
pregnancy and work in childcare

The leaflet is based on the *Pregnancy and Work Guide 2002*

PREGNANCY AND WORK IN CHILDCARE

The *Pregnancy and Work Guide 2002* published by WorkCover provides practical advice for employers and contractors to help them develop safe systems of work for pregnant and breastfeeding women and ensure their physiological and psychological welfare. It helps employers integrate requirements of industrial relations, anti-discrimination and industrial relations legislation in managing pregnant and breastfeeding employees.

Hazards

Hazards in the workplace that may have particular impact on pregnant or breastfeeding women fall into three categories: biological, chemical and physical. Relevant biological hazards are infectious agents which can cause developmental defects, stillbirth, and increased risk of miscarriage or infant mortality. While most infections during pregnancy have no effect on the foetus, some viruses, bacteria or parasites may be transmitted from mother to child across the placenta, during or after birth, through breastfeeding or other close contact. Infections resulting in high fever early in the pregnancy may harm the foetus. For most employees the risk of infection at work is no higher than ordinary risks in daily life, but some occupations such as childcare do expose workers to infection. The risk should be managed by effective risk assessment, careful use of suitable control measures and, where appropriate, access to immunisation. Employers in childcare should provide staff with information on risks of infectious diseases, and offer immunisation to employees at risk, noting that some relevant vaccines should not be given to pregnant women.

Human cytomegalovirus (CMV) is transmitted between humans, through breast milk, saliva, sexual intercourse and blood. Most healthy adults usually show no symptoms, but some may suffer an illness with symptoms similar to glandular fever (infectious mononucleosis). In adults, acute illness may last 2 - 3 weeks, then the virus persists in a latent state. A pregnant woman infected with CMV may transmit the virus across the placenta to her unborn child. A small number of babies thus infected may have symptoms at birth and can suffer long-term complications including damage to the nervous system, learning disability, and deafness.

◆ **Control measures:** Paying scrupulous attention to hygiene, including hand washing. Particular care should be taken when handling nappies, excreta etc from babies and children. No vaccine is available at present, but many women are immune because they caught the infection in early life.

Hepatitis A is transmitted by humans, and water or food contaminated by faeces. Although severe hepatitis is rare, the severity of disease increases with age and symptoms in adults and adolescents are more severe and last longer than in children, who often show no symptoms. Common symptoms and signs include fever, headache, jaundice, loss of appetite, nausea, vomiting and abdominal pain from a tender, enlarged liver. The incubation period varies between 15-45 days with an average of about 28 days. There is no risk of transmission one week after jaundice and darkening of the urine have appeared. There is no persistent or latent infection (carrier state). A mother may transmit the infection to the foetus but this is very rare. The virus multiplies mainly in the liver and passes into the faeces through the bile duct. Most transmission to babies is by mouth contact with faecally-contaminated objects.

◆ **Control measures:** Paying scrupulous attention to hygiene, especially hand washing. A vaccine is available for adults and children but it is not currently licensed for use in babies under one year old.

Hepatitis E is transmitted in a similar way to hepatitis A and infections have been reported in the UK, but usually in travellers returning from abroad. The symptoms are similar to hepatitis A and there is no persistent or latent infection (carrier state) with hepatitis E. However, there is a high death rate for pregnant women infected with the virus. There is no vaccine available.

Human parvovirus B19 is transmitted by humans via respiratory secretions, and causes Fifth disease (erythema infectiosum or slapped cheek syndrome). About 50% of people infected will show no symptoms. Where symptoms occur, they are commonly a mild upset, a fever and a characteristic rash, which can be confused with rubella. Adult women commonly have joint problems. Incubation is usually between 4 – 14 days (but may take up to 20 days) and symptoms may continue for weeks and sometimes months. Around a third of pregnant woman infected with the virus may transmit it across the placenta to their unborn child. Foetal death and spontaneous abortion may occur in the second and third trimesters. In some cases, this is associated with severe fluid accumulation (less than 10% of exposed fetuses).

