good relations between the military and the different actors. The more negative the impact is, the closer it is to undue hardship, because of the effects it will have on the mission and on the people involved. While the Canadian Forces does not dictate to the Canadian Government how to manage their projects, they are the specialists when it comes to combat zones. Their evaluation is indispensible when it comes to the living conditions in place in the combat zone and the level of risk in those situations. The evidence established that the military are in charge of determining which medical facility a casualty will be sent to and for planning all evacuations and every move of Canadian civilians from the different camps to other parts of the country. Cooperation and good relations with the military is necessary to successfully accomplish the mission.

[143] In the present case, relations were affected by the absence of a process needed to prevent medical incidents, such as the one that occurred involving the complainant in 2008.

[144] At the time of the incident, Ron Shatz, Director of Development at the PRT in Kandahar wrote an email to Mr. Hallihan and Mr. Metcalfe in the ATF, CIDA:

> it was a concern for those who attended to her. The thought of a reoccurrence does not sit well with any of us here

[145] Both the Complainant and Respondents relied in their evidence on this email from Ron Shaltz:

> the medical staff this morning, told me there was no way he would have he stay at the KPRT, that she was putting others at risk, *although I find it a stretch, he immediately ordered a chopper and she was evacuated to KAF within 90 minutes.* He reckons this type of condition (he was told by his medic that B. Was near to diabetic coma) cannot be accepted here and that if this were to happen in a FOB there would be no life support with potentially disastrous circumstances. He made it clear he would not accept B. For a short or long term assignment here.

[146] After the complainant's hypoglycaemic incident in 2008, the military, in consultation with their internal doctor, found that it was unwise of CIDA to send civilians to a war zone

without properly screening employees for chronic conditions that could put them, others and, the whole mission at risk. As a result, the *Afghanistan Guidelines* were modified and the evidence showed that this helped improve relations with the military. While the military is not in charge of CIDA missions, they certainly have a word on how they wish to operate when they put their soldiers at risk. In this regard, the intention of the *Afghanistan Guidelines* was to improve cooperation and safety between the different partners involved in the mission in Afghanistan. The complainant testified that the military and her employer overreacted in response to her hypoglycaemic incident in 2008. I disagree. I find the situation could have been much worse if no one heard her in her sleep or if an attack on the base had occurred at the time the complainant was incapacitated. In the light of the evidence, a person with type 1 diabetes may require the help of a third person to get a glucagon injection or intravenous glucose in case of a severe hypoglycaemic event or consequences could be disastrous. The complainant also fails to consider the overall consequences that another hypoglycaemic incident could have on her safety and the safety of others, let alone the repercussions this could have on the relationship between CIDA and the military and the success of the Afghanistan mission.

2. *The level of control over the environment*

[147] The more control one can exert over a given environment the less a BFOR and undue hardship is justifiable; the less control one can exert over a given environment the more the BFOR defence up to the point of undue hardship standard is preserved.

[148] An analysis of who has the control over the environment must be performed under this criterion. The more the employer has control over the environment and the outcomes of a mission, the more accommodation should be possible without suffering undue hardship. If the employer needs to rely on third parties to control the environment, the impact on the third party should be considered in the analysis of undue hardship. Will the accommodation be supported by other third parties who insure the success of the mission?

[149] In a war zone, control over the environment presents some challenges; if it did not, no civil casualties would occur because safety would be assured. The evidence above concerning the war zone context in Afghanistan establishes that the dangers over there are real and that lives are constantly in danger. In this light, it is imperative to keep in mind the answers to the following questions:

> What are the consequences if the accommodation is enforced? Will others be put in danger because of the accommodation? What are the impacts on the rights of other CIDA employees, civilians, soldiers, facilities, etc...?

[150] In the present case does accommodation require that others take action on the complainant's behalf that imposes undue hardship on them? Is it reasonable or even possible for an employer to respect the accommodation on its own without the collaboration of partners?

[151] CIDA's work in Afghanistan depends on the military for various purposes and, most importantly, for security reasons. Although CIDA operates civilian projects in Afghanistan, the military is directly involved in the operational aspects of these missions and the reality is that some are so involved that they lose their lives in the course of their duty.

[152] In assessing the evidence on this issue of who has control over the environment and the safety in the war zone, I prefer that of the respondent CIDA over that of the complainant's. When the complainant testified, she attempted to minimize the dangers in Afghanistan. At the same time, she claims the hostility bonus as a remedy in this case. She said that no CIDA employee had been killed or kidnapped. I do not consider this evidence to be relevant considering that a Canadian diplomat has been killed, and other Canadian civilians have been injured or kidnapped in Afghanistan. The complainant's evidence was not convincing on that issue. The evidence demonstrated that CIDA alone is not able to control the environment in Afghanistan to ensure reasonable safety to its employees. Moreover, it is difficult, if not impossible, for the military to control the safety of the environment in Afghanistan. I find that CIDA has a very low level of control over the complainant's work environment in Afghanistan. I

find the military has some level of control, but cannot guarantee complete control in the war zone in Afghanistan.

Conclusion on undue hardship

[153] The Commission argued that the risks already present in the environment should be taken into consideration when assessing whether accommodating the complainant would pose an unacceptable level of risk. The Commission and the complainant claimed that every civilian posted to Afghanistan accepts a certain amount of risk, as do the military in cooperating with CIDA. Although this is true, the question remains, is it wise to consider adding more risks to an already risky environment? Is this approach acceptable in a war zone?

[154] The Commission referred to *Multani v. Commission scolaire Marguerite-Bourgeoys*, 2006 SCC 6 [*Multani*] to sustain its position on risk. The events in the *Multani* case took place in a Quebec public school, in Canada, a peaceful country where no one expects a rocket to fall on the school's roof. If any emergencies arise, no insurgents will impede the paramedics or the police from arriving quickly to assist. In Afghanistan, the scenario is significantly different from that in *Multani*. However, I do find the *Multani* decision to be instructive in the sense that each environment is different and that the level of risk in that environment must be analysed on a case by case basis. In this regard, the Supreme Court stated the following:

> Although there is no need in the instant case for this Court to compare the desirable level of safety in a given environment with the desirable level in a school environment, these decisions show that each environment is a special case with its own unique characteristics that justify a different level of safety, depending on the circumstances.
>
> (See *Multani* at para. 66)

[155] In the same vein, in *Nijjar v. Canada 3000 Airlines Ltd.* (1999), 36 C.H.R.R. D/76 [*Nijjar*], the Tribunal stated the following:

> In assessing whether or not the respondent's weapons policy can be modified so as to accommodate Sikhs detrimentally affected, consideration must be given to the environment in which the rule must be applied. In this regard, we are satisfied that aircraft present a unique environment. Groups of strangers are brought together and are required to stay together, in confined spaces, for prolonged periods of time. Emergency medical and police assistance are not readily accessible.
>
> The Commission points out that airplanes contain all manner of items such as wine bottles, crutches and walking sticks, all of which have the potential to be used as weapons but are allowed on board. While it is true that these types of items could theoretically be used as weapons, in light of Dr. McAuliffe's evidence with respect to the offensive capacity of wine bottles, and having regard to the confined space inside an aircraft in which crutches or walking sticks could be wielded, we do not think that the risk posed by items of this nature can be equated to that posed by kirpans.
>
> Unlike the school environment in issue in the *Pandori* case, where there is an ongoing relationship between the student and the school and with that a meaningful opportunity to assess the circumstances of the individual seeking the accommodation, air travel involves a transitory population. Significant numbers of people are processed each day, with minimal opportunity for assessment.
>
> (*Nijjar* at paras. 123-125)

[156] That being said, proof of undue hardship can take "...as many forms as there are circumstances" (*Hydro-Québec v. Syndicat des employé-e-s de techniques professionnelles et de bureau d'Hydro-Québec, section locale 2000*, 2008 SCC 43 at para. 12). Indeed, accommodating an employee in a war zone is a unique situation and the respondents have led proof of the specific working conditions in Afghanistan as outlined above. As safety is at issue in this case, "...both the magnitude of the risk and the identity of those who bear it are relevant considerations" (*Central Alberta Dairy Pool v. Alberta (Human Rights Commission)*, [1990] 2 S.C.R. 489 at p. 521). The evidence outlined above indicates that not only are there serious health and safety risks present for Canadians working in Afghanistan, but that these risks

frequently materialize and the danger is real. The evidence also indicates that it is not only the complainant or CIDA employees who bear these risks, but also members of the Canadian Forces and other foreign military personnel; most notably, the helicopter teams that perform medical evacuations. The *Covenant on the Rights of Persons with Disabilities* addresses how to counterbalance persons with disabilities with others rights:

> *Article 10 - Right to life*
>
> *States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities* ***on an equal basis with others****.*
>
> *Article 11 - Situations of risk and humanitarian emergencies*
>
> *States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to* ***ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict****, humanitarian emergencies and the occurrence of natural disasters.*
>
> **(Emphasis added)**

[157] In this same vein, medical services are limited and bed space must be preserved for the treatment of troops, injured Afghani civilians and unpredictable emergencies that impact all civilians posted in Afghanistan. The complainant attempted to show that the situation in Afghanistan was not as dangerous as the respondents claimed, and that any risks could be brought within an acceptable level. However, the war conditions in Afghanistan are such that control over the complainant's work environment is limited at best due to the unstable conditions of war and the fact that CIDA relies on the military to provide security for their employees while in Afghanistan. Despite every military protection and precaution, many people have been hurt and killed in Afghanistan, attacks against military compounds occur, convoys are ambushed, and it has been necessary to evacuate CIDA personnel from certain locations at times. While the complainant argued that no CIDA employee has been kidnapped or killed, this does nothing to

minimize the risk or reduce the probability of it actually happening. Adding additional risks to the pre-existing circumstances and to the other unexpected circumstances in Afghanistan puts lives, aside from the complainant's, in added jeopardy.

[158] Everyone posted in Afghanistan accepts a level of risk to their safety. The complainant and the Commission argue that the level of risk for the complainant is a little higher, but could be brought within an acceptable level if the employer implements Dr. Beauregard's conditions and allows the complainant to work without travel. They both refer to a level of reasonable safety and argue that the standard applied by CIDA is a level of absolute safety. I do not find CIDA to be applying a standard of absolute safety, which would result in not allowing any CIDA employee to be posted in Afghanistan considering all the risks present in the environment. I do find the standard to be high, but this as it should be when lives and health are at stake. While military personnel risk their lives every day in Afghanistan, they assume this risk in furtherance of Canada's mission in Afghanistan. It would be an unreasonable risk for them to put their lives in danger for the sole purpose of accommodating the complainant. In this regard, "[t]he factors that will support a finding of undue hardship [...] must be applied with common sense and flexibility" (*McGill University Health Centre (Montreal General Hospital) v. Syndicat des employés de l'Hôpital general de Montréal*, 2007 SCC 4, at para. 15). The right to life commands that the highest standard possible be upheld, this is in accordance with principles of the Universal Declaration of Human Rights (UDHR). Any accommodation must respect the lives of others, lives that would be impacted by the decision to accommodate the complainant in Afghanistan. The argument that the military takes risks everyday is not sufficient to impose on those already risking their lives additional risk for the purpose of accommodating the complainant.

[159] After having examined all the evidence in this case, I believe that in a stable environment, the complainant manages the symptoms of her condition very well. She is well informed about her condition and explained very clearly how she manages it. On this issue, she is very credible. The same cannot be said about the management of her condition in Afghanistan.

She testified that she mistakenly gave herself two doses of insulin, when only one was required, and that she forgot to measure her blood sugar level before going to bed. When asked the reason for this mistake, she explained that it was because she was playing cards and was distracted. I believe her when she says that she learned from that experience; however, I also note that she requested sick leave in June 2008 because dealing with HC and CIDA caused her stress and was affecting her condition and evidence established the nexus between the low A-1-C a type of test that measures her blood sugar levels and the same period where stress was present for the complainant. This request was written by the same doctor, her treating doctor, Dr. Arnaout that originally said the complainant was fit for posting in Afghanistan. I weight this information in the rest of all the evidence induced. The stress related to the discrimination pales in comparison to the high level of stress in Afghanistan. My conclusions in this regard do not change even if an invasive psychological stress test declared her fit in Canada. I cannot give it more weight than the solid evidence that CIDA put forward with an extensive description by the military on the conditions present in the war zone in Afghanistan. Details were given on the mission, on medical evacuations and the complainant did not succeed in contradicting this evidence. The evidence showed that even if the restrictions suggested by Dr. Beauregard were enforced, they cannot necessarily be respected at all times if an emergency or life-threatening situation occurs. There is no guarantee that the complainant would always have all the necessary equipment for insulin administration on her, especially in a rocket attack or an ambush. Moreover, nothing in the evidence showed that she would properly manage her condition in an ambush or a rocket attack, and it becomes even more speculative when other CIDA employees' reactions are required to assist the complainant.

[160] Based on the evidence and my reasons above, and subject to my findings regarding CIDA's procedural breach of the duty to accommodate, I believe that it would constitute undue hardship for CIDA to have to accommodate the complainant in Afghanistan considering the risk to the complainant's health and safety, and the safety of CIDA employees and those fighting the war in Afghanistan.

