

PRACTICE GUIDELINE

PREGNANCY, POSTPARTUM PERIOD AND WORK

Advice and guidance by the occupational physician



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INTRODUCTION

As the number of women in employment continues to grow, it is increasingly common for occupational physicians to be confronted by questions concerning work, pregnancy and the postpartum period. In 2005, there were 3.7 million working women between the ages of fifteen and sixty-four in the Netherlands – 54.1 per cent of the 5.4 million women in that age group (Statistics Netherlands/Statline) – and the number continues to grow. The birth rate in the Netherlands has fallen in recent years: whereas 207,000 children were born in 2000, the figure had fallen to 187,910 by 2005. This has much to do with the decline in births in the early 1970s, as a result of which there was a fall in the number of women aged around thirty in the early part of this century. The less benign economic climate was also a factor. The number of women aged about thirty is significant because that is the age at which many women start a family. Fewer and fewer women who have children give up work, as more choose to combine work with bringing up a family. In 45 per cent of families with under-sixteens, one parent worked full time and the other part time in 2003. In the same year, eight out of ten young mothers were working before the birth of their first child. After giving birth, only 10 per cent gave up work, compared with 25 per cent in 1997 (Statistics Netherlands 2005).

Most occupational physicians are frequently consulted by pregnant employees. In 2005, 116,348 employees received benefit, as provided for in the Work and Care Act, in connection with a period of maternity leave. In the same year, the Employee Insurance Scheme Executive Body authorised benefit payments in 60,600 cases involving pregnancy-related illness (Sickness Benefit Act safety net); by 2006, the number had risen to 69,600.

During a normal pregnancy, a woman undergoes numerous physiological and anatomical changes. These have implications for her capacity for work and can lead to a variety of medical problems that do not affect non-pregnant women. While a woman is pregnant, her capacity for work is liable to change. After giving birth, it is a while before her capacity for work returns to normal, in which context breastfeeding is a significant factor. During pregnancy and the postpartum period, complications can occur that have a bearing on a woman's capacity for work. In addition, work-related risk factors can have undesirable implications for the pregnant employee herself, her pregnancy, the (unborn) child, and/or the breastfeeding.

TERMINOLOGY

In the context of the advice and guidance given by the occupational physician regarding pregnancy and postpartum period, three phases may be distinguished:

- **Pre-conception phase:** the period prior to pregnancy.
At work, both men and women can be exposed to factors – such as the presence of reprotoxic substances – that have an adverse effect on their reproductive organs. In this period, fertility-enhancing treatment may be in order.
- **Pregnancy:** the period from conception to delivery, inclusive.
A pregnant woman undergoes numerous physical and psychological changes, associated with the particular pregnancy trimester, which influence her capacity for work. Furthermore, the developing child needs to be protected against harmful influences in the mother's working environment.
- **Postpartum:** the period following delivery.
The postpartum period may be subdivided into the immediate postpartum period (the first ten days), the remainder of the puerperal period up to six weeks after delivery, during which the womb reverts to its former state (size and mucous membrane), and the subsequent period up to six or twelve months after delivery, during which the hormonal and musculoskeletal system return to their former state. After having a baby, a woman also needs to find a new psychosocial equilibrium. Lack of sleep and interrupted nights, breastfeeding, adjusting to parenthood (if it is the first child) and the need to balance work and motherhood can have implications for a woman's capacity for work. The exposure of a breastfeeding mother to toxic substances can put her baby at risk via her breast milk.

The recommendations made in these guidelines regarding female employees are restricted to the second and third phases: pregnancy and the postpartum period. In view of the extent of the issues associated with the pre-conception phase, it is recommended that this phase be addressed in a separate set of guidelines.

In the context of these guidelines, the term ‘**employee**’ should be interpreted more broadly than its dictionary definition. In this context, an employee is anyone who works, whether paid or unpaid, and whether employed, self-employed or a volunteer.

PURPOSE OF THE GUIDELINES

The purpose of these guidelines is to help occupational physicians to translate risk factors into preventive policies for the protection of women during pregnancy and the postpartum period. The guidelines also serve to support occupational physicians who need to provide guidance to women who consult them about medical problems or complications associated with their pregnancy or about the resumption of work following maternity leave. The provision of information and preventive advice has health benefits for pregnant women and their (unborn) babies; this in turn means less absenteeism both during pregnancy and in the postpartum period, and fewer premature births, low-birth-weight babies and other such problems.

CONTENT AND STRUCTURE OF THE GUIDELINES

The occupational physician’s first responsibility is to advise the employer on an appropriate Health, Safety and Welfare (OHS) policy for pregnant women. This policy should cover the provision of information on the maternity leave system, breastfeeding, childcare, work-related risks and the action required to control such risks. The occupational physician should support the employer in the analysis of work-related risk factors and advise on the associated preventive measures and revised working arrangements. An essential feature of a good OHS policy for pregnant women is provision of an opportunity for all expectant mothers to talk to the occupational physician about the prevention of problems.

Whenever the employer learns that an employee is pregnant, the employer should arrange for her to receive information about her rights and the schemes that she can take advantage of during her pregnancy and the postpartum period (breastfeeding). When discussing the prevention of problems, the occupational physician should ascertain whether the employer has provided the necessary information; in addition, an individual risk profile should be compiled – on the basis of the woman’s workload and capacity for work – and discussed with her. If the woman has a higher risk profile, the occupational physician should discuss preventive measures and revised working arrangements (the strategic plan). Where appropriate, arrangements should be made for further guidance during the pregnancy.

In case of absenteeism, consideration should be given to revising the employee’s risk profile and the associated measures. At predetermined points in the guidance process, the occupational physician should evaluate the effect of any interventions made, by reference to the defined objectives. It is important that the occupational physician’s policy is aligned with those of the midwife, gynaecologist, GP and workplace manager.

Section 1 considers how the occupational physician should go about determining whether an employer is pursuing a policy that complies with the legislation. Assessment of the policy and formulation of recommendations for improvement are also dealt with.

Section 2 is concerned with the formulation of individualised advice for the employee in the context of the preventive consultation. To this end, the occupational physician is expected to consider which work-related factors could influence the course of the individual’s pregnancy and the health of her (unborn) child. What physiological changes is the woman undergoing?

Is she experiencing any medical problems or symptoms that have implications for her performance at work? Is there anything abnormal about the way the pregnancy or postpartum period is progressing? Analysis of the employee's workload and capacity for work results in the definition of an individual risk profile, which is discussed with the woman. At the same consultation, the employee is provided with information about how a normal pregnancy and postpartum period may be expected to influence her capacity for work and her capacity to do things away from work.

In some cases, the conclusion will be that the woman is at elevated risk. In such cases, the occupational physician – in consultation with the midwife, gynaecologist or GP where appropriate – needs to draw up a strategic plan defining the action to be taken to avoid or minimise risk.

In the event of absenteeism, the occupational physician should consider whether the employee's risk profile needs to be revised and whether her working arrangements need to be changed. Continued guidance is provided either until the employee is able to make a full return to work, or until her maternity leave begins. The object of the evaluation described in section 3 is to determine whether the action taken has been successful, and what should be done if it has not been successful. The annexes contain tools for use in the practical implementation of these guidelines.

These guidelines are based on the findings of scientific research and the main legislation relating to pregnancy and the postpartum period. The separate background document – available at www.nvab-online.nl – provides the evidential basis and justification for the recommendations contained in these guidelines.

REVISION OF THE GUIDELINES

In view of what is currently known and developments in this field, the recommendations in these guidelines may be expected to remain valid for three to five years. In the interim, a number of members of the project group will closely monitor relevant scientific developments and draw attention to any matters that might warrant earlier revision of the guidelines.

KNOWLEDGE AND SKILLS NEEDED FOR APPLICATION OF THE GUIDELINES

An occupational physician is expected to possess the capability and skills to advise an employer on the formulation and implementation of an appropriate OHS policy for employees during pregnancy and the postpartum period. In addition, in the context of preventive consultations with individual pregnant women, the occupational physician needs to be able draw up a risk profile on the basis of anamnesis, physical examination and the analysis of risk factors. A further requirement is that the occupational physician is able to advise an employee and her manager on any preventive measures that may be necessary, and on returning to work. An occupational physician also needs the ability to advise other health care professionals regarding treatments which may facilitate return to work. The occupational physician is expected to align his/her policy with that of the midwife, gynaecologist, GP and manager.

During the preventive consultation, the occupational physician needs to inform the pregnant employee about the choices she needs to make regarding her workload and her out-of-work activities and commitments. This implies the possession of very good communicative skills. It is assumed that an occupational physician possesses such skills or can acquire them through additional or refresher training. It is recommended that a training module should be developed, with a view to acquainting occupational physicians with the content and systematics of these guidelines.

1

ADVISING THE EMPLOYER

ON THE DEVELOPMENT OF AN OHS POLICY FOR EMPLOYEES DURING PREGNANCY AND THE POSTPARTUM PERIOD AND A PROTOCOL FOR THE PROVISION OF INDIVIDUALISED INFORMATION

An employer has a statutory obligation to pursue a health, safety and welfare policy, which ensures that pregnant women and their children are not at risk, either during pregnancy or during the breastfeeding period

- > Advise the employer to fulfil the **statutory obligation** by taking the following four steps:
 - 1 Identify specific work-related risks.
 - 2 Organise work in an appropriate, risk-free manner.
 - 3 Offer a (voluntary) preventive consultation with the occupational physician.
 - 4 Develop a protocol on the provision of information.