◆ **Control measures:** Basic good hygiene. Additional control measures may be needed where pregnant women are exposed at work to infected people in whom viral excretion may be prolonged because they do not have a fully working immune system or have certain other blood disorders.

Rubella is transmitted by humans by close contact and by respiratory secretions. In adults the disease is usually mild, including a faint reddish purplish rash, sometimes accompanied by mildly inflamed eyes and joint pains, and lasts for less than one week. A pregnant woman with rubella may transmit the virus across the placenta to her unborn child. Many infected babies have no ill effects. However, a wide range of birth defects including deafness, eye disease (cataracts), heart defects, an abnormally small undeveloped head (microcephaly) and learning disability can occur. Mass immunisation has reduced the risks of infection in pregnancy to a very low level. If non-immune mothers catch rubella in the first three months of pregnancy, approximately 80% of the babies will have some rubella-associated problems. Between 12 and 16 weeks of pregnancy the risk of harm falls to about 5% and harm rarely occurs after that.

◆ **Control measures:** Rubella vaccine is given routinely to all children, and adults who have not had the infection. Screening for immunity is routine in antenatal clinics, so that those that are not immune can be offered vaccination after that pregnancy.

Varicella-zoster virus (VZV) (chickenpox) is transmitted between humans by direct contact, droplet infection or recently soiled materials such as handkerchiefs. Primary infection with VZV results in chickenpox, usually lasting 2-3 weeks, with symptoms generally more severe in adulthood. Following chickenpox the virus persists as a latent infection in the nervous system, and may return as shingles following reactivation of the virus. A pregnant woman infected with VZV may transmit the virus across the placenta to her unborn child.

Infection of the foetus is rare, but if it does occur can cause skin scarring, brain damage with resultant learning disability or limb abnormalities. There is no evidence of risk to the foetus if the mother has shingles.

◆**Control measures:** Hospital occupational health departments may enquire routinely about chickenpox in staff and test those without a history for antibody to VZV. Women who are not immune from past infection should avoid contact with known cases of chickenpox or shingles present in the workplace.

Manual handling is the major cause of back and shoulder injuries in the workplace. Lifting, lowering, pushing, pulling, carrying or restraining a load can all result in injury. Where repeated or prolonged bending is required (particularly when the load is low-lying) there is a risk of a back injury even when the load is very small, because the trunk and upper body themselves are loads. Pregnancy will increase the load borne by a pregnant woman, so if manual handling risks are identified in the workplace, a manual handling risk assessment should be undertaken and hazards addressed. Childcare workers routinely lift, lower or carry young children. In 2001, nearly 53% of NSW local government childcare workers surveyed by the Municipal Employees Union experienced muscle strain, and around 38% experienced back injury.

◆**How to avoid the risk:** The NOHSC National Code of Practice for Manual Handling (an approved Code of Practice in NSW) provides advice on risk assessment. While there are no set weight limits in legislation, these should be determined for your work situation. When the health of the worker affects capacity to perform a task, the work system should be adapted to suit the worker (or the worker should be allocated other tasks). The Code of Practice checklist covers age, disability or other special factors that may affect task performance. Special factors include pregnancy (clause 4.44 of the Code of Practice). Relevant medical advice should be considered when duties are allocated. Employees have the right to seek advice from a medical practitioner of their own choice. Consultation with employees during the risk assessment process will help to ensure that workloads are acceptable and not excessively heavy or awkward. While loads greater than 10 kgs are likely to be hazardous, the weight limit that can be safely handled depends on the physical strength of the woman and how she feels during pregnancy.

Standing for long periods

The risk of having a small- for-gestational-age infant (birthweight lower than the 10th percentile for gestational age and gender) is increased among women who work at least six hours per day in a standing position. Working in a standing position on a regular basis can cause sore feet, swelling of the legs, varicose veins, general muscle fatigue, lower back pain, stiffness in the neck and shoulders, and other health problems.