VII. Conclusion

[161] The evidence indicates that it would be an undue hardship for CIDA to accommodate the complainant in Afghanistan. Nonetheless, CIDA has breached its procedural duty to explore all reasonable accommodation measures for the complainant and, as a result, a violation of sections 7 and 10 of the *CHRA* has been made out against CIDA.

[162] For its part, HC developed the *Afghanistan Guidelines*, which do not reflect equality between all members of society. In the course of employment, the complainant suffered adverse differentiation on the basis of her disability by the application of the *Afghanistan Guidelines*. On this basis, HC has violated section 7(b) of the *CHRA*.

[163] Therefore, both complaints are substantiated and the Tribunal will consider appropriate remedial action to eliminate these discriminatory practices.

VIII. Remedies

[164] When a complaint under sections 7 and 10 of the *CHRA* has been substantiated, the Tribunal has remedial authority to make an order under the terms of sections 53(2), 53(3) and 53(4) of the *CHRA*, which sections provide as follows:

> **53.** (2) If at the conclusion of the inquiry the member or panel finds that the complaint is substantiated, the member or panel may, subject to section 54, make an order against the person found to be engaging or to have engaged in the discriminatory practice and include in the order any of the following terms that the member or panel considers appropriate:
>
> (a) that the person cease the discriminatory practice and take measures, in consultation with the Commission on the general purposes of the measures, to redress the practice or to prevent the same or a similar practice from occurring in future, including

(i) the adoption of a special program, plan or arrangement referred to in subsection 16(1), or

(ii) making an application for approval and implementing a plan under section 17;

(b) that the person make available to the victim of the discriminatory practice, on the first reasonable occasion, the rights, opportunities or privileges that are being or were denied the victim as a result of the practice;

(c) that the person compensate the victim for any or all of the wages that the victim was deprived of and for any expenses incurred by the victim as a result of the discriminatory practice;

(d) that the person compensate the victim for any or all additional costs of obtaining alternative goods, services, facilities or accommodation and for any expenses incurred by the victim as a result of the discriminatory practice; and

(e) that the person compensate the victim, by an amount not exceeding twenty thousand dollars, for any pain and suffering that the victim experienced as a result of the discriminatory practice.

(3) In addition to any order under subsection (2), the member or panel may order the person to pay such compensation not exceeding twenty thousand dollars to the victim as the member or panel may determine if the member or panel finds that the person is engaging or has engaged in the discriminatory practice wilfully or recklessly.

(4) Subject to the rules made under section 48.9, an order to pay compensation under this section may include an award of interest at a rate and for a period that the member or panel considers appropriate.

[165] The aim of the *CHRA* is remedial and is "...not aimed at determining fault or punishing conduct" (*Robichaud v. Canada (Treasury Board)*, [1987] 2 S.C.R. 84 at para. 13 [*Robichaud*]). Rather, the primary focus of the legislation is to "...identify and eliminate discrimination" (*Robichaud* at para. 13). The Tribunal deals with complex and emotional disputes between parties, which demands "...innovation and flexibility on the part of the Tribunal in fashioning

effective remedies and the Act is structured so as to encourage this flexibility" (*Grover v. Canada (National Research Council - NRC*) (1994), 80 F.T.R. 256 (Fed. Ct. TD) [*Grover*]). Although the Tribunal has remedial flexibility and discretion under section 53, this discretion is not unlimited. In the context of discussing the limit on the liability for compensation under the *CHRA*, the Federal Court of Appeal in *Chopra v. Canada (Attorney General)*, 2007 FCA 268 [*Chopra*], stated:

> The first limit is that recognized by all members of the Court in Morgan, that is, there must be a causal link between the discriminatory practice and the loss claimed. The second limit is recognized in the Act itself, namely, the discretion given to the Tribunal to make an order for compensation for any or all of wages lost as a result of the discriminatory practice. This discretion must be exercised on a principled basis.
>
> (*Chopra* at para. 37)

Stated more generally:

> ...orders of a remedial nature must be linked or have a nexus to the *lis* or subject-matter of the complaint substantiated by the tribunal: the "four corners of the complaint" or "the real subject matter". The remedy must be commensurate with the breach. The orders also must be reasonable and the remedial discretion exercised in light of the evidence presented.
>
> (*Hughes v. Elections Canada*, 2010 CHRT 4 [*Hughes*] at para. 50)

[166] In implementing remedial orders, the CHRC or other parties may be involved in terms of consultation or monitoring. The involvement of other actors recognizes that the Tribunal has an adjudicative role that does not translate well into the technical or task-specific aspects of the implementation of orders often affecting the day-to-day operations of a governmental or corporate respondent (see *Hughes* at para 51).

[167] In consideration of these principles, the following are my reasons with regards to the remedies requested by the complainant and the Commission.

Compensation for lost bonuses and allowances

[168] The complainant is seeking compensation pursuant to paragraph 53(2)(c) of the *CHRA* for lost bonuses and allowances for the 18 month period of the Afghanistan posting she did not receive. These bonuses and allowances include: a lost hostility bonus and a lost post differential bonus of $17,627.00 for a period of 12 months or $26,440.00 for a period of 18 months; a special risk premium of $10, 015.00 for a period of 12 or 18 months; a lost incidental relocation bonus of $4,106.00 for a period of 12 or 18 months; compensation for lost vacation travel allowance [allowance less hours required to be used for R&R Leave] at the PM-05 for the amount of $32,708.00 for 12 months for a one year posting and $49,062.00 for 18 months for a period of 6 months and a period of one year, at the PM-06 level for the amount of $31,779.00 for 12 months and $47,505.00 for 18 months; compensation for lost overtime opportunities less overtime already earned in Canada, at the PM-05 level [$5,034 less $774 per month] for 12 months $38,340.00, at the PM-06 level 2 2008 [$5,682 less $774 per month] for 12 months $44,174.00, at the PM-06 level 3 2009 [$5,767 less $774 per month] for 18 months $66,642.00, calculated based on level 2 for 12 months plus level 3 for 6 months; compensation for lost rental income for 12 months $14,400 and for 18 months $21,600; compensation for household expenses incurred for 12 months $5,808 and for 18 months $8,712.

[169] CIDA has established that it would cause undue hardship for it to accommodate the complainant in Afghanistan. Therefore, I will not grant any amount directly linked to the posting in Afghanistan such as the special risk premium or the hostility bonus. The hostility bonus is specific to dangerous areas with the highest hardship levels and is not allocated in every international mission. In the present case, for the Tribunal to award the complainant compensation for a hostility bonus, the Tribunal must be satisfied that she was to be posted in Afghanistan. Since it has been established that it would have caused undue hardship to post the complainant in Afghanistan, any amount related to the Afghanistan posting cannot be granted. Section 53(2)(c) aims to compensate the victim *for any expenses incurred as a result of the discriminatory practice.* I do not find any logical explanation for claiming relocation, lost rental

income, household expenses, etc. The complainant did not incur these expenses. The expenses should be reimbursed if spent and not claimed without being incurred. This being said, I believe that if it were not for the adverse differential treatment that the complainant received during the whole medical assessment and posting process, the complainant would have obtained a position in another country. Although she was denied the Afghanistan posting she would have been suited, at the least, for a friendly country. I find that she would have had to do overtime more than in Canada but not as much as in Afghanistan where conditions are harsh. The complainant testified that there is not a lot to do in Afghanistan, so in the end, CIDA employees tend to do more hours of work than normal. The evidence also established that it is reasonable to assume she would have been at a PM-06 level because of her previous work. I will elaborate on my reasons in this regard under the Appointment and Deployment section of the remedies in the decision. I do not have sufficient material before me to quantify the average amount of overtime that an employee at the PM-06 level would work in a friendly country. Therefore, I will allow two months for parties to provide submissions on the appropriate amount and remain seized of the matter until this information is available.

Compensation for pain and suffering

[170] The complainant is claiming compensation for pain and suffering in the amount of $20,000 pursuant to, paragraph 53(2)(e) of the *CHRA*. The amount of $20,000 is the maximum allowed within the boundaries of *CHRA* under this head of damages. Moral pain and suffering is difficult to quantify. When someone suffers, the only person that has real knowledge of that particular suffering is the person who experienced it. When someone goes through pain there is no amount of money that can accurately compensate for that pain. Moral pain related to discrimination is subjective and varies from one individual to another. From the point of view of the person that suffered discrimination, large amounts of money should be granted to reflect what they have experienced and to provide them justice. No one should suffer and no amount can reflect this injustice. The amount allowed will never fully put the person back in the situation as though the discrimination never occurred, because of the subjective element of it and the

limits of the *CHRA* and of the case law. Psychological scars often take a long time to heal and can affect a person's self worth. This being said, when evidence establishes pain and suffering an attempt to compensate for it must be made. The complainant requested sick leave because of how she felt at work with how CIDA and HC handled the medical assessment and accommodation process. She awaited answers from both respondents that never came. The complainant was told that the HC-MAC committee would accept the third medical opinion, but in the end they did not and, meanwhile, made the complainant undergo tests that kept her hopes up. The complainant's hopes were shattered by the way the situation was handled by both respondents. She was not informed of her rights and was mislead in two ways: (1) by being told that a list of countries where she could be posted would be provided; and, (2) that as soon as doctors in those countries provided the necessary medical information, she would receive more information. The information was never given and no follow up was made by the respondents. The complainant lost opportunities to be posted outside of Canada because of these delays. In the whole process, the complainant felt adversely treated because of her condition and felt her dignity was infringed upon. After considering previous amounts awarded by this Tribunal and all the evidence, I order the respondents to each pay the complainant $5,000.

Compensation for wilful and reckless discrimination

[171] The complainant is seeking special compensation for wilful and reckless discrimination in the amount of $20,000, pursuant to paragraph 53(3) of the *CHRA*. The complainant did not present any case law to support this claim nor were extensive arguments provided, but the evidence is sufficient to pursue the analysis on the matter. The evidence established that HC told the complainant they would accept the independent medical opinion whatever it may be. They were aware of what they said and modified their approach when the opinion was not what they expected. They also worded the "Absolute medical requirements'' and admitted at the hearing that it was a poor choice of words that indeed could mislead someone doing an assessment. HC did not try to correct the wording of the guidelines when they submitted the information to Doctor Beauregard, nor did they give him section one of the *OHAG*, which says that the

guidelines are instructive and not mandatory. Therefore, HC knew what they were doing. On its part, CIDA refused to respond to the complainant's email requesting it to exercise its discretionary power to post her to Afghanistan. CIDA cannot ignore the fact that no additional information was given to the complainant on other overseas postings. After reviewing the evidence and the Tribunal's other decisions under this head of compensation, I find that in behaving in such a way, both respondents engaged in wilful and reckless discrimination pursuant to the terms of section 53(3) of the *CHRA*. I order the respondents to each pay the complainant $5,000.

Sick leave credits

[172] Pursuant to section 53(2)(c) of the *CHRA*, the complainant seeks reinstatement of sick leave credits totalling 55 days. The 55 days are related to the sick leave she took in the summer of June 2009. It corresponds to a period of time when her doctor said that the stress related to the discrimination and work related issues affected her blood sugar levels and her condition. The evidence corroborated the doctor's recommendation. Therefore, I order the reinstatement of the totality of the complainant's sick leave credits.

Vacation day credits

[173] The complainant is also seeking reinstatement of vacation time credits totalling 15 days taken in order to prepare for and attend proceedings related to her complaint. Pursuant to paragraph 53(2)(C) of the *CHRA*, I order the reinstatement of the 15 vacation day credits.

Appointment and deployment

[174] The complainant is seeking an appointment to a position at the EX-01 level within CIDA, pursuant to paragraph 53(2)(b) of the *CHRA*. She also seeks deployment to an operational

position within CIDA's Geographic Programs Branch (GPB), pursuant to paragraph 53(2)(b) of the *CHRA* and requests to be posted to a family-friendly country of her choice.

[175] In December of 2008, the complainant was promoted to International Development Program Manager of the R+A Unit, a position at the PM-06 level (she had been acting in this position since May of 2007). At the same time, the complainant applied for and won an acting assignment as the Senior Departmental Assistant in the Minister's office, a position at the level of A/EX-1. The complainant resigned from her position as Acting Senior Department Assistant and took a short-term medical leave starting on or around June 20, 2009. On or around September 1, 2009, the complainant returned to her previous position as International Development Program Manager with the R+A Unit, where she continues to work. The respondents argued that there is no obligation to give a posting to the complainant since she already has a good position within CIDA and that she was hired at a higher position than a lot of CIDA employees start at. I disagree. I find if it were not for her disability she would have obtained a posting to Afghanistan or elsewhere because of her abilities to perform the duties required. CIDA never contested that she was a good employee with the abilities to succeed in higher positions. In fact, the evidence suggests in an email from Dave Metcalfe (Results and Accountability ATF CIDA) to Michael Collins they qualified her as "awesome a great resource and an excellent employee".