1.1 DO THE WORKING CONDITIONS INVOLVE EXTRA RISK FOR PREGNANT WOMEN AND WOMEN IN THE POSTPARTUM PERIOD?

In order to advise the employer on an appropriate OHS policy for employees during pregnancy and the postpartum period, it is necessary to know what risks the particular working conditions entail. During pregnancy and the postpartum period, certain work-related factors can lead to medical problems and conditions for the employee and/or her (unborn) child, or influence her breastfeeding

- > Determine whether there are any particular **work-related risks and hazards** for employees during pregnancy or the postpartum period. Use the tools provided in annexes 1, 3 and 4 and consult the recent general and specific Risk Assessment (in Dutch: RI&E).

Important work-related risk factors to consider:

- Physical strain
- Irregular working hours, shift work
- Mental strain (pressure of work, opportunity to regulate work, aggression)
- Chemical factors
- Biological agents
- Physical factors: (non-)ionising radiation, heat and cold, noise, vibration

Do the working circumstances involve risk?

- > Make an inventory of work-related risk factors and assess the risks and hazards identified in the Risk Assessment in relation to:
 - the risk factors relevant to the pregnant employee herself, her (unborn) child, the postpartum period and breastfeeding (annexe 1); and
 - the regulatory context (see annexe 6) or arrangements recorded in the OHS catalogues.

If the Risk Assessment indicates the existence of risks and hazards, the employer will need to take action to eliminate or minimise them. Any such action should be based upon an occupational hygiene strategy. The applicable legislation and regulations identify four explicit levels of action that may be necessary in relation to pregnancy and breastfeeding:

- Elimination of hazards through application of the occupational hygiene strategy
- Temporary changes to working arrangements or to working hours/breaks
- Temporary assignment to other work
- Temporary relief of duties

NB. An employer may resort to a lower level of action only if a higher level of action is not possible.

- > Where appropriate, consult an occupational hygienist, safety consultant or other experts dealing with working conditions.

No (recent) risk survey conducted?

- > Advise the employer about the statutory obligation to identify the risks and hazards that employees may be exposed to during pregnancy and/or the postpartum period (see annexe 7).

1.2 IS THERE AN OHS POLICY RELATING TO WOMEN DURING PREGNANCY AND THE POSTPARTUM PERIOD?

- > Assess whether the OHS policy is adequate and deals properly with the following matters:
 - Risks: identified, specified and minimised
 - At-risk groups: identified and specified
 - Provision of information: existence of a protocol
 - Individual health monitoring

Apply the limits and associated risk control strategies specified in annexe 1.

Where biological agents are concerned, refer to annexes 3 and 4 if necessary.

- > Advise the employer to ensure that women of childbearing age and pregnant women receive comprehensive, accurate information by (developing, appropriately introducing and) operating an **information provision protocol**. This protocol should address at least the following:
 - The provision of information to newly recruited women of childbearing age, regarding the organisation-specific reproductive risks and risks related to work and pregnancy: work-related factors that entail risks around the time of conception or during the first months of pregnancy, such as chemical factors, biological factors and radiation.
 - The provision of information to every employee who tells the employer she is pregnant, regarding:
 - Work-related risk factors
 - Facilities and opportunities for rest
 - The opportunity to consult the occupational physician on the prevention of problems
 - The maternity leave system
 - Breastfeeding when working (see annexe 5)
 - Childcare and parental leave arrangements and schemes.
- > Advise the employer to offer every employee who becomes pregnant the opportunity to consult the occupational physician on the prevention of problems (**preventive consultation**). Where necessary, support this advice with the following arguments:
 - Prevention of adverse effects on pregnant employees and their (unborn) children
 - Prevention of (claims relating to) occupational illness
 - Prevention of absenteeism during pregnancy and following maternity leave
 - Cost reduction through the prevention of adverse effects and absenteeism
 - Facilitation of anticipatory policy.

RESULT

Information about specific risks and hazards, and specification of risk factors.

An appropriate OHS policy and a protocol on the provision of information to individual employees.

Access to the occupational physician for preventive consultations.

2 INTERVENTION AND SECONDARY RISK AVOIDANCE

When an employee informs the employer that she is pregnant, she is automatically invited to see the occupational physician to discuss the prevention of problems. The occupational physician draws up a risk profile and provides information and advice to the pregnant employee and, if necessary, to her manager and/or the employer.

2.1 WHAT IS THE INDIVIDUAL'S WORKLOAD?

- > Determine the individual employee's workload during pregnancy and the postpartum period, using the data from the OHS policy.

No recent risk survey conducted?

- > Establish whether any particular risk factors apply in relation to the pregnant employee's role, by referring to annexe 1 and possibly annexes 3 and 4.
- > Where appropriate, consult an occupational hygienist, safety consultant or other expert in the field of working conditions.

(Non-)ionising radiation, chemical substances and biological agents

- > When an employee reports that she is pregnant, recommend the cessation of all exposure until there is clarity regarding the adverse implications (precautionary principle).

2.2 WHAT IS THE INDIVIDUAL'S CAPACITY FOR WORK?

- > Ask when the baby is due and assess how the pregnancy is progressing.
- > Establish whether the employee is under the supervision of a midwife or gynaecologist.
- > If necessary, ask to see the employee's midwifery supervision card.
- > If the employee is under the supervision of a gynaecologist, ask why.
- > Establish whether any **person-related risk factors** exist, which might have implications for pregnancy or the postpartum period:
 - Historic risk factors that could lead to medical problems and/or absenteeism
 - Problems apparent from the obstetric anamnesis
 - Medical problems/symptoms that could lead to abnormal changes in the employee's capacity for work during pregnancy or the postpartum periodIn this context, make use of annexe 2.

2.3 WHAT IS THE INDIVIDUAL'S RISK PROFILE?

- > On the basis of the individual's workload and capacity for work, draw up an individual risk profile for the pregnancy and postpartum period.

An employee has a **higher risk profile**:

- if one or more work-related risk factors exist; or
- if one or more person-related factors exist, which could have implications for the employee's capacity for work.

Higher risk profile?

- > Draw up a strategic plan that addresses one or both of the following, as appropriate:
 - Work-related risk factor(s)
 - Person-related risk factor(s)

- > Advise the employee and/or her manager to apply the occupational hygiene strategy and/or revise her working arrangements or hours.
See annexe 1: risk control strategies and recommendations.
- > Tell the employee about her legal right to extra breaks or shorter working hours (up to an eighth of her normal working hours).
- > Where appropriate, make a follow-up appointment, also in the postpartum period (see §2.5).

2.4 WHAT INFORMATION AND ADVICE SHOULD BE GIVEN TO ALL PREGNANT EMPLOYEES?

- > Tell the employee about:
 - The normal course of pregnancy and the postpartum period
 - The implications for the employee's capacity for work and for out-of-work activities and commitments
 - General work-related arrangements, such as extra rest time during pregnancy and the availability of a rest room
 - Combining breastfeeding and work (see annexe 5)
- > If necessary, advise the employee to gradually reduce her out-of-work activities and commitments during her pregnancy.
- > Check that the employer has informed the employee about the arrangements regarding leave, breastfeeding, childcare and parental leave/life pattern. If the employee has not been informed, refer her to her manager/employer.
- > Ask whether the employee has thought about how she – and, where relevant, her partner – intend(s) to balance work and family life after her maternity leave. If she has not done so, encourage her to do so in the near future.

2.5 HIGHER RISK PROFILES: WHAT ADVICE IS IN ORDER?

- > Discuss the strategic plan with the employee.
- > Ensure that the action proposed in the strategic plan is taken.
- > Consider whether consultation with the employee's manager is required.
If so:
 - Ask the employee's permission to consult her manager.
 - Consider arranging a three-way discussion with the employee and her manager.
- > If the employer has a proper OHS policy for pregnant women, refer the employee to her manager for further guidance.

No proper OHS policy for pregnant women?

- > Assess whether the employee's working arrangements can easily be altered and whether anything is being done on that front.
- > Then refer the employee to her manager for further guidance.
- > If the employee's working arrangements cannot easily be revised, make one or more follow-up appointments in order to provide further guidance and check whether any changes have been made.
- > Consider whether it is necessary to discuss the case with or refer the client to another physician or a paramedic (see annexe 8).

Higher risk profile for the postpartum period?

- > Arrange a preventive follow-up consultation (a face-to-face consultation before the employee's maternity leave starts, or a telephone consultation during her leave period, about eight weeks after she has given birth).

2.6 ABSENTEEISM DURING PREGNANCY

- > If a pregnant employee is absent for more than a week, ask her to come and see you.
- > Establish whether a risk profile has already been drawn up; if not, draw one up and proceed as described in §2.1 and §2.2.

Revision of the employee's risk profile

- > Assess whether any (new) symptoms/medical problems have come to light, which could have implications for the employee's capacity for work and/or for the course of the pregnancy, necessitating revision of the employee's risk profile.
- > Revise the risk profile as appropriate and proceed as described in §2.3.

Reduced productivity due to pregnancy?

- > Advise the employer to apply to the UWV¹ for the reimbursement of pay on the basis of occupational disability due to pregnancy or childbirth². If necessary, refer to the information on this topic published at www.nvvg.nl.
- > Continue to give the employee guidance, even if benefit is awarded by the UWV.

No obvious reason for absenteeism?

- > Assess whether other factors may be at work, such as anxiety, lack of social support (at work or in private life) or physical strain (at work or in private life).
- > Make a follow-up appointment for a date three weeks ahead and then start evaluation (§3.1).