During pregnancy, a woman's total blood volume can increase by 30-40% and the load on the heart increases. Blood tends to pool in deep veins in her legs which brings a risk of thrombosis (clotting) and varicose veins, and of fainting episodes if she spends long periods standing, especially in a hot environment. The risk of having a small infant (birthweight lower than the 10th percentile for gestational age and gender) is increased among women who work at least

six hours per day in a standing position. Ergonomically unsuitable working conditions could produce a preterm birth. During pregnancy an increase in body weight occurs, together with changes in body weight distribution and in the fit between body dimensions and the workplace layout. These changes may cause alterations in working posture that may, in turn, have adverse consequences for the biomechanical load on the musculoskeletal system, and so increase the risk of musculoskeletal disorders.

◆**How to avoid the risk:** Foot and leg pain and discomfort as well as low back pain can be reduced by ensuring that work stations are operable from both seated and standing positions. Managers should also seek advice (from ergonomists, workers in occupational health and safety services and medical practitioners) for improved ergonomic conditions suited for pregnant workers. Sitting or standing continuously for more than two hours may cause problems for a pregnant worker. Both constant sitting and constant standing can cause pain and discomfort. Sitting instead of standing and taking regular rest breaks when needed reduce physical stress.

Return to work

An employee is entitled to return after a period of maternity leave to the position she held before the leave, or transferred to part time work or to a safe job because of the pregnancy. If the position no longer exists, she is entitled to any other available position for which she is qualified and capable, and which is as nearly as possible comparable in status and pay to her former position. Failing to consult an employee who is absent on maternity leave about restructuring affecting her job may unlawfully discriminate against her. When restructuring or offering redundancy packages, employers must not discriminate against women who are pregnant or on maternity leave.

Discrimination

Federal and state anti-discrimination legislation provide that an employee returning to work after giving birth and/or maternity leave should not be discriminated against on the basis of her sex or pregnancy.

The Anti-Discrimination Act provides for employees to bring complaints of discrimination if employers discriminate directly or indirectly against them on the basis of their sex, marital status, pregnancy or carer's responsibilities. Examples could include a refusal to consider part time or other flexible working arrangements unless the refusal is reasonable in all the circumstances. Employers have a defence to a discrimination claim for refusal to hire or for termination of an employee if they can prove that the person's caring responsibilities meant that they were unable to carry the essential requirements of the position and/or the accommodation of the person's caring responsibilities would cause the employer unjustifiable hardship.

Legislation covering occupational health and safety and welfare of employees at work requires employers to take account of occupational health and safety risks to employees who are breast feeding.

Case Study

Shelley Lee v Diana Clyne HREOC No.H96/107 22.4.97

Ms Lee, a childcare worker, claimed she was discriminated against because of her pregnancy. There were some problems with her pregnancy and she cut her working week from five days to four. The employer claimed the complainant took too many sick days, and the complainant claimed the sick days related to colds and other conditions and not the pregnancy. The respondent cut the complainant's hours further. The employer said she needed someone who could take medication when they were sick, and pregnant women cannot take many medications. The employer said it was necessary to have employees who were in good health in childcare, and that the need to get another employee in when the complainant was sick increased costs. The complainant pointed out that when she left she still had five sick days left. The respondent referred to a previous unsatisfactory experience with a pregnant employee where the employee had been unable to do the early shift as she couldn't change nappies as they made her feel sick. It had been necessary for another staff member to be with her as she frequently felt sick and had to disappear quickly to the toilet. This was seen as putting extra pressure on other staff and leading to an increase in the salary bill as she could not be left alone.

The Commission found that the respondent had discriminated against the complainant in cutting her hours and otherwise, and awarded her \$1000 for her feelings of humiliation and required the respondent to provide her with a reference.

Phone contacts: Award enquiries Office of Industrial Relations 13 16 28;
Anti-Discrimination Board 0292685544; WorkCover 13 10 50;
Women's Information and Referral Service: 1800 817 227
Centrelink Family Payment Line 13 24 68

Websites: www.dir.nsw.gov.au
www.workcover.nsw.gov.au; www.lawlink.nsw.gov.au/adb
www.women.nsw.gov.au
www.familyassist.gov.au

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