> ...perhaps we can do what we can to perhaps position her elsewhere in the Agency that would lead to a posting in a different location for which HC would support given the situation....We should try to keep her within the ATF or at least within the Agency

[176] On this basis, pursuant to paragraph 53(2)(b) of the *CHRA*, I order CIDA to deploy the complainant in the GPB at the PM-06 level and to work with the complainant to post her in a friendly country within her top three choices where there are appropriate medical facilities and no medical restrictions that she will face.

Personnel file

[177] The complainant requested immediate removal from her personnel file any reprimand related to her pursuit of this complaint, pursuant to paragraph 53(2)(b) of the *CHRA*. The evidence tendered by CIDA indicated that the reprimand was linked to the complainant's behaviour at work when she sent emails and talked to more people than she needed to about the complaints. The evidence showed that she sometimes used a harsh tone in her emails. The complainant argued that she was asked to withdraw her complaint in exchange for a position. This allegation was not corroborated and the person in question that supposedly said this to her did not testify before the Tribunal. Therefore, I do not place any weight on it. If the reprimand was made because she made a complaint against CIDA, I would have considered it retaliation. I do not believe it was for this reason but rather because she made several attempts, even to the Minister's office, to make her point. When asked why she made threats and bad comments towards some of the CIDA management team, the complainant admitted that she did not act rationally in those acts. Although defending one's rights is legitimate, it has to be done within appropriate boundaries; if not, one has to bear the consequences. Therefore, the request is denied.

Legal fees

[178] The complainant is seeking compensation for legal fees in the amount of $2,712.68. In *Canada (Attorney General) v. Mowat*, 2009 FCA 309 [*Mowat*], the Federal Court of Appeal found that the CHRT has no authority to make an award of costs under the provisions of the *CHRA*. Leave to appeal to the SCC has been granted. However, based on *Mowat*, I do not award any amount for legal fees.

Systemic remedies

[179] The complainant is seeking the following:

> - an order that the respondents cease their discriminatory practices against employees seeking postings overseas who are captured by the absolute medical ban contained in the policies applied by the respondents in assessing employees' medical fitness for oversees postings;
>
> - an order that the respondents consult with the Commission (CHRC), in accordance with paragraph 53(2)(a) of the *CHRA*, to develop a plan to prevent further incidents of discrimination based on disability in the medical assessment of employees seeking overseas postings; and
>
> - an order that the respondents establish written policies satisfactory to Ms. Cruden and the Commission to address the assessment of medical suitability for overseas postings within six months, and that these policies include a process for individualized assessments of those being assessed.
>
> - Findings were made concerning the inappropriate wording of the *Afghanistan Guidelines*. The "Absolute medical requirements" create a *prima facie* case of discrimination against people living with chronic conditions and create adverse differential treatment when applied. Improvements are required in the medical assessment and posting processes to remedy this discrimination.
>
> - The *Covenant on the Rights of Persons with Disabilities* in its Preamble section o. mentions: "*Considering that persons with disabilities should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them,...*''.

[180] For these reasons, I order all of the measures outlined above in the light of the evidence and findings in this case.

Amendments to HC policies and guidelines and amendments to CIDA's policies

[181] The evidence and findings in the present case established the fact that the *Afghanistan Guidelines*, moreover, the "Absolute medical requirements" need to be replaced to prevent any adverse differential treatment and to allow a case by case assessment of individuals. The

guidelines must be clarified to ensure that their interpretation does not lead doctors in excluding every person with a chronic condition. CIDA needs to ensure that employees are fully informed of their rights and of the complete posting process, including the medical requirements and the possibility for an employee to seek a third opinion in a timely fashion. The wording of the "Absolute medical requirements" should be changed to reflect a high medical standard for posting to Afghanistan, while not instituting a complete ban. Evidence showed that CIDA officials were not familiar with HC's medical assessment process, or the existence of *FSD9*. The evidence tendered by the respondents did not demonstrate any real knowledge regarding accommodation measures, nor the *CHRA*. Therefore, the need for training is justified. I simply differ on the length of time to complete the training requested by the Commission. The Commission requested that the training be completed within six months. I disagree. I understand that it is better to set a deadline but I find that a six month delay is unreasonable for such large organizations like CIDA and HC. I am more inclined to say within a reasonable time frame not exceeding a year.

[182] Therefore, I order the following, in accordance with what was requested by the Commission:

(a) That HC amend the *OHAG* to remove any references in the *Afghanistan Guidelines* to "Absolute medical requirements", and to instead adopt an approach that simply lists factors that are to be considered as part of an overall individualized assessment, with an express recognition that no single factor will necessarily be determinative;

(b) That HC amend its policies, or create a new policy, requiring that in cases where a treating specialist physician provides an opinion on employee fitness that differs from the initial opinion of the OHMO, and HC does not agree with the specialist, HC will:

(i) consult with the treating specialist to explore the bases for the different opinions;

(ii) if still not in agreement, promptly offer to send the employee for an independent medical examination by a specialist in the appropriate field;

(iii) if dissatisfied with the independent specialist, consult with the independent specialist to explore the bases for the different opinions, and

(iv) ultimately, if no resolution has been reached, place before the employing department full, objective and impartial descriptions of all the recommendations as to fitness rendered by the various physicians who were consulted during the process.

(c) That HC and CIDA amend their policies, or create a new policy, to clearly state that the *CHRA* and the "duty to accommodate to the point of undue hardship" must be considered and applied whenever recommendations or decisions are being made with respect to the medical fitness of civilian employees for postings, regardless of where those postings might be;

(d) That CIDA amend its policies, or create a new policy, so as to put a mechanism in place to ensure that all employees who apply for postings (and for temporary duty assignments, in the case of Afghanistan) are first made aware:

(i) that all successful candidates will be required to undergo a pre-deployment medical assessment by HC, or by another provider if CIDA deems it appropriate;

(ii) that if they receive a negative assessment, they will have the right under *FSD9* to submit a written opinion from a treating physician to HC which will then provide a reassessment to CIDA, possibly after offering the employee an opportunity to undergo an independent medical examination;

(iii) that if HC does not request an independent medical opinion, CIDA may itself offer the employee an opportunity to undergo an independent medical examination, the results of which will be provided to HC for further assessment;

(iv) ultimately, the final decision about whether to put a candidate forward for head of mission concurrence lies with CIDA, and not with HC or any other department.

(e) That HC provide training to all managers and OHMOs involved in conducting pre-deployment medical assessments on:

(i) The application of the *FSD9* to their work, and

(ii) The application of the *CHRA* to their work, including insofar as it relates to legal principles relating to the assessment of health and safety risks as a possible form of undue hardship;

(f) That CIDA provide training to all managers and staff involved in making decisions about postings and temporary duty assignments on:

(i) The application of the *FSD9* to their work, and

(ii) The application of the *CHRA* to their work, including insofar as it relates to the assessment of health and safety risks as a possible form of undue hardship;

[183] That the steps to be taken under subparagraphs (a) to (f), above, be completed within one year of the Tribunal's decision.

[184] I retain jurisdiction and remain seized of the matter until the parties confirm that the terms of this order, and of any further orders, have been implemented.

Signed by

Sophie Marchildon
Administrative Judge

OTTAWA, Ontario
September 23, 2011

Canadian Human Rights Tribunal

Parties of Record

Tribunal File: T1466/1210

Style of Cause: Bronwyn Cruden v. Canadian International Development Agency & Health Canada

Decision of the Tribunal Dated: September 23, 2011

Date and Place of Hearing: January 17 to 21, 2011
January 25 to 28, 2011
February 1, 3 and 4, 2011

Ottawa, Ontario

Appearances:

Alison Dewar and Erin O'Hara, for the Complainant

Brian Smith and Jonathan Bujeau, for the Canadian Human Rights Commission

Alex Kaufman and Max Binnie, for the Respondents

APPENDIX 1

National Joint Council

Foreign Service Directives

Notice to the reader: This document is no longer in effect. It has been archived online and is kept purely for historical purposes.

This directive is now hosted by the National Joint Council, where it was co-developed by participating bargaining agents and public service employers. The document **has not** been changed and continues to apply.

Other related documents

- Foreword & Introduction
  - Foreword
  - Introduction
- Part I - General
  - FSD 1- Short title
    - Effective date
  - FSD 2 - Interpretation
  - Appendix A - Declaration
  - Appendix B
  - FSD 3 - Application
  - Appendix A - Short-term relocation outside Canada and the USA
    - (a) Housing and living allowances
    - (i) Housing
    - (ii) Meal cost assistance
    - Special circumstances
    - (iii) Laundry and dry-cleaning allowance
    - (b) Commuting assistance
    - (c) Incidental relocation expenses
    - (d) Storage and shipment of household effects
    - (e) Weekend travel home
    - (f) Telephone calls home
    - (g) Post differential allowance
    - (h) Employee accompanied by dependants
  - Appendix B
    - AND
    - Application
    - Effective Date
  - FSD 4 - Accountable advances
    - Introduction
- Part II - Pre-Posting
  - FSD 9 - Medical and dental examinations
    - Introduction
  - Appendix - Posts for which Pre-posting Dental Examinations are Required
    - April 1, 2000
- FSD 10 - Posting loan

National Joint Council

Part II - Pre-Posting

FSD 9 - Medical and dental examinations

Introduction

The employer wishes to ensure through preventive services that employees and their dependants are medically fit for service abroad. Examinations for this purpose will normally be provided by Health Canada. Where Health Canada is not in a position to conduct the examinations or the deputy head authorizes use of a private facility, the employer will pay the costs of related expenses for examinations conducted at a private facility. Health Canada has been delegated authority to amend the Appendix to this directive as and when required.

Directive 9

9.01 Prior to each posting an employee and each dependant who

(a) is to reside with the employee at a post, or

(b) is to be in full-time attendance at an educational institution outside of Canada,

shall have the right to a medical examination, or may as a condition of posting be required to undergo a dental and/or a medical examination which shall include specialist services, psychological assessments, x-rays and immunization against diseases as required. The posts for which pre-posting dental examinations are required are listed in the Appendix to this directive, and are indicated in the Foreign Affairs and International Trade's monthly Schedules to Foreign Service Directives and Meal Rates.

Instruction

Where a dental examination is required, such dental examination shall include an assessment of any special dental treatment which may be required prior to or during the employee's assignment.

9.02 The dental examination, medical examination and related hospitalization and any special examination required shall be administered in the manner prescribed by Health Canada at a Canadian government facility. In special circumstances, the deputy head may authorize the use of a private facility.

Instruction

The employer shall pay the cost of the medical and dental examinations at a private facility only where:

(a) Health Canada is not in a position to conduct such examinations, or

(b) the deputy head considers a private facility to be more appropriate.

9.03

(a) An assessment as to fitness for duty prepared by Health Canada shall be submitted to the deputy head with respect to any medical examination administered pursuant to this directive.

(b) An assessment as to the requirement for dental treatment which is not available at the employee's post shall be submitted by Health Canada to the deputy head with respect to any dental examination administered pursuant to this directive.

Instruction

The assessment as to fitness for duty prepared by Health Canada does not contain confidential medical information. Confidential medical information is available to an employee under the Privacy Act, or may be obtained informally by an employee from Health Canada.

9.04 Whenever medical matters are at issue, employees shall have the right to have their personal physician submit a written medical opinion to Health Canada. That department shall review such opinion and submit another assessment as to fitness for duty to the deputy head, taking into consideration the medical opinion of the employee's physician.

9.05

(a) Where a variance in the written medical opinion submitted pursuant to Sections 9.03(a) and 9.04 is significant, Health Canada may request a third and independent written medical opinion which shall be taken into consideration in resubmitting an assessment as to fitness for duty to the deputy head.

(b) Where the deputy head is not satisfied with the assessment as to fitness for duty and a third and independent written medical opinion has not been obtained by Health Canada, the deputy head may request that a third and independent written medical opinion be submitted to Health Canada, which shall take such opinion into consideration in forming an assessment as to fitness for duty

9.06 In arriving at a decision concerning the assignment of an employee, the deputy head shall give consideration to the medical and dental assessments submitted pursuant to Sections 9.03, 9.04 and 9.05.

Instruction

Where, after taking into account any medical assessment as to fitness for duty provided, the deputy head determines that an employee cannot be posted for medical reasons, the employee shall be so informed.