2.7 ABSENTEEISM IN THE POSTPARTUM PERIOD

- > If a new mother is off sick for more than two weeks³, ask her to come and see you.
- > Establish whether a risk profile has already been drawn up; if not, draw one up.

Revision of the employee's risk profile

- > Assess whether any (new) symptoms/medical problems have come to light, which could have implications for the employee's capacity for work and/or for the course of the pregnancy, necessitating revision of the employee's risk profile. In this context, make use of annexe 2.
- > Revise the risk profile as appropriate and proceed as described in §2.3.

Reduced productivity due to pregnancy or delivery?

- > Advise the employer to apply to the UWV (Dutch institute of social insurance) for the reimbursement of pay on the basis of occupational disability due to pregnancy or childbirth. If necessary, refer to the information on this topic published at www.nvvg.nl.
- > Continue to give the employee guidance, even if benefit is awarded by the Employee Insurance Scheme Executive Body.
- > Make a follow-up appointment for a date three weeks ahead and then start evaluation (§3.2).

¹ Dutch institute of social insurance.

² The final decision on entitlement to benefit rests with the social insurance physician of UWV.

³ NB: If the employee's absence is not reported to UWV immediately following her maternity leave, it cannot be classed as a pregnancy-related absence.

3 EVALUATION

*Start the evaluation **three to six weeks after the preventive consultation**, unless the employer has a good OHS policy and/or the employee's working arrangements can easily be revised. Make further evaluations until appropriate changes have been made or other action taken.*

3.1 HIGHER RISK PROFILE BUT NO ABSENTEEISM: HAVE THE INTERVENTION OBJECTIVES BEEN ACHIEVED?

- > Assess whether the work-related changes and other measures have eliminated risk to a sufficient extent.
- > Assess the progress of any medical problems and identify the reasons for any unfavourable developments.
- > Consider whether consultation with the employee's manager is required.
If so:
 - Ask the employee's permission to consult her manager.
 - Consider arranging a three-way discussion with the employee and her manager.
- > Enquire how supervision by the midwife, gynaecologist or GP is going and, if necessary, consult with the medical practitioner(s) in question (see annexe 8).
- > If necessary, revise the risk profile and the strategic plan for the remainder of the pregnancy and/or postpartum period.

3.2 ABSENTEEISM DURING PREGNANCY: HAVE THE INTERVENTION OBJECTIVES BEEN ACHIEVED?

*Start the evaluation **three weeks after the first absenteeism consultation**. Make further evaluations every three to six weeks until the employee starts maternity leave or fully resumes to work.*

- > Assess whether the work-related changes and other measures have eliminated risk to a sufficient extent.
- > Assess the progress of any medical problems and identify the reasons for any unfavourable developments.
- > Enquire how supervision by the midwife, gynaecologist or GP is going and, if necessary, consult with the medical practitioner(s) in question (see annexe 8).
- > If necessary, revise the risk profile and the strategic plan for the remainder of the pregnancy and/or postpartum period.

3.3 ABSENTEEISM DURING THE POSTPARTUM PERIOD: HAVE THE INTERVENTION OBJECTIVES BEEN ACHIEVED?

*Start the evaluation **two weeks after the end of the employee's maternity leave**. Make further evaluations every three to six weeks until she has fully resumed work*

- > Assess whether the work-related changes and other measures have eliminated risk to a sufficient extent.
- > Assess the progress of any medical problems and identify the reasons for any unfavourable developments.
- > Enquire how supervision by the midwife, gynaecologist or GP is going and, if necessary, consult with the medical practitioner(s) in question (see annexe 8).
- > If necessary, revise the risk profile and the strategic plan for the remainder of the postpartum period.

ANNEXE 1

WORK-RELATED RISK FACTORS, LIMITS AND RISK CONTROL STRATEGIES

NB: The following risk factors relate to the pregnant employee, her unborn child, the postpartum period and breastfeeding.

Risk factor	Risk factor limit	Risk control strategy ⁴
Physical strain	<p>Daily limit from the 20th week:</p> <ul style="list-style-type: none"> - 5 x 10 kg lifting - 25 bending movements - 2 hours standing - 3 hours walking - 5 x 15 steps climbing stairs <p>Daily limit from the 30th week:</p> <ul style="list-style-type: none"> - 5 x 5 kg lifting - 10 bending movements - 1 hours standing - 2 hours walking <p>Postpartum Increase strain (particularly lifting, carrying, pushing and dragging) gradually over first six months after birth. Throughout pregnancy and until three months post-partum: maximum weight to be lifted = 10 kg.</p>	<p>General occupational hygiene measures</p> <ul style="list-style-type: none"> • Manual workers: no working on items lower than belly height. If unavoidable, limit such work, particularly in last three months of pregnancy. • Replace standing work with seated work: make sure of a good chair and adequate legroom. Avoid operation of pedals while standing in the last three months. • Take action to limit lifting. • Standard lifting technique (bending the legs, keeping the object close to the body) inappropriate in the last three months; inform employee accordingly. <p>Occupational hygiene strategy:</p> <ul style="list-style-type: none"> • Eliminate or reduce physical strain by: <ul style="list-style-type: none"> - removing the need for strenuous tasks or activities by making logistic changes or by mechanisation. • Provide appropriate aids and resources. • Improve workplace design, taking account of lifting weight, frequency and height, as well as reach. • Reduce the duration and frequency of activities. • Divide work among more employees.
<p>Working hours NB: The limits recommended here are not the same as those referred to in the Working Hours Act 4:5 and 4:7 (annexe 7).</p>	<p>Pregnancy and Postpartum period</p> <ul style="list-style-type: none"> - From the 20th week, no night working: no working between 23.00 and 07.00 hours. - If the employee wishes, no unsocial working hours before the 20th week. - Regular working hours with twelve hours between shifts for travel, eating and sleeping. - No overtime, no more than nine hours per day, forty hours per week. - Entitlement to spend a quarter of working hours feeding/expressing milk. 	<ul style="list-style-type: none"> • Adjustment of working hours and rest times. • A pregnant employee is entitled to one or more extra breaks of a duration totalling one eighth of her working hours. • Replace night working and shift work with regular daytime work (or possibly regular evening work), from the start of the pregnancy. <p>Maintain the arrangements referred to above for the first six months after giving birth.</p>

⁴ The suggestions in the column headed 'Risk control strategy' are based partly on Health & Safety Information Sheet 12: Pregnancy and work (Sdu Uitgevers, The Hague, 2004).

<p>Mental strain</p> <p>NB. The limits recommended here are not the same as those referred to in Policy Rule 1.42 of the Working Conditions Decree (annexe 6)</p>	<ul style="list-style-type: none"> - Does the employee perceive herself to be under undue pressure of work; does she have little opportunity to regulate her work or make her own decisions; does she lack social support? - Is the employee exposed to aggression and inappropriate behaviour? 	<p>During pregnancy:</p> <ul style="list-style-type: none"> - Minimise exposure to stress. - Minimise exposure to aggression and inappropriate behaviour. <p>Postpartum/breastfeeding</p> <ul style="list-style-type: none"> - Gradually reintroduce exposure to stress • Ensure adequate psychosocial support by arranging regular discussions with key individuals (manager, HR personnel). Establish what activities the employee finds onerous, paying particular attention to pressure of work and the opportunity to regulate work. • Increase opportunities to regulate work: more flexible working hours, ability to adjust working tempo and duration of work. • Reduce pressure of work: less working to deadlines, spread work out over a longer period or share work with more colleagues. • Possibly: temporarily relieve employee of mentally strenuous activities involving substantial pressure of work and a high working tempo, with little opportunity to regulate work. <p>Postpartum to six months after giving birth</p> <p>After maternity leave, gradually reintroduce exposure to pressure of work, time constraints, deadlines, fixed working hours.</p>
<p>Chemicals</p>	<p>During pregnancy and breastfeeding:</p> <ul style="list-style-type: none"> - In the period around conception, during pregnancy and when breastfeeding, a female employee should not be exposed to substances that have a direct genotoxic effect mechanism. All mutagenic and many carcinogenic substances have such an effect mechanism. No safe exposure levels can be defined for such substances. - Other substances: limit to be determined by OHS professional with appropriate expertise, see column headed 'Risk control strategy'. - Substances on the list of carcinogenic, mutagenic and reprotoxic substances: see http://home.szw.nl and/or www.arbo.nl. 	<ul style="list-style-type: none"> • Where the employee's work involves the possibility of exposure to a substance that is known to be potentially harmful to a mother's unborn child or breastfeeding infant but has no genotoxic effect mechanism, a safe exposure level may be defined by an OHS professional with appropriate expertise. Defining such a level requires a high degree of specialist expertise, which cannot be expected of any OHS professional. • If the statutory exposure limit for the relevant substance takes account of any reprotoxic effect, the employee may work with the substance when pregnant and breastfeeding, provided that the statutory exposure limit is demonstrably adhered to in the workplace. However, consideration should be given to the possibility that the statutory exposure limit is out of date. Therefore, before advice is given on the basis of a statutory exposure limit, an OHS professional should make a careful study of at least the advisory reports published by the Health Council of the Netherlands regarding the relevant substance.

- Other substances: see annexes 1 and 2 of the European Directive 92/85/EEG see: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31992L0085:NL:HTML>
- If the statutory exposure limit for the relevant substance takes account of any reprotoxic effect, the employee may work with the substance when pregnant and breastfeeding, provided that the statutory exposure limit is demonstrably adhered to in the workplace. However, consideration should be given to the possibility that the statutory exposure limit is out of date. Therefore, before advice is given on the basis of a statutory exposure limit, an OHS professional should make a careful study of at least the advisory reports published by the Health Council of the Netherlands regarding the relevant substance.
- If not enough is known about a substance's reprotoxicity and/or it is not clear how safe the actual exposure level is, taking account of possible absorption through the skin, a precautionary approach should be adopted. This implies advising against all exposure. If necessary, consult the NCvB helpdesk or visit <http://nl.osha.Europe.eu>.
- Draw up a list of all the substances used within the organisation, which are potentially hazardous around the time of conception or during pregnancy and the postpartum period. In many cases, this list can simply expand upon the information in the existing Risk Assessment. The list should be checked against the substances referred to in the column to the left. The list should be regularly updated within the organisation.
- Establish a policy that pregnant employees should be relieved of any duties that could involve exposure to potentially hazardous substances. Subsequently inform all newly recruited female employees about this policy. This will prevent privacy problems arising later, because it will become more or less the norm to be relieved of relevant duties.
- Let all new employees (women and men) know that, if they work with potentially hazardous substances and they are planning a family, they should inform the employer. When an employee does so, action should be taken to prevent exposure. Where female employees are concerned, exposure prevention should continue into any pregnancy that may follow.
- Recommend that, if they work with any relevant substance, pregnant women and women who plan to breastfeed should inform the employer of their pregnancy as early as possible. When an employee does so, action should be taken to prevent exposure. Exposure prevention should continue until the employee and her child are no longer at risk.
- NB: Be alert to the privacy implications of any action undertaken.

Biological agents	During pregnancy:	The OBH (occupational bio-hygiene) principle
For full details see annexes 3 and 4	<p><i>Toxoplasmosis</i> Testing for toxoplasmosis compulsory in at-risk professions. Information and hygiene.</p> <p><i>Rubella (German measles)</i> Vaccination status to be determined on appointment in health care, primary education, childcare. If in doubt: vaccinate.</p> <p><i>Cytomegalie</i> Information and hygiene if work may involve intensive contact with children. Avoid contact with source if there is a clinically proven infection in the workplace.</p> <p><i>Herpes Simplex</i> Information and hygiene if work may involve contact with saliva.</p> <p><i>Varicella (chicken pox)</i> Screen joiners to ascertain whether they have had chicken pox. If in doubt: vaccinate.</p> <p><i>Lyme borreliose</i> Standard preventive advice.</p> <p><i>AIDS/HIV</i> Standard preventive advice.</p> <p><i>Erythema infectiosum</i> (parvovirus, fifth disease) IgG screening on appointment in health care, primary education, childcare: - IgG +: no action - IgG -: intervention</p> <p><i>Syphilis (lues)</i> Information and hygiene</p> <p><i>Hepatitis B</i> Vaccinate according to standard procedure Prevention through information provision and hygiene</p> <p><i>Morbilli (measles)</i> Establish vaccination status on appointment in health care, primary education, childcare. If in doubt: vaccinate</p>	<p>The OBH (occupational bio-hygiene) principle</p> <p>1 Addressing the source</p> <ul style="list-style-type: none"> • Tackle the agent itself. • Prevent the agent entering the source. • Address the source (e.g. a vector, an animal), repellents. • Disinfection; ultraviolet light, chemicals (potential for added hazards). • Screening for antibodies and/or vaccination prior to possible exposure. • Relieve pregnant women of duties that could involve exposure. <p>2 Technical measures</p> <ul style="list-style-type: none"> • Separation • Make contact unnecessary: ‘no touch’ taps and doors • Replace fabric towels with paper towels • HEPA-filters, locks, over- and under-pressure, etc • Bio-hazard cabinets • Use non-porous materials only <p>3 Organisational measures</p> <ul style="list-style-type: none"> • Minimise the number of people working near the sources. • Establish clean/dirty zones. • Limit the number of employees at any give location. • Prevent or minimise the presence of pregnant women in hazard zones at certain work sites. • Take special steps to keep at-risk groups (sensitive groups) away from the source. • Provide information instructions and education and monitor hygiene. • Keep everything properly clean. <p>4 Hygiene measures</p> <ul style="list-style-type: none"> • Behaviour: no hand-shaking, nose-picking, or eye-rubbing • Hand-washing, showering • Avoidance of certain contacts • Safe coughing habits • Toilet hygiene <p>5 Personal protective gear</p> <ul style="list-style-type: none"> • Skin protection: gloves, clothes, apron, hair cover, shoes • Eye protection: goggles, screen • Respiratory tract protection: mouth/nose mask <p>6 PEP (post-exposure prophylaxis) Following potentially hazardous contact (blood-blood contact, Exanthematous childhood diseases), first assess the risk, then if appropriate proceed to diagnostic testing at the source (is the source really infectious?); proceed to post-exposure prophylaxis is necessary. NB: Prophylactic agents can adversely affect a woman’s (unborn) child.</p>

	<p><i>Morbilli (measles)</i> Establish vaccination status on appointment in health care, primary education, childcare. If in doubt: vaccinate</p> <p>During breastfeeding: Information and hygiene; see also 'During pregnancy', particularly prevention of exposure to: Herpes simplex virus HIV, CMV Hepatitis B, C Other infectious diseases: see www.kiza.nl</p>	<p>7 Therapeutic treatment</p> <ul style="list-style-type: none"> • Make or obtain a diagnosis as soon as possible: if employees are taught to recognise warning signs, they can facilitate diagnosis and treatment. • Proceed to therapeutic treatment as soon as possible (legionella, Weil's disease).
Ionising radiation	<p>During pregnancy: The maximum dose for the foetus is 1 mGy (or mSv) resulting from radiological work undertaken by the mother during the pregnancy as a whole.</p> <p>During breastfeeding: Minimise the risk of accidents involving ionising radiation.</p>	<p>Female employees should be asked to inform the employer if they are trying for children or as soon as they become pregnant, so that the employer can make sure exposure is consistent with Section 32 ('Radiological protection') of the Nuclear Energy Act. No activities should be undertaken above 1 mGy.</p> <p>It is important that a radiological worker informs her departmental manager as soon as knows she is pregnant. In most cases, pregnant women do not have to be taken off radiological work. However, the employer needs to ensure that the risk of an accident involving a high radiation dose is minimal, both during the pregnancy and while the mother is breastfeeding. It is very important that women receive good explanatory information regarding the potential risks. In this context, the radiation expert and radiological doctor (occupational physician with radiological protection expertise) can play important roles. The possible need for changes to the pregnant employee's radiological activities can then be discussed with her.</p>
Non-ionising radiation (Radio frequency, microwave)	<p>During pregnancy: Potential exposure should be established by a specialist, by reference to the government's 'Guidelines on Electromagnetic Fields in the Workplace'.</p>	<p>Guidance should be provided by an expert with specialist knowledge concerning non-ionising radiation.</p> <p>Female employees should be asked to inform the employer if they are trying for children or if they become pregnant, so that the employer can ensure the government guidelines are complied with.</p> <p>The possible need for changes to the pregnant employee's relevant activities can then be discussed with her (concerns should be discussed and reliable information provided).</p>

Temperature	<p>During pregnancy: No exposure to uncomfortable climatic conditions.</p> <p>During breastfeeding: Employee should be exposed to extreme heat or cold only in consultation with the occupational physician.</p>	<ul style="list-style-type: none"> • Employee should be relieved of duties that involve working in extreme heat or cold. • Employee should be allowed the opportunity to periodically cool off/warm up. • Adequate opportunity for drinking should be provided when working in hot conditions. • Adequate (well-fitting!) protective clothing for an employee working in the cold. • When working under more normal circumstances, the employee should be able to regulate the temperature of her surroundings, in consultation with
Noise	<p>During pregnancy: No more than 80 dB(A) per eight-hour working day No peaks of more than 200 Pa.</p>	<ul style="list-style-type: none"> • Limit environmental noise by enclosure and screening of the source. • Limit duration of exposure. • NB: Ear protectors do not protect the foetus.
Vibration	<p>During pregnancy: No exposure to bodily vibration of more than 0.25 m/s² for eight hours per day</p>	<p>No activities involving exposure to more than 0.25 m/s² for eight hours per day. Consider whether the employee has an appropriate, properly adjusted chair; driving speed and/or duration may need to be adjusted.</p>
Multiple factors	Identify all risks.	Tackle and eliminate all risks

ANNEXE 2

PERSON-RELATED RISK FACTORS AND ASSOCIATED RECOMMENDATIONS

- A Problems apparent from general anamnesis
- B Problems apparent from obstetric anamnesis
- C Abnormal change in capacity for work during pregnancy
- D Abnormal change in capacity for work during postpartum period