9.07 The deputy head shall authorize:

(a) payment of actual and reasonable medical examination expenses, and/or

(b) payment of actual and reasonable dental examination expenses for examinations conducted as a condition of posting to those posts listed in the Appendix to this directive,

Arusha, Tanzania

Baghdad, Iraq

Bamako, Mali

Beijing, P.R. China

Belgrade, Serbia

Bratisllavia,Slovakia

Bridgetown, Barbados

Bucharest, Romania

Chandaghar, India

Chonquing, China

Colombo, Sri Lanka

Conakry, Guinea

Cotonou, Benin

Dakar, Senegal

Damascus, Syria

Dar-es-Salaam, Tanzania

Dhaka, Bangladesh

Doula, Cameroun

Georgetown, Guyana

Guangzhou,China

Hanoi, Vietnam

Harare, Zimbabwe

Havana, Cuba

Ho Chi Minh City, Vietnam

Islamabad, Pakistan

Kandy, Sri Lanka

Katmandu, Nepal

Kigali, Rwanda

Kingston, Jamaica

Kinshasa, Zaire

Kyiv, Ukraine

Lagos, Nigeria

La Paz, Bolivia

Libreville, Gabon

Lusaka, Zambia

Managua, Nicaragua

Mumbai, India

Nairobi, Kenya

Niamey, Niger

Ouagadougou, Burkina-Faso

Panama City, Panama

Port-au-Prince, Haiti

Porto Nuovo, Benin

Prague, Czech Republic

Pristina, Kosovo

Quetta, Pakistan

Quito, Ecuador

Rabat, Morocco

San Jose, Costa Rica

San Salvador, Salvador

Santo Domingo, Dominican Republic

Sarajevo, Bosnia

Shanghai, P.R. China

Tegucigalpa, Honduras

Tehran, Iran

Thies, Senegal

Tirana, Albania,

Tripoli, Libya

Tunis, Tunisia

Warsaw, Poland

Yaounde, Cameroon

Zagreb, Croatia

Notwithstanding the provisions of Section 107 of the *Public Service Labour Relations Act*, revisions to this Appendix shall not constitute a change in terms and conditions of employment for employees subject to the Foreign Service Directives. (revised April 21, 2006)

FSD 10 - Posting loan

Introduction

This directive provides for a loan to employees, on an as-needed basis, normally so that they may purchase items needed at post or to otherwise facilitate the posting. Items may include clothing and foodstuffs and a private motor vehicle, for the employee's use at a post. The intent of FSD 10 is not to fund personal investments.

The employee will be required to identify the purpose of the loan.

Directive 10

Maximum Loan Amount

10.01 Subject to the discretion of the deputy head and the limitations and conditions of this directive, an employee may be granted an interest-bearing posting loan in an amount not exceeding the lesser of the following amounts:

(a) fifty per cent of the employee's gross annual salary;

(b) $35,765, (or such amount as shall be established annually on April 1st in accordance with

National Joint Council

NJC Directives

These Directives were developed in partnership by employer and bargaining agent representatives at the National Joint Council. Their provisions form part of the collective agreements of the participating parties under the By-Laws of the National Joint Council. The provisions also apply to persons not covered by collective agreements as indicated in the Directive or by employer policy.

NJC Directives

- **Bilingualism Bonus Directive** - June 1, 1993
- **Commuting Assistance Directive** - June 1, 2010
  - Archived version: April 1, 2005
  - Archived version: April 1, 1994
- **First Aid to the General Public - Allowance for Employees** - April 1, 1982
- **Foreign Service Directives** - April 1, 2009
  - Archived version: June 1, 2003
- **Isolated Posts and Government Housing Directive** - August 1, 2007
  - Archived version: April 1, 2003
- **Motor Vehicle Operations Directive** - April 1, 1995
- **NJC Relocation Directive** - April 1, 2009
  - Archived version: April 1, 2005
- **Occupational Health and Safety Directive** - April 1, 2008
  - Archived version: January 1, 2006
  - Archived version: Committees and Representatives Directive - April 1, 2005
  - Archived version: Refusal to Work Directive - January 1, 1994
- **Pesticides Directive** - November 1, 1993
- **Public Service Health Care Plan Directive** - April 1, 2006
- **Travel Directive** - April 1, 2008
  - Archived version: October 1, 2002
- **Uniforms Directive** - July 1, 1997
- **Work Force Adjustment Directive** - June 1, 2006

The Directives with the exception of the Foreign Service Directives may also be found in the two volume set entitled "NJC AGREEMENTS" which is available from Publishing and Depository Services at:

- Telephone: 1-800-635-7943 (Canada and USA)
- Telephone: 613-941-5995
- Fax: 1-800-565-7757 (Canada and USA)
- Fax: 613-954-5779

- Email: publications@pwgsc.gc.ca
- Web site: http://publications.gc.ca
- Mail:
  Public Works and Government Services Canada
  Government Information Services Branch
  Ottawa, ON, Canada K1A 0S5

Related directives or policies:

- NJC Directives or Policies deemed part of Collective Agreements
- Directives or policies which are agreed upon but not deemed part of Collective Agreements

- Search Directives

National Joint Council

NJC Directives

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  - Archived version: Refusal to Work Directive - January 1, 1994
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  Public Works and Government Services Canada
  Government Information Services Branch
  Ottawa, ON, Canada K1A 0S5

Related directives or policies:

- NJC Directives or Policies deemed part of Collective Agreements
- Directives or policies which are agreed upon but not deemed part of Collective Agreements

- Search Directives

National Joint Council

Part II - Pre-Posting

FSD 9 - Medical and dental examinations

Introduction

The employer wishes to ensure through preventive services that employees and their dependants are medically fit for service abroad. Examinations for this purpose will normally be provided by Health Canada. Where Health Canada is not in a position to conduct the examinations or the deputy head authorizes use of a private facility, the employer will pay the costs of related expenses for examinations conducted at a private facility. Health Canada has been delegated authority to amend the appendix to this directive as and when required.

Directive 9

9.01 Prior to each posting an employee and each dependant who

(a) is to reside with the employee at a post, or

(b) is to be in full-time attendance at an educational institution outside of Canada,

shall have the right to a medical examination, or may as a condition of posting be required to undergo a dental and/or a medical examination which shall include specialist services, psychological assessments, x-rays and immunization against diseases as required. The posts for which pre-posting dental examinations are required are listed in the appendix to this directive, and published on the Department of Foreign Affairs and International Trade's website.

Where an employee is posted to a hardship post, as specified in FSD 58 - Appendix, the cost of a pre-posting eye examination will be reimbursed for employees and their dependant(s). Pre-posting eye examinations are not mandatory for the issuance of a Posting Confirmation Form (or equivalent).

Instruction

Where a dental examination is required, such dental examination shall include an assessment of any special dental treatment which may be required prior to or during the employee's assignment.

9.02 The dental examination, medical examination and related hospitalization and any special examination required shall be administered in the manner prescribed by Health Canada at a Canadian government facility. In special circumstances, the deputy head may authorize the use of a private facility.

Instruction

The employer shall pay the cost of the medical and dental examinations at a private facility only where:

(a) Health Canada is not in a position to conduct such examinations, or

(b) the deputy head considers a private facility to be more appropriate.

9.03

(a) An assessment as to fitness for duty prepared by Health Canada shall be submitted to the deputy head with respect to any medical examination administered pursuant to this directive.

(b) An assessment as to the requirement for dental treatment which is not available at the employee's post shall be submitted by Health Canada to the deputy head with respect to any dental examination administered pursuant to this directive.

Instruction

The assessment as to fitness for duty prepared by Health Canada does not contain confidential medical information. Confidential medical information is available to an employee under the *Privacy Act*, or may be obtained informally by an employee from Health Canada.

9.04 Whenever medical matters are at issue, employees shall have the right to have their personal physician submit a written medical opinion to Health Canada. That department shall review such opinion and submit another assessment as to fitness for duty to the deputy head, taking into consideration the medical opinion of the employee's physician.

9.05

(a) Where a variance in the written medical opinion submitted pursuant to Sections 9.03 (a) and 9.04 is significant, Health Canada may request a third and independent written medical opinion which shall be taken into consideration in resubmitting an assessment as to fitness for duty to the deputy head.

(b) Where the deputy head is not satisfied with the assessment as to fitness for duty and a third and independent written medical opinion has not been obtained by Health Canada, the deputy head may request that a third and independent written medical opinion be submitted to Health Canada, which shall take such opinion into consideration in forming an assessment as to fitness for duty

9.06 In arriving at a decision concerning the assignment of an employee, the deputy head shall give consideration to the medical and dental assessments submitted pursuant to Sections 9.03, 9.04 and 9.05.

Instruction

Where, after taking into account any medical assessment as to fitness for duty provided, the deputy head determines that an employee cannot be posted for medical reasons, the employee shall be so informed.

9.07 The deputy head shall authorize:

(a) payment of actual and reasonable medical examination expenses, and/or

(b) payment of actual and reasonable dental examination expenses for examinations conducted as a condition of posting to those posts listed in the appendix to this directive,

and, where appropriate,

(c) payment of travelling expenses, as defined in FSD 2.01(cc), which means expenses for air transportation and local transportation to and from airports at the points of departure and destination and, when authorized in advance by the deputy head, for accommodation, meals and local transportation to and from the airport for a necessary stopover, where it is not possible or practicable to arrange an itinerary which will permit continuing travel to the approved destination.

9.08 Where the use of a private facility is authorized by the deputy head, the written opinion and professional account shall be submitted to Health Canada and the account shall be verified and recommended for payment when the quality of the written opinion is satisfactory to Health Canada.

9.09 Where it is necessary for a medical or dental examination authorized under this directive to be conducted during normal working hours, the employee shall be considered to be on duty for the period required for such examination.

9.10 Where an employee is required to undergo a medical or dental examination authorized under this directive and it is not possible to conduct such an examination during scheduled working hours, the deputy head may authorize overtime compensation as provided for in the applicable collective agreement for the period required for such examination.

9.11 Expenses incurred by the employee pursuant to Sections 9.02 and 9.04 shall not be a charge against the employee's health or hospitalization insurance plan.

Instruction

This directive also covers a cross-posting.

Guideline

Provisions for preventive medical services expenses other than pre-posting ones are covered in FSD 38 - Preventive medical services expenses.

Appendix
Posts for which Pre-posting Dental Examinations are Required

April 1, 2009

Abidjan, Ivory Coast
Abuja, Nigeria
Accra, Ghana
Addis Ababa, Ethiopia

Algiers, Algeria
Amman, Jordan
Baghdad, Iraq
Bamako, Mali
Beijing, P.R. China
Belgrade, Serbia
Bratisllavia, Slovakia
Bridgetown, Barbados
Bucharest, Romania
Chandaghar, India
Chonquing, China
Colombo, Sri Lanka
Cotonou, Benin
Dakar, Senegal
Damascus, Syria
Dar-es-Salaam, Tanzania
Dhaka, Bangladesh
Georgetown, Guyana
Guangzhou,China
Hanoi, Vietnam
Harare, Zimbabwe
Havana, Cuba
Ho Chi Minh City, Vietnam
Islamabad, Pakistan
Katmandu, Nepal
Kigali, Rwanda
Kingston, Jamaica
Kinshasa, Zaire
Kyiv, Ukraine
Lagos, Nigeria
La Paz, Bolivia
Libreville, Gabon
Lusaka, Zambia
Managua, Nicaragua
Mumbai, India
Nairobi, Kenya
Niamey, Niger
Ouagadougou, Burkina-Faso
Panama City, Panama
Port-au-Prince, Haiti
Prague, Czech Republic
Pristina, Kosovo
Quetta, Pakistan
Quito, Ecuador
Rabat, Morocco
San Jose, Costa Rica
San Salvador, Salvador
Santo Domingo, Dominican Republic
Sarajevo, Bosnia
Shanghai, P.R. China
Tegucigalpa, Honduras
Tehran, Iran
Tirana, Albania,
Tripoli, Libya

Tunis, Tunisia
Warsaw, Poland
Yaounde, Cameroon
Zagreb, Croatia

Notwithstanding the provisions of Section 107 of the *Public Service Labour Relations Act*, revisions to this Appendix shall not constitute a change in terms and conditions of employment for employees subject to the Foreign Service Directives.

FSD 10 - Posting loan

Introduction

This directive provides for a loan to employees, on an as-needed basis, normally so that they may purchase items needed at post or to otherwise facilitate the posting. Items may include clothing and foodstuffs and a private motor vehicle, for the employee's use at a post. The intent of FSD 10 is not to fund personal investments.

The employee will be required to identify the purpose of the loan.

Directive 10

Maximum Loan Amount

10.01 Subject to the discretion of the deputy head and the limitations and conditions of this directive, an employee may be granted an interest-bearing posting loan in an amount not exceeding the lesser of the following amounts:

(a) fifty per cent of the employee's gross annual salary; and

(b) $37,638, (or such amount as shall be established annually on April 1st in accordance with the methodology agreed to in the National Joint Council Committee on Foreign Service Directives). (revised April 1, 2009)

Eligibility

10.02 A posting loan may be granted to an employee:

(a) who is notified officially in writing of an impending assignment to a post; or

(b) who is on assignment at a post where a posting loan was not granted in anticipation of that assignment; and/or

(c) who has been granted a posting loan and is notified officially in writing of an impending assignment from one post to another post.

Instructions

1. A posting loan is normally granted in advance of posting or during the first twelve months of an assignment at a post.

APPENDIX 2

Health Canada Santé Canada

Your health and safety... our priority. *Votre santé et votre sécurité... notre priorité.*

Occupational Health Assessment Guide

Revised February 2010

Canada

Health Canada is the federal department responsible for helping Canadians maintain and improve their health. *We assess the safety of drugs and many consumer products, help improve the safety of food, and provide information to Canadians to help them make healthy decisions. We provide health services to First Nations people and to Inuit communities. We work with the provinces to ensure our health care system serves the needs of Canadians.*

Published by authority of the
Minister of Health

Également disponible en français sous le titre :
Guide de l'évaluation de la santé au travail

This publication can be made available on request on
diskette, large print, audio-cassette and braille.