Person-related risk factor	Recommendation
A Problems apparent from general anamnesis	
<ul style="list-style-type: none"> • Diabetes mellitus If risk of hypoglycaemia present: carefully regulated medication around conception and during pregnancy. 	Risk during pregnancy dependent on whether complications/ organ damage occurs. Avoid unsocial working hours, stress and physically strenuous work, which increase the risk of metabolic instability.
<ul style="list-style-type: none"> • Pre-existing hypertension Risk of superimposed pregnancy-related hypertension and growth impairment. 	Revise the employee's working arrangements and reduce work-related stress, unsocial working hours, night working and physically strenuous work.
<ul style="list-style-type: none"> • Hyper-/hypothyroidism/Graves' disease During pregnancy adjusted medication. Postpartum risk of exacerbation of Graves' disease. 	No special action needed if thyroid abnormalities are under control; consult a specialist if abnormalities prove difficult to control using medication.
<ul style="list-style-type: none"> • Vascular/renal disease Risk of pregnancy-related hypertension and growth impairment. 	Reduce physical strain and stress, avoid unsocial working hours, revise working arrangements/hours. Consultation with the curative sector recommended.
<ul style="list-style-type: none"> • Employee receiving treatment from another (organ) specialist Risks resulting from altered medication use: protect (unborn) child (e.g. from anti-epileptics). 	Dependent on the condition: consultation with the curative sector.
<ul style="list-style-type: none"> • Chronic back problems High risk of exacerbation during pregnancy. 	If necessary, limit physical strain.
<ul style="list-style-type: none"> • Historic psychological/psychiatric problems Anamnestic mood disorder, anxiety disorder and/or psychosis associated with increased risk of such problems during pregnancy and/or postpartum. Other risk factors influencing recurrence: <ul style="list-style-type: none"> - Relationship problems - Lack of social support - Living alone - Major life event 	<p>Estimate the risk of a psychiatric condition occurring; check for risk factors.</p> <p>If risk exists, <i>consider</i>:</p> <ul style="list-style-type: none"> • Referral to the curative sector, provision of active support in consultation with the midwife, partly with a view to evaluating medication use. • As a preventive measure, revise working arrangements/ hours, particularly to avoid stress. • Arrange a follow-up appointment with the occupational physician.
B Problems apparent from obstetric anamnesis	
<ul style="list-style-type: none"> • Anamnestic perinatal mortality 	Show understanding and empathy, reduce stress. With many common causes of perinatal mortality – e.g. premature birth, growth impairment, preeclampsia/HELLP syndrome – there is a risk of repetition. Revise the employee's working arrangements in line with particular risk.

<ul style="list-style-type: none"> • Pregnancy-related hypertension, preeclampsia, HELLP syndrome 	Throughout the pregnancy, avoid physical strain, stress, unsocial working hours and night working; revise working arrangements/hours.
<ul style="list-style-type: none"> • Growth impairment 	Throughout the pregnancy, avoid physical strain, stress, unsocial working hours and night working; revise working arrangements/hours. Consultation with the curative sector
<ul style="list-style-type: none"> • Premature birth Risk factors: <ul style="list-style-type: none"> - History of premature birth - History of cervical surgery - Multiple pregnancy - Abnormal amniotic fluid level - Congenital uterine abnormalities - In <i>utero</i> DES exposure 	Throughout the pregnancy, avoid physical strain, stress, unsocial working hours and night working; revise working arrangements/hours.
<ul style="list-style-type: none"> • Spontaneous abortion 	Only a risk factor if >2 previous occurrences; risk then depends on test results.
<ul style="list-style-type: none"> • Pelvic problems Risk of recidivism in subsequent pregnancy. 	Modify intensity and duration of work, particularly where physical strain and prolonged working in the same position (e.g. sitting) are involved. Short periods of movement with rests; postural and movement therapy (physiotherapy); referral to rehabilitation specialist where indicated.
<ul style="list-style-type: none"> • History of psychological/psychiatric conditions before or during pregnancy or postpartum Serious risk of recidivism in subsequent pregnancy. Other risk factors: <ul style="list-style-type: none"> - Relationship problems - Lack of social support - Living alone - Major life event 	Estimate the risk of a psychiatric condition developing and establish whether risk factors are present. If risk present, <i>consider</i> : <ul style="list-style-type: none"> • Consultation with or referral to a specialist • Adjusting working arrangements/hours as a preventive measure, with particular emphasis on stress avoidance (certainly where employee also has somatic problems or is off work) • Explaining the situation to employee's manager • Arranging a follow-up appointment
C Abnormal change in capacity for work during pregnancy	
<ul style="list-style-type: none"> • Antenatal diagnostics 	Employee unfit for work on day of tests. If problems detected: one or more subsequent days.
<ul style="list-style-type: none"> • IVF: embryo replacement 	If the employee asks for time off, she should be excused on the day of embryo replacement.
<ul style="list-style-type: none"> • 'Precious' pregnancy e.g.: <ul style="list-style-type: none"> - Older primigravida - Prolonged infertility 	If pregnancy is proceeding normally, no special work-related measures are required. Otherwise: refer to relevant item in this annexe.
<ul style="list-style-type: none"> • Multiple pregnancy 	From 20-24 weeks, limit work to four hours per day; stop work altogether at 26-30 weeks. No night working (23.00 to 07.00) at any time during the pregnancy; regular working hours if possible. From twenty weeks, avoid physical strain (earlier if there are problems or complications). Limit work-related stress.

<ul style="list-style-type: none"> • Growth impairment 	<p>Avoid physical strain, stress, unsocial working hours and night working; revise working arrangements/hours. Consultation with the curative sector and/or partial/complete cessation of work is recommended.</p>
<ul style="list-style-type: none"> • (Pregnancy-related) hypertension 	
<ul style="list-style-type: none"> • Preëclampsia: 	<p>With all forms of pregnancy-related hypertension/ preeclampsia, it is advisable to limit day-to-day activities and take extra rest. At least avoid physical strain, stress, unsocial working hours and night working, revise working arrangements/hours. Consultation with the curative sector is recommended.</p>
<ul style="list-style-type: none"> • (Pregnancy-related) diabetes mellitus Risk during pregnancy depends on whether complications/ organ damage occur. If risk of hypoglycaemia present: carefully regulated medication, also around conception. 	<p>Avoid unsocial working hours, stress and physically strenuous work, which increase the risk of metabolic instability.</p>
<ul style="list-style-type: none"> • Elevated risk of premature birth 	<p>Avoid physical strain, stress, unsocial working hours and night working throughout the pregnancy; revise working arrangements/hours. Consultation with the curative sector is recommended.</p>
<ul style="list-style-type: none"> • 'Hard belly' problems without other signs of premature birth 	<p>Replace standing/walking work with seated work. If necessary, adjust working hours.</p>
<ul style="list-style-type: none"> • Pelvic problems 	<p>Modify intensity and duration of work, particularly where physical strain and prolonged working in the same position (e.g. sitting) are involved. Short periods of movement with rests; postural and movement therapy (physiotherapy); referral to rehabilitation specialist where indicated.</p>
<ul style="list-style-type: none"> • Back problems 	<p>Limit physical strain. Consider cutting back daily activities considerably and referral to a physiotherapist specialising in pregnancy-related problems.</p> <p>With regard to the various specific conditions that affect the back, see the NVAB guidelines and the note at the end of this annexe.</p>
<ul style="list-style-type: none"> • Hyperemesis 	<p>Moderate vomiting or nausea: an individualised approach is likely to be most practical, such as adjusting the employee's working hours or taking extra breaks and avoiding nauseating smells. Serious medical problems: referral to curative sector.</p>
<ul style="list-style-type: none"> • Excessive fatigue 	<p>Enquire after possible work-related causal factors (external physical factors, physical strain, stress, unsocial working hours).</p> <p>Enquire after other possible causal factors:</p> <ul style="list-style-type: none"> • Psychological factors (anxiety, mood swings) • Situational factors (support from partner, domestic responsibilities) <p>Revise working arrangements/hours, provide support with removal of causal factors.</p>

<ul style="list-style-type: none"> • Vaginal haemorrhaging 	<p>Referral to a specialist: investigation of the cause is required. If no cause is found, there is an elevated risk of complications. Consider individualised revision of working arrangements, possibly in consultation with the curative sector (avoid physical strain, stress, non-standard working hours, exposure to vibration, etc).</p>
<ul style="list-style-type: none"> • Varices 	<p>Adjust working posture; avoid standing in particular and prolonged working in the same position (including sitting); periodically walk around. Assess the advisability of using elastic stockings.</p>
<ul style="list-style-type: none"> • Oedema 	<p>Revise the employee's working arrangements: seated work instead of standing work, regular breaks, raising the legs, partial/complete cessation of work. Assess the advisability of using elastic stockings.</p>
<p>Carpal tunnel syndrome</p>	<p>Avoid frequent repetitive wrist movements, activities requiring the use of considerable hand strength, holding the wrist in an extreme position and exposure to hand-arm vibrations.</p> <p>During pregnancy: conservative policy (in consultation with GP: pain killers, splint).</p>
<p>Depression</p> <p>Risk factors:</p> <ul style="list-style-type: none"> - Personal or family history of depression (during pregnancy/postpartum or at other times) - Youth - Lack of social support - Living alone - Having numerous children - Major life events - Relationship problems - Ambivalence to pregnancy <ul style="list-style-type: none"> • Personal factors: <ul style="list-style-type: none"> - Relationship problems - Lack of social support - Living alone - Domestic violence - Financial problems - Difficult commuting 	<ul style="list-style-type: none"> • Provide guidance according to NVAB guidelines on psychological problems (see note at the end of this annexe). • Establish whether the employee is receiving appropriate therapy. • If possible, the employee should continue to work as part of the therapeutic process, possibly subject to revision of working arrangements/hours. • Avoid stress. <p>Discuss the problems. Encourage the definition of priorities and offer support with the resolution of causal factors. Where possible, use the help of the employee's partner, other lay carers, occupational social worker, employer.</p> <p>If necessary, revise working arrangements/hours.</p>
<p>D Abnormal change in capacity for work during postpartum period</p>	
<ul style="list-style-type: none"> • Birth between 16 and 24 weeks 	<p>Standard recovery period of four weeks for the promotion of mental and physical recovery.</p>
<ul style="list-style-type: none"> • Birth of any of the following: <ul style="list-style-type: none"> - Premature baby - Dysmature baby - Seriously ill baby - Baby with a serious congenital abnormality 	<p>If the progress of the postpartum period is abnormal because the baby has abnormalities/medical problems, maternity leave should be extended by up to ten weeks.</p>
<ul style="list-style-type: none"> • Sectio Caesarea 	<p>Provided there are no complications, the employee will normally recover within ten weeks. If there are complications, consultation with the curative sector is required.</p>

<ul style="list-style-type: none"> • Assisted birth 	<p>Provided there are no complications, the employee will normally recover within ten weeks. If there are complications, (e.g. pelvic floor problems), the employee's working arrangements should be revised – if necessary in consultation with the curative sector.</p>
<ul style="list-style-type: none"> • Postpartum depression Risk factors <ul style="list-style-type: none"> - History of depression - Depression during pregnancy - Anxiety during pregnancy - Major life events - Lack of social support - Personality factors (nervous or negative outlook) - Relationship problems - Lower social-economical status - Obstetric problems during the pregnancy 	<ul style="list-style-type: none"> • Provide guidance according to NVAB guidelines on psychological problems (see note at the end of this annexe). • Intensive individual psychological/ psychiatric guidance by an expert or at a multidisciplinary centre. • Be alert to the possibility of suicidal/infanticidal inclinations • If possible, the employee should continue to work as part of the therapeutic process, possibly subject to revision of working arrangements/hours and avoidance of stress. • Explaining the situation to employee's manager. • See also notes on postpartum thyroiditis.
<ul style="list-style-type: none"> • Postpartum psychosis Risk factors: Pre-existing disorder: <ul style="list-style-type: none"> - Bipolar disorder - Schizophrenia - Previous (postpartum) psychosis 	<ul style="list-style-type: none"> • Provide guidance according to NVAB guidelines on psychological problems (see note at the end of this annexe). • Arrange for treatment at a multidisciplinary centre. • Reintegration in consultation with curative sector.
<ul style="list-style-type: none"> • Anxiety problems Risk factor <ul style="list-style-type: none"> - Personal or family history of psychiatric illness - Relationship problems 	<ul style="list-style-type: none"> • Provide guidance according to NVAB guidelines on psychological problems (see note at the end of this annexe). • Individualised psychological/psychiatric guidance. • Revise working arrangements/hours; avoid stress.
<ul style="list-style-type: none"> • Post-traumatic stress disorder Risk factors: <ul style="list-style-type: none"> - Difficult pregnancy or partus - Child with abnormalities or neonatal problems - History of sexual trauma 	<ul style="list-style-type: none"> • Provide guidance according to NVAB guidelines on psychological problems (see note at the end of this annexe). • Individualised psychological/psychiatric guidance. • Revise working arrangements/hours; avoid stress.
<ul style="list-style-type: none"> • Personal factors: <ul style="list-style-type: none"> - Relationship problems (mother/child) - Lack of social support - Living alone - Domestic violence - Financial problems 	<p>Discuss the problems. Encourage the definition of priorities and offer support with the resolution of causal factors. Where possible, use the help of the employee's partner, other lay carers, occupational social worker, employer. If necessary, revise working arrangements/hours.</p>

B: DETAILED RECOMMENDATIONS PER INFECTIOUS DISEASE

Infectious disease	Recommendations For sector-specific recommendations, see annexe 4
Toxoplasmosis	<ul style="list-style-type: none"> • Test for toxoplasmosis in pregnant women in at-risk professions (particularly in the meat processing industry, horticulture, animal care, home care and travel outside Europe). • Modify the activities of seronegative pregnant women in at-risk professions (in line with the Working Conditions Decree). • Ensure that pregnant employees in general and seropositive pregnant women in at-risk professions in particular are properly informed (with seropositivity, there is a small risk of congenital toxoplasmosis).
Rubella (German measles)	<ul style="list-style-type: none"> • When a female employee of childbearing age starts work in the health sector, primary education or childcare: <ul style="list-style-type: none"> - Establish vaccination status and, if in doubt, re-vaccinate. - Screen unvaccinated female employees of childbearing age for Rubella immunity; if seronegative, offer MMR vaccination. • <i>Unvaccinated employees in the first half of the pregnancy in the event of a Rubella epidemic in the Netherlands:</i> <ul style="list-style-type: none"> - Advise avoiding the workplace until twenty-three days after the disappearance of skin lesions from the last infected patient (max incubation period is 12-23 days). - Advise resuming work sooner if IgG positive or more than twenty weeks pregnant. - Possibly offer immunological testing for Rubella via the GP; first discuss implications thoroughly.
Cytomegalie	<ul style="list-style-type: none"> • Pregnant employees in close contact with children must be told that the prevention of CMV infection depends on following standard hygienic procedures. • If a CMV infection is demonstrated by a clinician and/or by lab tests to exist in the workplace, pregnant employees must avoid all contact with saliva (hugging) and urine. • Pre-conception screening of employees for IgG antibodies is not advised.
Herpes Simplex	<ul style="list-style-type: none"> • Advise use of standard hygienic procedures, particularly by pregnant employees who have frequent 'saliva contact' (dentists, oral hygienists, etc.). • Otherwise no specific advice regarding HSV for pregnant employees.

<p>Varicella (chicken pox)</p>	<ul style="list-style-type: none"> • Female employees of childbearing age starting work in the health sector, primary education or childcare should be screened for Varicella (chicken pox). <ul style="list-style-type: none"> - Positive anamnesis: no further action - Negative anamnesis (common in employees from (sub)tropical countries): establish immune status - Negative immune status and planning pregnancy: offer vaccination (vaccine available in the Netherlands). • Where exposure to Varicella is suspected or pregnant employee has clinical symptoms, the following advice applies throughout the pregnancy (CBO guidelines): <ul style="list-style-type: none"> - Positive anamnesis or status after vaccination: reassurance and no further action - Negative anamnesis: refer to hospital and establish immune status if suspected exposure less than 96 hours earlier - Negative status or status not known within 96 hours: start administration of Varicella Zoster Immunoglobulin (VZIG) - Chicken pox already established or exposure was more than 96 hours earlier: VZIG is of no benefit. • A seronegative pregnant employee may return to work twenty-eight days after appearance of the last chicken pox case (infectious period is up to seven days after appearance of vesicles and maximum incubation period is twenty-one days).
<p>Lyme borreliosis (Lyme's disease)</p>	<ul style="list-style-type: none"> • In view of the very low incidence of congenital Lyme borreliosis, the preventive advice applicable to any Dutch person in an endemic region during the 'tick season' (March to November) is equally appropriate for pregnant employees. • Treat pregnant employees who have Erythema migrans or another form of early Lyme borreliosis with Amoxicillin, 500 mg three times a day for fourteen days (CBO guidelines).
<p>AIDS/HIV</p>	<ul style="list-style-type: none"> • The preventive advice applicable to all personnel in at-risk professions is equally appropriate for pregnant employees. In particular: <ul style="list-style-type: none"> - Guidelines of the Infection Prevention Committee - Sector-specific guidelines (e.g. use of disposable blades by hairdressers) - Where increased risk of infection exists following a 'needle accident', the employee should immediately be referred to an AIDS treatment provider (all occupational physicians working in sectors with a 'needle accident' risk should have access to such professionals).

Erythema infectiosum (Parvovirus / Fifth disease)	<p>Step 1</p> <ul style="list-style-type: none"> Female employees of childbearing age starting work in the health sector, primary education or childcare should be screened for Parvo B19: <ul style="list-style-type: none"> Positive IgG: no further action required Negative IgG: elevated risk. <p>Step 2</p> <ul style="list-style-type: none"> Employees whose immune status is unknown or seronegative and are actively seeking to become pregnant should be offered repeat blood tests. <p>Step 3</p> <ul style="list-style-type: none"> In the case of a pregnant woman whose immune status is unknown or seronegative, if there is a suspected outbreak of Erythema infectiosum in the workplace (school/ nursery): <ul style="list-style-type: none"> Less than twenty weeks pregnant: employee should avoid the workplace. Workplace attendance is safe three weeks after the last case of Erythema infectiosum or when employee is more than twenty weeks pregnant. <p>Step 4</p> <ul style="list-style-type: none"> In the circumstances described in step 3, it is advisable to establish the immune status of the pregnant employee (in the event of acute infection, follow-up action by the gynaecologist should be initiated).
Syphilis (lues)	<ul style="list-style-type: none"> For pregnant employees in at-risk professions (particularly the sex industry), information provision and personal hygiene are the most important preventive measures. In relation to all activities, consideration should be given to the risk of haematogenic transfer or transfer via active lesions.
Hepatitis B	<ul style="list-style-type: none"> All personnel working in professions with an elevated risk of Hepatitis B infection should be vaccinated; see for www.kiza.nl for a list of professions. The preventive advice applicable to all personnel in at-risk professions is equally appropriate for pregnant employees.
Morbilli (measles)	<ul style="list-style-type: none"> Female employees of childbearing age starting work in the health sector, primary education or childcare: <ul style="list-style-type: none"> Establish vaccination status and, if in doubt, re-vaccinate. Screen unvaccinated female employees of childbearing age for Morbilli immunity; if seronegative, offer MMR vaccination. Because of the high transmission rate and highly infectious nature of measles, in the event of a measles epidemic in the Netherlands, the following advice should be given to unvaccinated employees (particularly at children's centres and schools in pietistic reformed Christian or anthroposophic communities): <ul style="list-style-type: none"> Avoid the workplace until fourteen days after the disappearance of skin lesions from the last infected patient (max incubation period is 8-14 days). Advise resuming work sooner if IgG positive. Possibly offer immunological testing for measles via the GP; first discuss implications thoroughly.
Travellers, personnel seconded to (sub)tropical countries	<ul style="list-style-type: none"> Refer to travellers' vaccination bureau.
Other infectious diseases	<p>See www.kiza.nl</p>