© Her Majesty the Queen in Right of Canada, represented by the Minister of Health Canada, 2008

Occupational Health Assessment Guide

Revised February 2010

This guidebook is intended solely for the use of the Occupational Health Professionals of Health Canada under the Public Service Health Program. The guidelines apply to occupational health assessments for only the federal jobs described in this OHAG Guidebook.

NOTICE

OCCUPATIONAL HEALTH ASSESSMENT GUIDE (OHAG)

The Occupational Health Assessment Guide (OHAG) has been developed by the Workplace Health and Public Safety Programme (WHPSP) for the exclusive use of its health care professionals. These include Occupational Health Nurses (OHNs), Occupational Health Medical Officers (OHMOs), and physicians contracted by WHPSP to perform occupational health assessments (e.g., pre-employment, periodic, fitness to work, special requests) on workers in jobs with specific risks to health and safety.

The intention of the OHAG is to provide a guide for health professionals on which to base their occupational health assessments. No manual or set of standards can replace judgement based on the examiner's knowledge of the individual, the job, and the circumstances under which the job will be carried out.

WHPSP accepts no responsibility for any use of this document other than use for its intended purposes, by intended users.

SECTION 1

GENERAL INFORMATION

SECTION 1

GENERAL INFORMATION

PREAMBLE

The intention of the Occupational Health Assessment Guide is to guide the examiner to reach decisions and not to provide a set of rigid standards. No manual or set of standards can replace judgement based on the examiner's knowledge of the individual, the job, and the circumstances under which the job will be carried out.

I PURPOSE

This Guide is directed to examiners who performs occupational health assessments on behalf of the Workplace Health and Public Safety Programme (WHPSP). These would include assessments, tests, and immunizations where required for all employees including visiting scientists, students, term and casual employees. The Guide is designed to provide:

1. a summary of considerations that should be borne in mind when determining the medical fitness of a particular individual for his or her duties;
2. assistance to the assessing Occupational Health Medical Officers (OHMOs) and Occupational Health Nursing staff (OHNs) who, while maintaining confidentiality, advise organizations on the fitness of the individual to carry out the tasks of the job and to define any limitations;
3. guidance concerning the periodic occupational health assessments of employees exposed to specific hazards; and
4. recommendations concerning immunization and screening related to the job.

II MEDICAL STANDARDS

In deriving the standards outlined in this guide, the reviewing committee relied on the principles established by the *Canadian Task Force on Periodic Health Examinations* and by the *Health Surveillance of Workers: The Report of the Task Force on Health Surveillance of Workers*, (Department of National Health and Welfare), March/April 1986.

The standards contained in this guide are deliberately worded in such a way as to require the exercise of sound medical expertise, considering the requirements of the job and current occupational health practice. When necessary, a description of the job is included.

Medical standards are to be distinguished from physical and mental ability.

In a situation where physical abilities testing is required, the role of the OHMO will be to assess whether the candidate can safely undergo such testing. Arrangements for specialized tests and/or consultation may be required.

Standards are laid down for preplacement and periodic medical assessments. Please note that all/any Chapters that apply to an occupational category are to be consulted. When the requirements of more than one chapter apply, all standards will be applicable. An employee's inability to meet these standards does not necessarily preclude continuing employment as other factors may be taken into consideration. The OHMO should discuss the outcome of the

assessment with the employee. If necessary and with the employee's consent, discussions should be arranged with the employer to determine appropriate action.

When an individual is unable to meet the occupational health medical requirements of a given position as outlined in this Guide, the employing department will, to the point of undue hardship, undertake further medical testing and/or other accommodation, as part of its duty to make every effort up to the point of undue hardship to accommodate the individual. Consideration of this further medical testing and/or accommodation will be done in consultation with the regional Health Canada OHMO.

Where a person does not meet the medical requirements and the matter is not resolved by further medical testing, if done, and/or by accommodation, the employing department will undertake to conduct a practical test, if it does not impose undue hardship on the employing department.

The Treasury Board's "Occupational Health Evaluation Standard" forms the basis upon which the OHAG is developed."

An employee may show a progressive decline in ability to meet certain standards. Such a decline may lead the assessing officer to feel that the employee may soon be unfit for the job. Under these circumstances, the employer should be advised of the situation and in consultation with the employee, the employer, and the WHPSP assessor, to determine appropriate action.

III PREPLACEMENT / PERIODIC ASSESSMENTS

1. Preplacement assessments require that the OHMO be familiar with the employee's duties and work environment.

2. Candidates for positions should not be examined or assessed with the object of determining whether or not a candidate is in a perfect state of health. The assessment should be used to determine whether the candidate can meet the essential requirements of the position. The diagnosis, adequacy of treatment, medical control, and the state of any resulting or residual impairment or limitation are all factors that will be considered in making an assessment determination. Alternatives or accommodations to enable the individual to do the job may be suggested. These suggestions are nonbinding and may be discussed with the parties involved. It is up to the employer to make the final decision regarding the placement.

   Where an individual does not meet the OHAG requirements and continues not to meet these requirements upon further medical testing identified in consultation with the OHMO, the employing department will make every effort, up to the point of undue hardship, to accommodate the individual. If the matter is not resolved by further testing, if done, and/or by accommodation, the employing department will undertake to conduct a practical test, if it does not impose undue hardship on the employing department.

   The purpose of the practical testing is to determine whether the individual can safely and efficiently perform the critical tasks associated with the relevant position. Practical testing may also assist the employing department to assess the need and scope of accommodation.

   The duty to accommodate is not exhausted at any particular stage of the assessment process. Accommodation may occur at any stage. The responsibility for medical testing,

accommodation and practical testing belongs to the employing department. Fulfillment of this responsibility should as a general rule involve communication and consultation with Health Canada's Occupational Health Medical Officer(s)."

3. The employer must consider its obligation to protect the safety and health of all employees under the *Canada Labour Code Part II*, as well as respect the policies, legislation, and directives related to human rights, employment of the disabled, etc.

   A document entitled *Criteria Adopted by the Human Rights Commission*, prepared by the Canadian Human Rights Commission for the guidance of employers, is enclosed as Annex "A" for information purposes.

4. The *Canadian Human Rights Act* makes it an offence for an employer to refuse to employ, or to continue to employ, any person on the basis of a prohibited ground of discrimination including physical disability. The requirements set down by the employer will not however, be considered discriminatory if the employer can establish that such requirements are bona fide or valid occupational requirements. Accommodation must be provided to the point of undue hardship.

5. The Treasury Board, as employer, establishes Occupational Safety and Health (OSH) policies and standards for the Public Service (authority is *Financial Administration Act*). In addition to this, WHPSP provides advice to the Treasury Board on health matters and also acts as medical advisor to departments. Under delegation from the Treasury Board, Workplace Health and Public Safety Programme of Health Canada has the responsibility to carry out occupational health assessments of Public Service employees. It is important to note that as a minimum, employer OSH policies must meet the requirements of the *Canada Labour Code Part II*. Moreover, all policies are subject to the Canadian *Charter of Rights and Freedoms* and the *Canadian Human Rights Act*.

   The following policies, standards and directives relate to occupational health assessments:

   Treasury Board Manual

   Occupational Health Evaluation Standards
   Isolated Post Directive
   Foreign Services Directive
   Injury on Duty Leave

   Public Service Commission Staffing Manual

   Staffing Policies and Guidelines
   Selection Standards

IV HEALTH ASSESSMENT CATEGORIES

The three health assessment categories are as follows:

Category I A confidential personal health declaration or questionnaire completed by the employee and reviewed by an appropriate health professional.

Category II A confidential health questionnaire completed by the employee and reviewed with a nurse, who may also perform certain basic tests depending on the type

of work and particular hazards. Clinical histories of concern will be brought to the attention of the OHMO, who will determine whether follow-up action is necessary. A qualified technician may carry out some of these procedures, including the completion of special reports, but does not administer the general health questionnaire. The final assessment whether the employee meets medical requirements is made by the Health Canada WHPSP assessor.

Category III A confidential health questionnaire, completed by the employee and reviewed with a physician. This is followed by a full clinical history and physical examination, and special tests. The final assessment whether the employee meets medical requirements is made by the Health Canada WHPSP assessor.

Additional assessments may be requested at the discretion of the assessor.

V OCCUPATIONAL AND ADVISORY REQUIREMENTS

1. In the sections of this guide dealing with Occupations and Environments, the following terms are defined.

   Occupational requirements: standards believed to be necessary to do the job in a safe, efficient, and an effective manner.

   Advisory requirements: refer to health conditions or characteristics which may influence the ability to do the job. The degree of this influence in any specific case will be assessed by the OHMO.

2. Within occupational groups there may be a variety of jobs and environments. The OHMO or the OHN may use discretion to determine whether an assessment is required and the contents of that assessment for a given employee.

VI FITNESS TO WORK EVALUATION

A Fitness to Work Evaluation (FTWE) is a medical assessment of an employee with respect to a specific job under specific working conditions. It is designed to determine if an employee is medically fit to safely perform the tasks of a specific job.

A FTWE can be requested by the employer in a variety of situations including:

1. the employee has been on medical leave for some time, and a return to work date has not been established,

2. the employee is returning to work after a period of medical leave, and there is a concern regarding his/her fitness for duties, or

3. an employee appears to have difficulty in performing the duties required by his/her position, and there may be a medical explanation.

These assessments are carried out using a variety of tools including: clinical occupational history and physical assessments, request for reports from care providers, discussions with care providers, clinical investigations including formal functional capacity assessments and

referrals for additional assessment. The particular tools used for any given case will vary depending on the nature of the problem, the duties performed, geographic factors, etc.

Following completion of the assessment, the employer (and the employee) will be provided with a written report concerning the employee's fitness for duties. In addition to this report, there are a number of outcomes which are not reported to the employer, including: identification of previously undiagnosed conditions, recommendations for additional or alternative treatments or investigation and often reassurance of the employee that his/her health problems do not preclude continuing in his/her current position. The employee may be referred for Employee Assistance Program (EAP) services.

The OHMO can be contacted for information on how to arrange a Fitness to Work Evaluation.

VII CONFIDENTIALITY

1. The examiner's duty to maintain confidentiality, remains a fundamental principle. In providing advice to employers, the assessing officer should be careful to disclose only the information necessary to permit the employer to take appropriate action.

2. It may be in the interest of the employee for the assessing officer to provide to the employer certain medical information which may be essential if the employee is, for example, to receive some form of special consideration. In cases of this sort, the OHMO should ensure that he/she has the employee's consent to disclose this information.

VIII AMENDMENT PROCESS

This Guide will be reviewed on a regular basis. Recommendations for amendment are welcome and can be made as outlined in - Request for Review of Item/Issue/Section in the Occupational Health Assessment Guide and Required Forms.

Chairperson - or - National Medical Advisor
Occupational Health Assessment Guide (OHAG) Committee
Workplace Health and Public Safety Programme
Health Canada
1505 Barrington Street, Maritime Centre
Suite 1817
Halifax, NS
B3J 3Y6

CRITERIA ADOPTED BY THE CANADIAN HUMAN RIGHTS COMMISSION (reviewed by the Canadian Human Rights Commission)

1. *Are the reasons for the decisions relevant to the specific job in question?*

   The decision must not be based on general requirements which are broadly applied across a whole category or chain of positions. Rather, the candidate for a specific position must be assessed against the specific requirements of that job.

2. *Are the reasons for the decision relevant to the specific person being considered?*

   a. The decision must not be based on general assumptions about all persons having a given characteristic or condition. Rather, an assessment must be made of the particular individual's ability to perform job-related tasks safely and efficiently.

   b. General rules which eliminate all epileptics or all hearing-impaired persons, or all the members of any other category of disability, make a premature judgement of inability without regard for the actual job worthiness of the individual.

   c. For a refusal to hire to be nondiscriminatory, the decision must be based on the abilities or potential abilities of the individual.

3. *Has the decision taken into account the possibility of alternate methods of accomplishing the tasks?*

   The decision will be found to be discriminatory if it is insisted that the tasks making up the job be performed only in a certain way, when reasonable alternate methods of performing the tasks could be chosen.

4. *Has the decision been based on the candidate's skill capability, knowledge and experience?*

   The decision that a person is not qualified to do a job (even if "accommodation to the point of undue hardship" was provided) must be supported by evidence that:

   a. the essential skills, capabilities, knowledge and experience required to perform the tasks have been identified and separated from nonessential qualifications;

   b. an assessment of the person's skills, capabilities, knowledge, and experience has been carried out in terms of what the person can do, and not in terms of general assumptions about his or her special needs;

   c. physical requirements for a position (visual and aural acuity, absence of certain health conditions, etc.) not met by the candidate can be demonstrated to be validly related to the safe and efficient performance of the job.