ANNEXE 4

BIOLOGICAL AGENTS: SECTOR-SPECIFIC RECOMMENDATIONS

Sector	Infectious disease For specific recommendations per agent: see annexe 3	General recommendations
Health care	<ul style="list-style-type: none"> • Rubella (German measles) • Cytomegalie (CMV) • Hepatitis B (HBV) • Varicella (chicken pox) • Human immunodeficiency virus (HIV) • Erythema infectiosum/ 'Fifth disease' (Parvo B19) • Morbilli (measles) • Other infections (incl. Hepatitis C/HCV) 	<ul style="list-style-type: none"> • On appointment, screen for: <ul style="list-style-type: none"> - Varicella (anamnesis: already had it?) No: serological screening and/or vaccination - MMR (anamnesis: vaccinated?) No: serological screening and/or vaccination for Morbilli and Rubella - Erythema infectiosum: serological testing (IgG Parvo B19) - Hepatitis B (anamnesis: vaccinated?) No: vaccination • Seronegative pregnant women: <ul style="list-style-type: none"> - Advise avoidance of contact with children with Exanthema or Varicella (if contact has occurred: see annexe 3). • CMV: provide information about standard hygienic procedures. • Clinically proven CMV infection in the workplace: avoid source (see annexe 3). • Needle accident: consultation with experienced assessor.
Laboratories	<ul style="list-style-type: none"> • Toxoplasmosis • Syphilis • Rubella (German measles) • Cytomegalie (CMV) • Herpes simplex • Varicella (chicken pox) • Lyme borreliosis (Lyme's disease) • Human immunodeficiency virus (HIV) • Erythema infectiosum/ 'Fifth disease' (Parvo B19) • Hepatitis B (HBV) • Morbilli (measles) • Other infections (incl. Hepatitis C/HCV) 	<ul style="list-style-type: none"> • On appointment screening for: <ul style="list-style-type: none"> - Varicella (anamnesis: already had it?) No: serological screening and/or vaccination - MMR (anamnesis: vaccinated?) No: serological screening and/or vaccination for Morbilli and Rubella - Erythema infectiosum: serological testing (IgG Parvo B19) - Hepatitis B (anamnesis: vaccinated?) No: vaccination • Seronegative pregnant women: <ul style="list-style-type: none"> - Advise avoidance of contact with children with Exanthema or Varicella (if contact has occurred: see annexe 3). • CMV: provide information about standard hygienic procedures. • Clinically proven CMV infection in the workplace: avoid source (see annexe 3). • Needle accident: consultation with experienced assessor. • Questions raised regarding risk to pregnancy or rare infections: <ul style="list-style-type: none"> - consultation with experts (medical microbiologist, Clb or GGD www.ggd.nl).

Childcare/ disability care	<ul style="list-style-type: none"> • Rubella (German measles) • Cytomegalie (CMV) • Varicella (chicken pox) • Erythema infectiosum/'Fifth disease' (Parvo B19) • Morbilli (measles) • Other infections 	<ul style="list-style-type: none"> • On appointment screening for: <ul style="list-style-type: none"> - Varicella (anamnesis: already had it?) No: serological screening and/or vaccination - MMR (anamnesis: vaccinated?) No: serological screening and/or vaccination for Morbilli and Rubella - Erythema infectiosum: serological testing (IgG Parvo B19) - Advise avoidance of contact with children with Exanthema or Varicella (if contact has occurred: see annexe 3). • CMV: provide information about standard hygienic procedures. • Clinically proven CMV infection in the workplace: avoid source (see annexe 3).
Primary education	<ul style="list-style-type: none"> • Rubella (German measles) • Varicella (chicken pox) • Erythema infectiosum/'Fifth disease' (Parvo B19) • Morbilli (measles) • Other infections 	<ul style="list-style-type: none"> • On appointment screening for: <ul style="list-style-type: none"> - Vaccinated against Varicella? No or status unknown: serological testing or vaccination. - Had MMR vaccination? No or status unknown: serological testing or vaccination for Morbilli and Rubella - Erythema infectiosum: serological testing (IgG Parvo B19) • Seronegative pregnant women: <ul style="list-style-type: none"> - Advise avoidance of contact with children with Exanthema or Varicella (if contact has occurred: see annexe 3)
Animal care/ livestock farming	<ul style="list-style-type: none"> • Toxoplasmosis • Lyme borreliosis (Lyme's disease) • Other infections (incl. leptospirosis, Q fever, Chlamydomphila abortus) 	<ul style="list-style-type: none"> • In at-risk professions: <ul style="list-style-type: none"> - Test pregnant employees and provide good information (see also Toxoplasmosis and Lyme's disease in annexe 3).
Outdoor workers (forestry/ park-keeping)	<ul style="list-style-type: none"> • Toxoplasmosis • Lyme borreliosis (Lyme's disease) • Other infections (incl. leptospirosis, listeriosis) 	<ul style="list-style-type: none"> • In at-risk professions: <ul style="list-style-type: none"> - Test pregnant employees and provide good information (see Toxoplasmosis and Lyme's disease in annexe 3).
Meat processing	<ul style="list-style-type: none"> • Toxoplasmosis • Other infections (incl. listeriosis, Salmonella, Hepatitis E) 	<ul style="list-style-type: none"> • In at-risk professions: <ul style="list-style-type: none"> - Test pregnant employees and provide good information (see also Toxoplasmosis and Lyme's disease in annexe 3).
Police, fire brigade and prison officers	<ul style="list-style-type: none"> • Human immunodeficiency virus (HIV) • Hepatitis B (HBV) • Other infections (incl. Hepatitis C/HCV) 	<ul style="list-style-type: none"> • Vaccinated against Hepatitis B?: No: vaccinate • Needle accident: consultation with experienced assessor.
Cleaning	<ul style="list-style-type: none"> • Human immunodeficiency virus (HIV) • Hepatitis B (HBV) (incl. Hepatitis C /HCV) 	<ul style="list-style-type: none"> • Vaccinated against Hepatitis B?: No: vaccinate • Needle accident: consultation with experienced assessor.

Travellers, personnel seconded to (sub) tropical countries	<ul style="list-style-type: none"> • Other infections (incl. Malaria, Hepatitis E) 	<ul style="list-style-type: none"> • Refer to travellers' vaccination bureau
Sex industry	<ul style="list-style-type: none"> • Syphilis • Human immunodeficiency virus (HIV) • Hepatitis B (HBV) • Other infections 	<ul style="list-style-type: none"> • Vaccinated against Hepatitis B? No: vaccinate • Information and regular STD checks

ANNEXE 5

BREASTFEEDING AND WORK

Section 4:8 of the Working Hours Act gives an employee who is breastfeeding the right to breaks during the first nine months after giving birth, for the purpose of breastfeeding the infant or expressing milk. If an employee wishes to exercise this right, she must give her employer notice, preferably before taking maternity leave. The employer must then provide a suitable closable room, with a bed or couch. The employee is entitled to breastfeed or express milk as often and for as long as necessary, subject to a limit of a quarter of her working hours. The employer is obliged to pay the employee for such time, as if it were working time. The timing and duration of the breaks has to be decided in consultation with the employer.

Before an employee begins her maternity leave, the employer has to provide her with information about any work-related risks that exist for an employee with a new baby, about any work-related hazards that could have implications for the quantity and quality of her milk and about the measures in place to control such hazards. The main risks for breastfeeding mothers involve chemicals, biological agents and psychological strain.

Why breastfeed?

The WHO advises that all babies should be exclusively breastfed for at least six months. Breastfeeding is beneficial to the health of mother and child.

Breastfeeding in practice

It is a good idea for an employee to make arrangements for breastfeeding or expressing milk with her employer before she starts her maternity leave. A number of tips are given below.

Advise the employee:

- to inform her employer and colleagues in good time that she intends to combine breastfeeding and work and that she would appreciate their support (explain that entitlement to the necessary breaks is temporary, because breastfeeding is required for a few months only);
- to start practising expressing milk in good time (after about five weeks, a baby should be able to breastfeed well and is ready to learn the new technique needed to drink from a bottle);
- to find out where the expression and/or rest room is and whether there is a refrigerator, or to ask her manager to make the appropriate arrangements.

The employer is advised to provide a room with hot and cold running water for cleaning the expression flask. Possibly the employee can provide a cool bag in which to keep expressed milk.

Ideas for combining breastfeeding and work

- Express milk at work.
- Go home or to the nursery or child minder's to feed the baby, if time constraints allow (up to a quarter of working hours allowed as breaks).
- Arrange for the baby to be brought to the workplace to be fed.
- Replace breastfeeding with bottle feeding at one or more feeding times. NB: It takes a while to scale down breastfeeding.
- Make (temporary) flexible arrangements for working around the baby's feeding times, e.g. to enable an early return home or some working from home.
- Arrange a period of part-time parental leave, holiday or unpaid leave for the period immediately after maternity leave, to allow more time for breastfeeding.
- Arrange a period of full-time parental leave, holiday or unpaid leave for the period immediately after maternity leave, so as to remove the need to feed or express milk at work, or to reduce the length of time that feeding/expression at work is necessary.

PRACTICAL INFORMATION

Women particularly need practical information about breastfeeding, expressing milk and saving expressed milk. There are various good websites providing such information (e.g. www.borstvoeding.nl) and advice can also be obtained from lactation specialists.

SOURCES

www.voedingscentrum.nl

www.rivm.nl

www.nationaalkompas.nl

ANNEXE 6

POLICY RULE 1.42 OF THE WORKING CONDITIONS DECREE: WORKING ARRANGEMENTS FOR PREGNANT AND BREASTFEEDING EMPLOYEES

INTRODUCTION

In 2007, the revised Working Conditions Act came into force. The new act introduced few material changes in the rules on pregnancy and the postpartum period. However, private sector employers and employees were obliged to make a choice before 2010, either to adopt Policy Rule 1.42 or to make alternative arrangements regarding the risks and to record these arrangements in their own OHS catalogues. The arrangements made may differ from one industry to another. In the public sector, the government is responsible for making the necessary arrangements. Policy Rule 1.42 is automatically applicable unless and until alternative arrangements are recorded in OHS catalogues.

POLICY RULE 1.42

- 1** The employer's obligation to organise the work of pregnant and breastfeeding employees so that it entails no hazards to such employees' health or safety and has no adverse effect on pregnancy or lactation implies at least the following:
 - A** At work, a pregnant employee must not be exposed to body vibrations or shocks involving an acceleration of more than 0.25 m/s².
 - B** At work, a pregnant employee must not be exposed to an equivalent noise level exceeding 80 dB(A) or a peak noise level exceeding 200 Pa.
 - C** A pregnant employee must not be exposed to climatic conditions that may be regarded as unpleasant.
 - D** The need for a pregnant employee to bend, crouch or kneel in the context of her work should be removed as far as possible. In the last three months of pregnancy, an employee cannot be obliged to spend more than an hour bending, crouching, kneeling or operating (a) foot pedal(s) while standing.
 - E** During pregnancy and in the first three months after giving birth, the need for an employee to manually lift weights in the context of her work should be removed as far as possible. Where the need for manual lifting cannot be removed:
 - at any time during pregnancy and in the first three months after giving birth, the weight to be lifted at any one time must always be less than 10 kilograms;
 - from the twentieth week of pregnancy, no more than 5 kilograms should be lifted, no more than ten times a day;
 - from the thirtieth week of pregnancy, no more than 5 kilograms should be lifted, no more than five times a day.
 - F** At work, a pregnant or breastfeeding employee must not be exposed to any substance that could be detrimental to her health and/or that of her (unborn) child.
 - G** The work to be undertaken by a pregnant employee under raised atmospheric pressure must be confined to activities where the overpressure is limited to 1.5.10s Pa and the zero times are not exceeded.
 - H** A pregnant employee cannot be obliged to come into direct contact with an ultrasonic vibration source. The provisional occupational exposure limit for ultrasonic atmospheric vibration with a frequency above 20 kHz is 110 dB(A) per tierce band.
- 2** Climatic conditions shall be regarded as unpleasant, in the sense of the first clause, under C, if the predicted percentage of dissatisfaction (PPD), as determined in accordance with NEN-ISO 7730, exceeds 20 per cent.
- 3** The substances referred to in the first clause, under F, shall be deemed to include at least the following:
 - A** substances that are capable of adversely affecting health by means of a genotoxic effect mechanism and are liable to reach an infant or unborn child via its mother, including all mutagenic and almost all carcinogenic substances;
 - B** substances that are capable of adversely affecting the health of an infant or unborn child, by means of a non-genotoxic effect mechanism, in the event of maternal exposure.

ANNEXE 7

WORKING CONDITIONS LEGISLATION RELATING TO PREGNANCY AND THE POSTPARTUM PERIOD

The legislation is aimed at keeping a woman in touch with her workplace during pregnancy, with a view to facilitating her return to work after giving birth (Monster). At the time of writing (1 July 1997), the most important statutory rules concerning pregnancy and work were contained in the Working Conditions Decree and the associated OHS regulations and OHS Policy Rules.

An employer is expected to pursue a health, safety and welfare policy that takes account of pregnancy, so that when an employee becomes pregnant, neither she nor her (unborn) child are at risk as a result of her work.

In order to take advantage of the entitlements that stem from the special regulations covering pregnancy and the postpartum period, a woman has to notify her employer about her pregnancy and – in due course and where relevant – about her breastfeeding plans (Working Conditions Decree, Article 1.1, clauses 5a and 5b).

The employer's Risk Assessment (in Dutch: RI&E) has to identify the risks and hazards to employees during pregnancy and the postpartum period (Working Conditions Act, Article 5, Working Conditions Decree, Article 1.41). In this context, 'pregnancy' should be interpreted broadly, as the period from when a woman seeks to become pregnant to when she stops breastfeeding. To comply with Article 1.41 of the Working Conditions Decree, the Risk Assessment must at least cover the matters specified in European Directive 92/85/EEC. Annexe I to that directive refers in turn to five other documents. Article 4, clause 1, of annexe I to the directive deals with evaluation and information concerning a non-exhaustive list of agents (external physical factors, physical strain, biological and chemical agents), procedures and working circumstances that could have implications for pregnancy. Article 6 of Annexe II to the directive deals with a number of exposure-related agents and working circumstances during pregnancy and lactation.

If the Risk Assessment highlights the existence of hazards, the employer is required to take action to eliminate them as far as possible. Where elimination is not possible, an employer may temporarily modify working methods and/or rest times. If such modifications cannot provide adequate protection, the employer may offer the employee a temporary change of duties. In extreme cases, an employee may be relieved of all duties (Working Conditions Decree, Article 1.42). The employer must provide information about potential risks and the corresponding countermeasures (Working Conditions Act, Article 8). The employer is not expected to review the employee's working arrangements until the employee has made her pregnancy or her breastfeeding intentions known (Working Conditions Decree, Article 1.1, clauses 5a and 5b). Policy Rule 1.42 of the Working Conditions Decree serves to specify how an employer is expected to organise a pregnant or breastfeeding employee's work so as to exclude or minimise risk (see annexe 6 to these guidelines).

A pregnant woman is entitled to extra breaks or a reduction in working hours, totalling up to one eighth of her normal working hours. She is also entitled to a regular working and rest pattern and cannot be obliged to work overtime or at night. These entitlements continue until six months after she has given birth (Working Hours Act 4:5 and 4:7). If a pregnant woman's medical condition justifies rest time exceeding an eighth of her normal working hours, appropriate arrangements need to be made using the Sickness Benefit Act system. The rules relating to pregnancy and work are the subject of an OHS information sheet (The Hague, SDU, 2004).

ANNEXE 8

COOPERATION BETWEEN CURATIVE AND OCCUPATIONAL PRACTITIONERS: DIVISION AND ALIGNMENT OF RESPONSIBILITIES

(ER = employer, OP = occupational physician)

When	Who			
	Occupational physician	Midwife Gynaecologist GP-midwife	GP	Other RIVM, NCvB, Erfocentrum, genetic centres
Pre-conception	<ul style="list-style-type: none"> Advise ER on formulation of OHS policy Provide new employees and those seeking to become pregnant with information about risks and countermeasures 	<p>See note at end of table</p> <ul style="list-style-type: none"> If work-related risks identified: Refer to ER/OP 	<p>See note at end of table</p> <ul style="list-style-type: none"> If work-related risks identified: Refer to ER/OP 	<p>See note at end of table</p> <ul style="list-style-type: none"> If work-related risks identified: Refer to ER/OP
First four months of pregnancy	<ul style="list-style-type: none"> Preventive consultation: <ul style="list-style-type: none"> Draw up risk profile Advise on preventive action (if work-related risks identified) Give information on combining breastfeeding and work, combining motherhood and work, find out whether information has been given regarding leave, childcare and parental support schemes Pregnancy (suspected to be) not progressing normally: refer to curative sector 	<ul style="list-style-type: none"> First consultation <ul style="list-style-type: none"> Enquire about work Medical problems/ work-related risk factors for which changes are indicated: refer to OP 	<ul style="list-style-type: none"> Coordinating and mediating role 	<ul style="list-style-type: none"> Antenatal diagnostics if particular abnormalities detected

Fifth month to maternity leave	<ul style="list-style-type: none"> Higher risk profile/ absenteeism: continue guidance 	<ul style="list-style-type: none"> Medical problems/ work-related risk factors for which changes are indicated: refer to OP 	<ul style="list-style-type: none"> Coordinating and mediating role 	
During maternity leave	<ul style="list-style-type: none"> Higher risk profile: <ul style="list-style-type: none"> Eight weeks after birth, phone to enquire after recovery and return to work, action on risks, breastfeeding 	<ul style="list-style-type: none"> After check at six weeks post-partum, if indicated: <ul style="list-style-type: none"> Limited capacity for work: refer to OP Give information on limiting factors and communicate with OP 	<ul style="list-style-type: none"> Coordinating and mediating role Limited capacity for work: refer to OP 	
After maternity leave	<ul style="list-style-type: none"> Higher risk profile/ absenteeism: continue guidance 		<ul style="list-style-type: none"> Limited capacity for work: refer to OP 	

Note on pre-conception period

A Committee of the Health Council of the Netherlands is currently preparing a report to the minister regarding pre-conception care, which will look at work-related factors and will consider the nature of and organisational arrangements for 'pre-conception advice'.