5. *Could accommodation to the point of undue hardship for the person's disability have been made?*

   a. It is not sufficient to establish that the individual cannot meet all of the requirements of the position as it is usually presented to employees without special needs.

   b. In cases where accommodation to the point of undue hardship is feasible, the decision not to employ must be based on a judgement that the candidate does not have the qualifications to perform the job even if accommodation to the point of undue hardship were made for his or her disability. The requirement is to accommodate to the point of undue hardship. Practical testing must be considered by the employer.

c. The decision not to make accommodation for the candidate's disability must be supported by evidence that either:

i. the job and/or the work environments are such that no method of accommodation exists; or

ii. making accommodation for the candidate's special needs would impose undue hardship on the employer; or

iii. making accommodation would entail a predictable safety hazard for the employee, co-workers, and the public or present a risk to property.

6. *Are the reasons for the decision related to safety?*

a. The decision to deny an opportunity because the individual's physical condition is such that his or her employment in a particular job would pose a risk to the safety or health of fellow employees or the public must be supported by evidence that:

i. the risk has been evaluated in terms of the probability of an accident. In evaluating probability, consideration must be given to whether the risky situation arises on a significantly regular basis out of normal working conditions or only out of unusual or hypothetical circumstances;

ii. the risk has been evaluated in terms of the severity of the consequences of an accident;

iii. the risk has been evaluated as significantly greater than the risk that would be entailed if the employee did not have the particular special needs;

iv. the risk has been shown to be related to the specific condition of the individual.

b. Where the decision is made because the individual's physical condition is such that his or her employment in a particular job would compromise his or her own safety or health, in addition to I, ii, iii, and iv, it must be established that: exposure of the individual to the risk would have probable consequences which would entail a disruption of the employer's business.

c. It is not sufficient, in other words, to establish that there is a risk to the candidate unless that risk would have likely consequences for the employer's business. This criterion, strongly supported by those representatives of persons with special needs consulted, is intended to allow candidates with special needs the dignity of risk. Many individuals with special needs choose to take greater than normal risks in their daily lives merely by crossing the street or turning on a household appliance. They should similarly be allowed to determine for themselves the degree of risk to which they choose to expose themselves in employment situations, except where their choice entails a likely disruption of the employer's business. It is the responsibility of the employer to inform the individual of the risk if the condition of the person with special needs could be aggravated by the job itself.

7. *Is the nature of the job such that certain physical capabilities are inherent in the performance of the tasks?*

A bona fide occupational requirement will exist where it can be established by the employer that the very nature of the job determines that given physical capabilities are self-evident.

APPENDIX 3

Medical Evaluation Guidelines for Posting, Temporary Duty or Travel to Afghanistan (Hardship Post level 5 with Hostility Bonus): July 31, 2009

Deployment to Afghanistan requires its own medical evaluation guidelines due to its current wartime status. Kabul and Kandahar are level 5 hardship posts each with a hostility bonus due to ongoing active hostilities.

Other special considerations for Afghanistan include:

1) The duration of posting may vary from 4 months to 1 year or longer: Medical evaluation is recommended.

2) Employees staying in Afghanistan for 2 weeks to < 4 months are usually employees assigned to temporary duty (TD): Medical evaluation is recommended.

3) Employees, whose stay in Afghanistan is <2 weeks, should be issued the "Dear Client" letter in Annex 1.

4) All travelers to Afghanistan are advised to obtain travel medicine consultations, and to provide their blood type for obtaining their "civilian dog tags". These "civilian dog tags" are issued to all civilians travelling to Afghanistan.

Canadian-based staff CBS) on posting for 1 year or more are covered under the Foreign Service Directives (FSDs).

CBS who are posted to Afghanistan between 4 months and 1 year, are usually covered under the FSD-3 - Appendix A.

Employees on temporary duty replace the CBS while they are on leave from the post. Canadian Federal Government employees, assigned or travelling for less than 4 months, are covered under travel directives.

Departments are requested to provide employees leaving for Afghanistan for **less than 2 weeks** with the Health Canada letter listed in **Annex 1,** as soon as such a trip is being considered. Employees who have medical conditions and/or are under active medical care are requested to discuss their condition and the advisability of the planned trip with their treating physician.

Federal Government employees whose assignment to Afghanistan is for **at least 2 weeks or longer** (either on temporary duty or posting) should undergo a medical evaluation to determine if they meet the medical requirements for the assignment.

Some employees require medical clearance for a single assignment temporary duty. Other employees may be sent repeatedly on temporary duty. In this case, medical clearance is valid for 12 months. If during this time period, new medical conditions arise or an employee becomes pregnant, it will be incumbent on the employee to contact their employer in order to request a new medical assessment.

Kandahar and Kabul are unaccompanied posts. The employees at these posts are living and working under severe adverse conditions. These include adverse climatic conditions, such as extreme heat, frequent violent sandstorms, severe atmospheric pollution, poor sanitation, cultural shock, hostility and violence, overcrowding, isolation, exposure to infectious diseases and substandard medical care. Employees may have to work long hours, including weekends with limited time for recreation. What distinguishes Afghanistan even further from other level 5 hardship posts is living in a country under war or war-like conditions. The employees may be required to live in close quarters or confined areas. Venturing beyond these areas and travelling "outside the wire", may pose significant risks of injuries or death. Employees live under the threat of physical attacks, even in the secured zones. The provision of medical care is often very limited. Access to urgent medical care may be significantly delayed or may not be available. Furthermore, for complications arising during pregnancy, adequate care comparable to Canadian standards is not available in Kabul or in Kandahar Airfield. Pregnant women should not travel to Afghanistan.

There is a military field hospital in Kandahar. Medical care is in place primarily for the military, to treat illnesses and injuries of troops. Medical care is provided for civilian Canadians posted or assigned to Kandahar. However, the need for medical care or emergency care for civilians is to be minimized to the extent possible by the use of pre-posting or pre-assignment screening. The military field hospital will be placed under US Military supervision in fall 2009.

In order to be able to withstand the extraordinary stresses imposed by the conditions at post, and to minimize the requirement for medical care, employees assigned to such posts must be in satisfactory mental, emotional and physical health.

N.B.: Unless there is cross-reference to another OHAG section, which applies directly to their position, the employees are evaluated for their medical fitness to live/travel at the posts and/or surrounding areas for which they have been assigned. The employees are not evaluated as to whether or not they are able to perform the duties of their position [1].

[1] The Occupational Health Medical Officers assume that employees who are selected for assignment are found capable of performing the duties of their position, either while working in Canada or at a foreign post. If there are concerns with regard to an employee's ability to perform the **assigned duties** of his/her position, then a fitness to work evaluation is appropriate, using the established protocol.

In general, the evaluation of employees with regard to their medical fitness to be assigned to posts in Afghanistan takes the following factors into account:

- Adverse conditions at post (e.g., concerning available medical services, risk of violence, communicable diseases, pollution, and other conditions),
- Medical conditions of the employees,
- Probability of a medical emergency arising while posted,
- Probability of relapse of a significant medical condition
- Ongoing treatment requirements,
- Increased susceptibility to diseases while posted,
- Psychological/psycho-social/psychiatric conditions,
- Substance abuse/addictions,
- Impairment/disability with special needs.

Employees may be found to **meet** or **not to meet** medical requirements for travel, temporary duty, or for posting. Should the medical recommendation state that an employee does not meet the medical requirements, it will be specified whether this may be temporary or for a prolonged period of time.

Absolute medical requirements:

Employees do not meet the medical requirements for assignment or posting:

- If there is a reasonable probability of premature termination of the assignment or posting due to a medical, including mental health, condition.
- If they have a medical or mental health condition, which presents a risk of a relapse/reactivation, requiring evaluation, ongoing medical follow-up for therapy and/or monitoring at post.
- If they have a medical or mental health condition
    1) that cannot be safely treated or accommodated at post,
    2) that places them / others at a security risk,
    3) that places them at an unacceptable health risk when exposed to conditions at post (e.g. communicable diseases, pollution, violence).
- If they have a medical condition that would likely lead to a life-threatening medical emergency if access to prescribed medication and/or other treatment is interrupted for a short period of time.
- Until they have completed all dental work, if required, and have a dental certificate by a licensed dentist confirming completion.
- If a woman is known to be pregnant.
- If they have a medical condition with significant risk of sudden incapacity.

Advisory medical requirements:

Employees may or may not meet the medical requirements for assignment, depending on the severity of the medical condition and/or the risk of deterioration. If the medical condition is judged to be of a severe nature and/or degree, then absolute medical contraindications may apply, on a case by case basis

In addition,

- Employees should show willingness to receive appropriate immunizations and other prophylaxis.

If a vaccine/prophylactic is contraindicated for an employee, the employee is evaluated with regard to the risk of acquiring the vaccine-preventable illness.

Recommended procedures when preparing for short-term travel, temporary duty or posting to Afghanistan:

(A) **All employees travelling to Afghanistan** should have travel medicine services (**see Annex 2, Appendix G**), and blood typing (A-B-0-Rh).

(B) **Letter to employees travelling to Afghanistan for less than 2 weeks** **(See Annex 1)**. The department responsible for arranging the trip should provide this letter to the employees.

(C) **Examination guidelines to evaluate medical fitness for assignments of ≥2 weeks (temporary duty or posting) to Afghanistan** **(see Annex 2)**.

Annex 2 contains:

- A "Dear Client" Letter,
- a consent form to exchange medical information with the DND medical officer in Kandahar Airfield,
- Checklist for the Examination Guidelines,
- Appendices A to G.

(D) **Return from Temporary Duty Questionnaire to be completed by employees returning from assignments of ≥2 weeks to <4 months** **(see Annex 3).**

The questionnaire and included consent form should be completed by returning employees and forwarded to the Occupational Health Clinic within the first week of return to Canada. Where concerns are identified, the employee will be contacted by staff of the Occupational Health Clinic.

If the employee is required to travel repeatedly to Afghanistan within short intervals, the medical evaluation for temporary duty is valid for 12 months, provided that the employee has completed the above-cited questionnaire, sent it to the clinic after each assignment and completed any necessary follow-up as recommended by the Occupational Health Clinic.

Upon review of the questionnaire and of the completed consent form, the Clinic sends an e-mail to the departmental contact person with a copy to the employee,

1) either confirming the ongoing validity of the last medical assessment
2) or, in case of a medical condition of concern, revoking the validity of the medical assessment, and recommending to the departmental contact to set up a medical appointment for a new assessment.

It is recommended that the employing department advises the employee of this procedure and that the employee follows the above steps.

(E) **Return from Posting Examination Guidelines for posting of ≥4 months.**

The following examination should be performed on returning employees, and assessed by an Occupational Health Medical Officer:

Full medical history and physical examination, with particular emphasis on:

- Infectious diseases such as enteric infections, malaria, leishmaniasis, animal bites (including post-exposure prophylaxis for rabies and tetanus),
- Respiratory and cardio-vascular diseases, particularly with reference to air-pollution,
- Witness to life-threatening events causing injuries or deaths,
- Physical attacks, accidents,
- Significant medical treatments received at post, including instrumentations, blood transfusions, etc.
- Psychiatric illnesses, especially with regard to PTSD, anxiety disorders, depression,
- Substance abuse, and other addictions,
- Medical evacuations,
- Any other diseases/medical conditions.

Medical tests:

- Any other diseases/medical conditions.
- Tuberculin skin test
- Stool test x3 for ova and parasites and/or for culture and sensitivity,
- if clinically indicated,
- Other tests as indicated by history/examination.

If victim or witness of life threatening events, or if there is concern about PTSD, follow-up in 3 months and/or referral to a psychiatrist are indicated.

Vaccinations:

- Update of the Immunization Records System regarding vaccines received while posted,
- completion of any series started during the pre-posting process.

Annex 1: Re: Letter to clients who stay in Afghanistan for less than 2 weeks:

Dear Client,

Before making a final decision to travel to Afghanistan, we recommend that you take a moment to review your general health: Do you have a medical condition and are you under medical care?

There are different and significantly increased demands on yourself, while travelling in Afghanistan, living in Kabul or in one of the military camps around Kandahar or travelling outside the wire. Afghanistan presents an inhospitable environment and the risk of a worsening of a medical condition is significantly increased, as compared to living in Ottawa. The ambient temperature in summer is extremely hot with dust in the air. The air is very dry, which easily leads to dehydration. There are frequent and violent sandstorms during summer and significant air pollution during winter. Depending on the location, there is a high risk of being exposed to various infectious diseases such as malaria, leishmaniasis, tuberculosis, food-borne diseases or respiratory diseases. The working hours are particularly long and strenuous and the living conditions are often cramped, basic and do not allow for privacy. Above all, even in the more secure locations such as in Kandahar Airfield (KAF), there are repetitive attacks (for instance, rocket attacks) by insurgents.

There is a military hospital in Kandahar Airfield. However, the military medical resources are limited and frequent arrivals of injured soldiers put a high strain on the medical resources. The military physicians advised us that the medical resources are designed to cope with newly arising medical problems, not with ongoing treatment of known active or chromic medical conditions.

There are primary care facilities within Kabul. However, if hospital admission is required, you would be taken by embassy car to the international military hospital in the outskirts of Kabul, as long as hostilities do not restrict travel. There are no ambulances in Kabul. Using private hospital care in Kabul is not recommended.

There are no medical facilities in Afghanistan comparable to Canadian standards which are equipped to deal with complications during pregnancy. Pregnant women should not travel to Afghanistan.

Persons who require hospital admission in Kabul or in Kandahar will likely be medically evacuated at high cost to the employer and significant delay in definitive treatment for the employee.

Persons with known medical conditions and under active medical care who wish to travel to Afghanistan for a period of less than two weeks, are requested to show this letter to their treating physician and to review their medical condition with the physician. Their risk of a worsening of their condition due to severe and extreme living conditions in Afghanistan and the likelihood of requiring medical care in Afghanistan should be evaluated.

We strongly recommend that you follow your physician's advice should you be told that it is not prudent to travel to Afghanistan.

Should you prefer, you may ask your manager or departmental contact officer to refer you to the Health Canada Occupational Health Clinic for a medical evaluation by one of the Occupational Health Medical Officers before leaving for your trip to Afghanistan.

Persons who are assigned to Afghanistan for two weeks or longer should be referred by their employer to our clinic for a medical evaluation by one of the Occupational Health Medical Officers.

Thanking you for your cooperation,

Sincerely,

Medical Officer in Charge,
Occupational Health Clinic
Workplace Health and Public Safety Programme
Health Canada

Annex 2: Pre-posting and Temporary Duty Examination Guidelines for Posting and Temporary Duty (TD) to Afghanistan

Ottawa: July 31, 2009

Dear Client,

The attached documents contain medical examination guidelines for posting or temporary duty to Afghanistan. Please refer to these guidelines and present them to the physician who will perform your posting examination.

We are committed to process your medical assessment in a timely manner. However, we also require sufficient medical information to allow us to form an opinion regarding your medical fitness for posting or cross-posting. Therefore, we ask the examining physician to provide details of significant medical physical and psychological findings, as well as copies of required medical reports, including laboratory test results and immunization records.

Please forward medical documentation by mail or courier. In addition, please provide us with your confidential e-mail address to enable us to reach you directly if required.

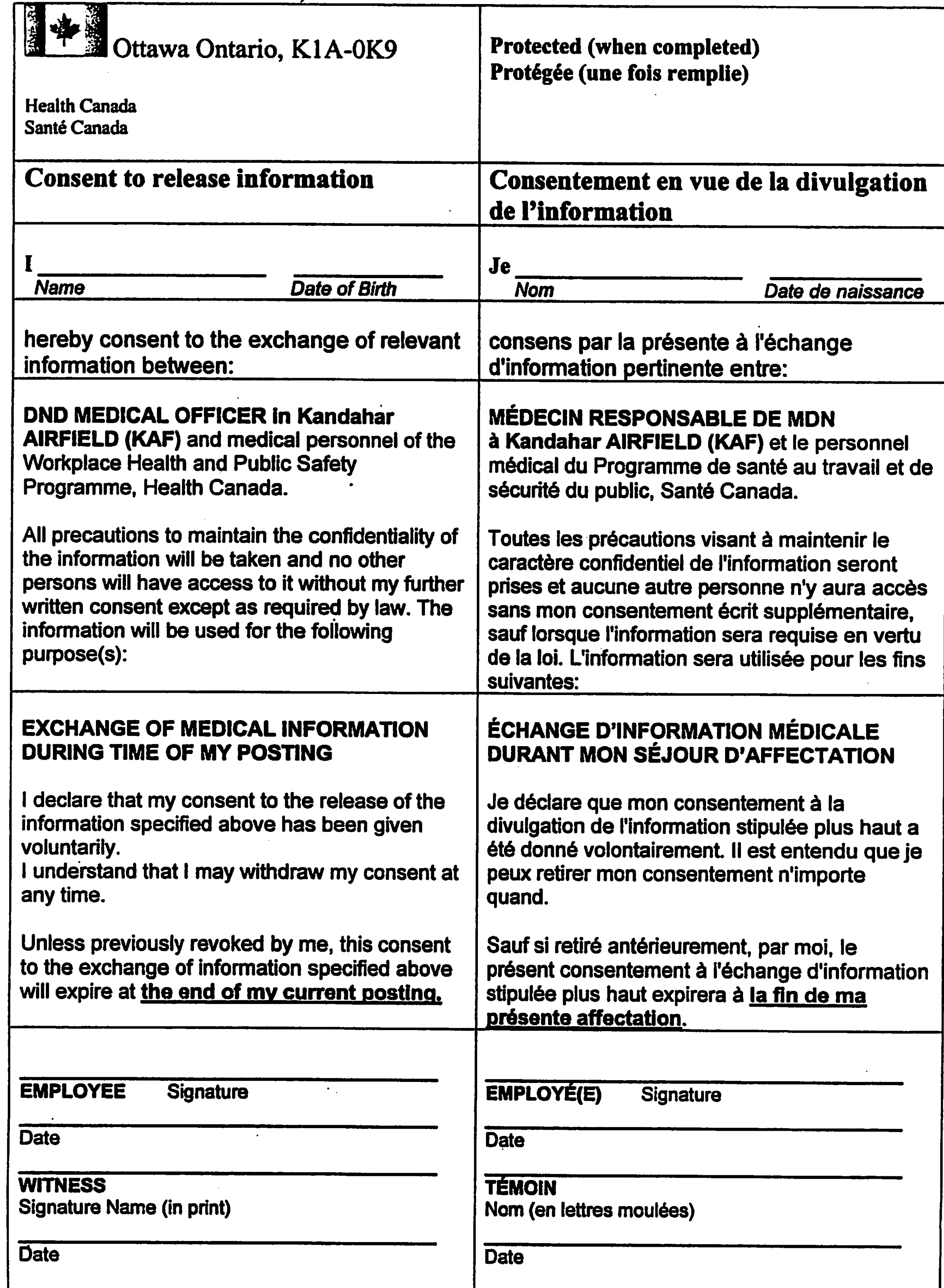
If you are assigned to Kandahar: the DND military physicians request a copy of the medical pre-posting reports. Therefore, if you agree, please complete the attached consent form, and we will mail the medical reports to the DND physicians stationed in Kandahar.

Should you require any further information, or should you wish to obtain a copy of either, your medical assessment/reports for your posting or your immunization records, please do not hesitate to send your request to our office, attention:

WHPSP_PSTSP_Medical_Service_International@hc-sc.gc.ca

Yours sincerely

Eva Callary, MD, FRCPC,
Medical Officer in Charge,
Occupational Health Clinic,
Workplace Health and Public Safety Programme,
Health Canada



P.L.3712M - 171 Slater Street, Ottawa Ontario, K1A-0K9 Health Canada Santé Canada	**Protected (when completed)** **Protégée (une fois remplie)**
Consent to release information	**Consentement en vue de la divulgation de l'information**
I ________________ ____________ *Name* *Date of Birth*	Je ________________ ____________ *Nom* *Date de naissance*
hereby consent to the exchange of relevant information between:	consens par la présente à l'échange d'information pertinente entre:
DND MEDICAL OFFICER in Kandahar AIRFIELD (KAF) and medical personnel of the Workplace Health and Public Safety Programme, Health Canada. All precautions to maintain the confidentiality of the information will be taken and no other persons will have access to it without my further written consent except as required by law. The information will be used for the following purpose(s):	**MÉDECIN RESPONSABLE DE MDN à Kandahar AIRFIELD (KAF)** et le personnel médical du Programme de santé au travail et de sécurité du public, Santé Canada. Toutes les précautions visant à maintenir le caractère confidentiel de l'information seront prises et aucune autre personne n'y aura accès sans mon consentement écrit supplémentaire, sauf lorsque l'information sera requise en vertu de la loi. L'information sera utilisée pour les fins suivantes:
EXCHANGE OF MEDICAL INFORMATION DURING TIME OF MY POSTING I declare that my consent to the release of the information specified above has been given voluntarily. I understand that I may withdraw my consent at any time. Unless previously revoked by me, this consent to the exchange of information specified above will expire at **the end of my current posting.**	**ÉCHANGE D'INFORMATION MÉDICALE DURANT MON SÉJOUR D'AFFECTATION** Je déclare que mon consentement à la divulgation de l'information stipulée plus haut a été donné volontairement. Il est entendu que je peux retirer mon consentement n'importe quand. Sauf si retiré antérieurement, par moi, le présent consentement à l'échange d'information stipulée plus haut expirera à **la fin de ma présente affectation.**
____________________ **EMPLOYEE** Signature ____________________ Date ____________________ **WITNESS** Signature Name (in print) ____________________ Date	____________________ **EMPLOYÉ(E)** Signature ____________________ Date ____________________ **TÉMOIN** Nom (en lettres moulées) ____________________ Date

CHECKLIST

Pre-Posting or TD Medical Examination Guidelines for Assignments to Afghanistan

Examinations/ tests	Posting or TD <1 year	Posting ≥1 year
Complete medical history (sections D & E)* **Complete Physical exam** (section F) * *** All positive findings should be explained in detail in the appropriate sections of Form HC 3312 E**	**Including:** Detailed mental health examination by examining physician, **If clinically indicated:** Breast exam in women Pelvic exam and Pap Test in women Digital rectal exam	**Including:** Detailed mental health examination by examining physician. **Strongly recommended:** Breast exam in women: 40 yrs Pelvic exam and Pap Test in women (see Appendix **A**) Digital rectal exam: 50 yrs **Above examinations are required** at any age, **if clinically indicated:**
MANTOUX TEST (Tuberculin Skin Test) **BASELINE 2 step (see Appendix B&C)**	**YES**, for postings or repeat Tds, then on yearly basis if ongoing assignments, and only if negative	**YES**
CHEST X-RAY	**If clinically indicated**, including positive Mantoux test	**If clinically indicated**, including positive Mantoux test
URINALYSIS	**YES**	**YES**
COMPLETE BLOOD COUNT (CBC)	**YES**	**YES**
BIOCHEMISTRY (RANDOM, i.e. fasting not required) Glucose, Creatinine, AST(SGOT), ALT(SGPT),	**YES**	**YES**
Other Blood Tests:(fasting) Lipid Profile, TSH, Vit B_{12}, Folate, PSA, etc	**If clinically indicated**	**If clinically indicated**
Blood typing (Blood Group and Rh Type)	**YES**	**YES**
ELECTROCARDIOGRAM 40 years old	No Baseline	Baseline if 40 years old
ECG all age groups	**If clinically indicated**	**If clinically indicated**
Cardiac stress test	**If clinically indicated** by cardiac risk factor assessment, ECG and/or symptoms	**If clinically indicated** by cardiac risk factor assessment, ECG and/or symptoms
SPIROMETRY	YES, if respiratory or cardiovascular condition	YES, if respiratory or cardiovascular condition
MAMMOGRAM	at any age, **if clinically indicated**	at any age **if clinically indicated, but strongly recommended:** for all woman 50 years, (see Appendix **D**)

DENTAL CERTIFICATE (Appendix E & F)	If <4 months TD, if clinically indicated If 4 months assignment: YES-required	YES
VACCINATION UPDATE (Appendix G)	YES	YES

APPENDIX A: GUIDELINES FOR PAP EXAMS (ONTARIO)
APPENDIX B: 2 STEP MANTOUX TESTING
APPENDIX C: LIST OF TB ENDEMIC POSTS
APPENDIX D: ONTARIO BREAST SCREENING PROGRAM
APPENDIX E: DENTAL CERTIFICATE TO BE COMPLETED BY DENTIST
APPENDIX F: LISTING OF POSTS WHERE DENTAL CERTIFICATE IS REQUIRED
APPENDIX G: SPECIFIC TRAVEL HEALTH RECOMMENDATIONS FOR KANDAHAR AND KABUL

APPENDIX A: GUIDELINES FOR PAP TESTS (ONTARIO)

For information on screening for cervical cancer, please follow the provincial cancer screening guidelines of your province:

http://www.hpvinfo.ca/hpvinfo/professionals/guidelines.aspx

For Quebec:

http://www.inspq.qc.ca/pdf/publications/915_AvisOptDepCancerCol.pdf

Canadian Cancer Society:

http://www.cancer.ca/Canada-wide/About%20cancer/Types%20of%20cancer/Screening%20for%20cervical%20cancer.aspx?sc_lang=en

http://www.cancer.ca/canada-wide/about%20cancer/types%20of%20cancer/screening%20for%20cervical%20cancer.aspx?sc_lang=fr-CA

APPENDIX B: 2 STEP MANTOUX TESTING/ 2 STEP TST (TST = Tuberculin Skin Test)

REFERENCE: **Canadian Tuberculosis Standards 6th Edition 2007** ***(pp. 67-69***

http://www.phac-aspc.gc.ca/tbpc-latb/pubs/tbstand07-eng.php

This publication is a joint project of Tuberculosis Prevention and Control, Public Health Agency of Canada, and the Canadian Lung Association/Canadian Thoracic Society.

PLEASE NOTE: TST = Tuberculin Skin Test
LTBI = Latent Tuberculosis Infection (or Latent TB Infection)

Two-step TST and the booster effect

A single TST may elicit little response yet stimulate an anamnestic immune response, so that a second TST at any time from 1 week to 1 year later will elicit a much greater response. This phenomenon is important to detect, as it could be confused with TST conversion. The booster effect was first described in older persons in whom it was felt to show LTBI acquired many years before (remotely) with subsequent waning of immunity.[62] It has also been described in persons with prior BCG vaccination[18, 63] or sensitivity to nontuberculous mycobacterial antigens. [18, 64]

Indications for 2-step testing

A two-step TST should be performed if subsequent TSTs will be conducted at regular intervals or following exposure to an infectious TB case, for instance among health care or correctional service workers (see Chapter 16, Tuberculosis Control Within Institutions). This is to reduce the chance of a false-positive TST conversion when the TST is repeated. One controversial area is whether travellers
should be given two-step TST before and/or after travel to a region with high TB incidence. Please refer to Chapter 13, Surveillance and Screening in Tuberculosis Control, for recommendations. The two-step protocol needs to be performed ONCE only if properly performed and documented. It never needs to be
repeated. Any subsequent TST can be one step, regardless of how long it has been since the last TST. In a contact investigation, two-step TSTs (to detect boosting) should not be performed. A single TST is performed soon after the contact is identified. If this TST is negative and it is performed less than 8 weeks after contact with the source case was broken, then a second TST is performed. This second TST is performed no sooner than 8 weeks after the contact was broken. It is performed to detect TST conversion from infection that occurred just before contact was broken, as a positive TST can develop any time within 3 to 8 weeks of the infection.

Technique

The same material and techniques of administration and reading should be used. The second test should be performed 1 to 4 weeks later. Less than 1 week does not allow enough time to elicit the phenomenon, more than 4 weeks allows the possibility of a true TST conversion to occur. Both tests should be read and recorded at 48 to 72 hours. In some centres, to reduce the total number of visits required to three, the first TST is read at 1 week, so that persons with a negative TST can have a second TST immediately. However, reading performed at 1 week is less accurate and is not recommended.

Interpretation

The only two longitudinal studies of the risk of TB following a booster reaction defined the reaction simply as a second TST result of 10 mm or more induration.[15,65] Therefore, it is recommended that a second TST result of 10 mm or more should be considered significant and the patient referred for medical evaluation and chest radiography.

..l the elderly, a significant booster effect most likely represents remotely acquired LTBI. In longitudinal studies, subjects with a second TST response of 10 mm or more had a risk of TB that was approximately half that of subjects whose first TST response was 10 mm or more.[65] Therefore, individuals with a reaction of 10+ mm on a second TST should be considered to have a risk of TB disease that is intermediate between individuals with initial positive and individuals with initial negative TST results from the same population group.

Management

All subjects with a reaction of 10+ mm on the second TST of a two-step TST do not need a TST in the future. There is no clinical utility. They should be referred for medical evaluation, as performed for those with a positive first TST. Since the risk of TB is about half that of patients whose initial TST result is positive, the decision to give INH should be individualized. A common question is how to manage a person whose first TST measured 5-9 mm and the second test measured 10+ mm but increased by less than 6 mm from the first test. This should be managed as a "positive TST", meaning referral for medical evaluation and no further TSTs. While appropriate epidemiologic data are lacking, it seems reasonable to suggest that the risk of active TB development would be lower than in persons whose second TST increased by at least 6 mm. The decision to give INH should be individualized, but it seems unlikely to provide substantial benefit.

APPENDIX C: LIST OF TB ENDEMIC POSTS

HIGH TUBERCULOSIS PREVALENCE COUNTRIES

Mantoux testing (TST) is recommended for people who have lived or travelled in countries with tuberculosis incidence rates of 15/100 000 or above as determined by WHO. Please consult the Public Health Agency of Canada website for countries with tuberculosis incidence rates ≥15/100 000 population.

http://www.phac-aspc.gc.ca/tbpc-latb/itir_e.html

APPENDIX D: ONTARIO BREAST SCREENING PROGRAM

Breast screening is the regular examination of a woman's breasts to find breast cancer early. It includes mammography (breast X-ray) and a physical examination of the breasts by a physician or a nurse.

Please refer to the website of the Canadian Cancer Society for more detailed information about breast cancer screening:

http://www.cancer.ca/canada-wide/about%20us/media%20centre/our%20positions%20on%20cancer-related%20issues/breast%20cancer%20screening%20in%20your%2040s.aspx?sc_lang=en

http://www.cancer.ca/canada-wide/about%20us/media%20centre/our%20positions%20on%20cancer-related%20issues/breast%20cancer%20screening%20in%20your%2040s.aspx?sc_lang=fr-CA

APPENDIX E: DENTAL CERTIFICATE / CERTIFICAT DENTAIRE

This dental certificate is required to enable Health Canada to assess the fitness of the employee and any dependant(s) for service at the missions mentioned herein. Fees for the Dental Examination, including any prior cleaning and / or x-rays required by the dentist, will be reimbursed to the employee on submission of an expense claim (form EXT 160), together with detailed official receipts, tot he FSD Policy and Relocation Division (HPM)

Le présent certificat est nécessaire pour permettre à Santé Canada d'évaluer l'aptitude, du point de vue médical, de l'employé et des personnes à sa charge à servir à la mission indiquée. Les frais de l'examen dentaire, y compris le nettoyage préalable et / ou les radiographies exigées par le dentiste, seront remboursés à l'employé après soumission à la Direction des DSE et des Voyages (HPM) d'une Demande d'indemnité (formulaire EXT 160) appuyée des reçus officiels détaillés.

.ne of employee / Nom de l'employé(e)	Post / Mission
Certificate for employee ☐ / Certificat pour l'employé(e) ☐ — Certificate for family member: ☐ / Certificat pour membre de la famille: ☐	Departure Date / Date de départ
Name of family member / Nom du membre de famille: N.B. One certificate per person - Un certificat pour chaque personne	Tour Length / Durée de l'affectation

I have examined the above-named and the following treatments have been / will be carried out prior to the employee's expected departure on posting.

J'ai examiné la personne citée ci-haut et les traitements suivants ont été / seront complétés avant la date prévue de départ.

TREATMENT / TRAITEMENTS

The following treatment(s) may / will be required during the period of the employee's / family member's assignment.

Les traitments suivants peuvent être / seront nécessaires pendant la période d'affectation de l'employé(e) / membre de la famille.

TREATMENT / TRAITEMENTS

Is there any anticipated orthodontic treatment required? If yes, briefly describe extent and duration of treatments.

Est-cequ'il y a des tratements orthodontiques de prévus? Si oui, décrivez ces traitements ainsi que leur durée.

Dentist's signature, printed name, address and telephone number / Signature du dentiste, nom en lettres moulées, adresse et numéro de téléphone:

____

____

Date of examination / Date de l'examen:

____

FORWARD TO:	FAIRE PARVENIR À:

Workplace Health and Public Safety Programme Medical Clinic, NCR 171 Slater Street 12th Floor, P.L. 3712M Ottawa, Ontario K1A 0K9	Clinique médical, RCN 171 rue Slater 12e étage, L.P. 3712M Ottawa, Ontario K1A 0K9

APPENDIX F: LISTING OF POSTS WHERE DENTAL CERTIFICATE IS REQUIRED

The list of posts for which dental certificates are required can be found in the Appendix of FSD-9. The last update was April 1, 2000. Please refer to the following website:

www.tbs-sct.gc.ca/pubs_pol/hrpubs/TBM_1112/fsd-dse-9_e.asp

In addition, until the FSD-9 list will be updated, there are the following additional posts for which dental certificates are required:

- Antananarivo, Madagascar
- Chandigarh, India
- Chongqing, China
- Jakarta, Indonesia
- Kabul, Afghanistan
- Kandahar, Afghanistan
- Khartoum, Sudan
- Maputo, Mozambique
- Central Asian Countries

Appendix G: SPECIFIC TRAVEL HEALTH RECOMMENDATIONS FOR KANDAHAR AND KABUL:

The following are recommendations for vaccinations, malaria chemoprophylaxis and travel health education for Kandahar and Kabul:

1. **Immunizations should be up to date or provided for:**
   - 1.1. Measles/Mumps/Rubella,
   - 1.2. Tetanus/Diphtheria (Td), or Tetanus/Diphteria/Pertussis (Tdap) as indicated
   - 1.3. Poliomyelitis,
   - 1.4. Hepatitis A,
   - 1.5. Hepatitis B,
   - 1.6. Typhoid,
   - 1.7. Quadrivalent Meningococcal (as per risk assessment)
   - 1.8. Influenza vaccine for the current influenza season,
   - 1.9. Pre-exposure rabies, if at increased risk of exposure to potentially rabid animals (e.g. veterinary or animal control workers)
2. **Tuberculin skin test (see Checklist)**
3. **Malaria chemoprophylaxis:**
   - 3.1. Kandahar Airfield (KAF): No Malaria chemoprophylaxis indicated.
   - 3.2. Camp Mirage or Kabul: No Malaria chemoprophylaxis indicated.
   - 3.3. All locations other than KAF, Camp Mirage or Kabul: Malaria chemoprophylaxis is indicated during malaria risk season.

N.B. Please document as to whether or not there are travel plans to the Provincial Reconstruction Team (PRT) or to other locations outside Kabul or KAF.

4. **Travel health education in regards to:**
   - 4.1. Insect precautions
   - 4.2. Food and water precautions,
   - 4.3. Hazardous flora and fauna,
   - 4.4. Personal hygiene,
   - 4.5. Geohelminths (foot coverings)
   - 4.6. Heat and sun protection,
   - 4.7. Blood-borne diseases

Annex 3: Workplace Health and Public Safety Programme

Questionnaire for employees who return from temporary duty of 4 months or less to Afghanistan:

NAME:		D.O.B.:	dd mm yy
Date of Departure:	dd mm yy	Date of Return:	dd mm yy
employee e-mail	D.O.B.:	phone (w / h)	
DEPT. contact name	D.O.B.:	phone (w) and e-mail	

	QUESTIONS	YES	NO
1	Were you ill from an infectious disease, such as traveller's diarrhea, malaria, or other infections transmitted by the bite of an insect, such as mosquito, sandfly, tick?		
2	Were you bitten by a dog or other wild/domestic animal?		
3	Did you experience any serious respiratory infection?		
4	Did you have any heart or circulatory problems?		
5	Did you witness or experience life-threatening events causing injuries or deaths?		
6	Did you suffer any physical attacks or accidents?		
7	Did you receive any significant medical treatments at post, including instrumentations, blood transfusions, etc?		
8	Did you experience other significant physical or mental symptoms?		
9	Were you medically evacuated?		
10	Were you asked to return to the Travel Clinic to complete vaccinations?		
	Since you have commenced your assignments to Afghanistan, did you notice changes or do you have concerns with regard to the following questions:	**YES**	**NO**
11	Do you have problems with concentration/memory?		
12	Are you more tearful or do you cry more easily?		
13	Have you lost interest in activities that you usually enjoy?		
14	Have you lost your appetite?		
15	Do you feel anxious?		
16	Do you have difficulties falling or staying asleep?		
17	Do you startle more easily?		
18	Do you have nightmares?		
19	Do you feel as if you are back in Afghanistan and reliving frightening experiences?		

SIGNATURE	DATE

Please proceed to page 2 for additional details and completion of your consent.

.../2

The completed questionnaire should be mailed or, preferably, faxed within one week of return from Afghanistan to the attention of:

Occupational Health Nursing Manager

Occupational Health Clinic

Workplace Health and Public Safety Programme

Fax: 613 - 990-9397

E-mail: WHPSP_PSTSP_Medical_Service_International@hc-sc.gc.ca

(The fax machine is located in the Occupational Health Clinic. The faxed questionnaire is protected by medical confidentiality.)

If you provided a positive answer to any of the above questions, you will be contacted by a nurse of the Occupational Health Clinic for more detailed information. If indicated, you may be asked to see a medical officer, or a designated physician (if outside the National Capital Region) for a re-evaluation for Afghanistan assignments, or an occupational health nurse for completion of your vaccination series.

Please sign the consent below allowing the Occupational Health Clinic staff to send an e-mail to your employer as to either confirming continued validity of your medical clearance or informing them that you would require a reassessment.

N.B.:

1) Please note, should you require treatment, this is to be provided by your personal physician. Therefore, please ensure to follow-up with your personal physician with regard to any persistent symptoms. The medical officers of the Occupational Health Clinic in Health Canada are not authorized to provide medical treatment.that places them / others at a security risk,

2) Please ensure that you inform this clinic should you develop any new condition (including pregnancy) for which you require medical follow-up by your treating physician. To do so, you may ask your manager or your departmental contact/assignment officer to refer you to the Occupational Health Clinic for a new medical assessment.

CONSENT:

Herewith, I authorize the staff of the Occupational Health Clinic, Workplace Health and Public Safety Programme to inform my employer by e-mail, with a copy to me, as to:

- whether the validity of my last medical assessment for short-term assignment to Afghanistan continues to be valid (the validity date will be indicated)
- or, the validity of the last medical assessment for Afghanistan assignments is revoked and a new assessment is needed.

____________________________________ _______________________

Signature and please print

____________________________________ _______________________

Witness (signature and please print) Date