Health-Related Maternity Leave
in the Uncomplicated Pregnancy and Birth

Reference Guide for Healthcare Providers

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Health-Related Maternity Leave in the Uncomplicated Pregnancy and Birth

This reference guide is a consensus-based document developed by the Health-Related Maternity Leave Working Group of the Alberta Perinatal Health Program. Its goal is to inform practitioners about the medical, social and legal context in Alberta for determining health-related maternity leave in uncomplicated pregnancies, and to enhance clinical decision-making and communication with women throughout pregnancy and postpartum care.

PLEASE NOTE: This reference guide supersedes Health Related Maternity Leave – Information for Physicians (Alberta Medical Association, 1992). It should not be interpreted as a defined standard of care or a legal directive.

Principles Guiding Determination of Health-Related Maternity Leave

- The experience of pregnancy is unique to each woman and her family.
- Every woman will require a period of health-related maternity leave.
- The period of health-related maternity leave is to be determined by a qualified healthcare professional through individual assessment.
- Assessment should include an evaluation of a woman's health status and environment to identify risks to her health, that of her unborn baby and the place of employment.

Health-related maternity leave time periods provided in this document (that are not legislated) are not intended to be interpreted as presumptive periods or entitlements.

Conclusions

Based on the review of the literature, there is no conclusive evidence for a presumptive period of health-related maternity leave for the uncomplicated pregnancy and birth.

Highlights

1. If desired, most employed women can continue working through pregnancy if it is safe and feasible to do so.
2. Risks or threats to optimal fetal or maternal health which could be prevented, mitigated or eliminated by a modification, reduction or cessation of work related duties or environmental factors must be addressed preconception, antepartum and postpartum.
3. In every pregnancy there is a period of time during which it is inadvisable for a pregnant or postpartum woman to work, called the period of health-related maternity leave. The timing and duration of health-related leave is unique to each woman and should be determined in consultation with the health practitioner. The period of leave should be based on an assessment of the woman's health, pregnancy, work environment and personal circumstances.
4. To manage risks and complications during the antepartum period, complete cessation of work should be considered in cases where, in the practitioner's opinion, the efficacy or certainty of the work environment/conditions being appropriately modified is in question. Cessation of work under these circumstances is also considered health-related maternity leave.
5. In the absence of risks or complications necessitating an earlier departure from work, all pregnant women are deemed unfit to work beginning no later than the onset of labour. Medical consensus suggests that for uncomplicated, singleton pregnancies, health-related maternity leave may be required two to six weeks prior to the estimated date of birth (EDB).
6. All women should remain on health-related leave until they are deemed to have recovered from childbirth based on an assessment of their physical, mental and psychosocial health. The fitness-to-work assessment should occur whether or not the woman intends to return to work upon recovery, as the timing of recovery may determine the woman's entitlement to remuneration/benefits while off work.
7. Health-related leave may last for 6 to13 or more weeks postpartum, with uncomplicated vaginal deliveries skewing slightly toward 6 to 8 weeks and complicated deliveries skewing toward 9 to 13 weeks or longer. Alberta Employment Standards state that women must take at least 6 weeks off work postpartum unless she is deemed fit to work by her health practitioner and there is mutual agreement between her and the employer to an earlier return to work.
8. Many employed women are entitled to a period of up to 52 weeks of voluntary (maternity and parental) leave from work. The health-related maternity period falls within the 52-week voluntary leave period. Women not entitled to a 52-week period of maternity leave are only permitted to be off work during the health-related portion of their pregnancy and postpartum period.
9. Women who do not have financial resources to support themselves (food, clothing, shelter) should be informed that they may qualify for income support if they meet eligibility criteria. Information on the Income Support Program is obtained by contacting the Alberta Works Contact Centre at 1-866-644-5135. Pregnant women with a low household income may qualify for Alberta Adult Health Benefits (dental, optical, prescription drugs). Contact the Health Benefits Contact Centre at 1-877-469-5337 for information. Online information is available at www. employment. alberta.ca.
10. Women must be made aware that it is their physician's or midwife's role to determine the appropriate period of time for health-related maternity leave which may or may not be equivalent to their employee benefits.
11. Women should be encouraged and supported to take an adequate period of voluntary leave postpartum to recover, to breastfeed and to nurture their infants.

Introduction

Purpose and Scope

This reference guide is intended to support practitioners in assessing employed women with an uncomplicated pregnancy regarding their need for accommodation at work, or time off work, in the following contexts:

- Modification, reduction or cessation of work-related duties to accommodate maternal or fetal health needs, or to minimize risks to fetal or maternal health, during the antepartum period.
- Cessation of work for a period of time prior to, or upon the estimated date of birth (EDB) to optimize maternal and fetal health for impending childbirth.
- Cessation of work for a period of time following childbirth to accommodate maternal recovery and readiness to return to work.

Exclusions

This reference guide is not intended to inform or direct the care of complicated or high-risk pregnancies; however, some portions of this guide are applicable to all pregnancies.

Goals

This reference guide is developed to:

- Inform practitioners regarding relevant legislation in Alberta and Canada pertaining to pregnancy, childbirth and postpartum.
- Summarize current evidence regarding work-related risks and stressors that may affect fetal outcomes or become potentially disabling to pregnant women.
- Present current evidence regarding the factors contributing to postpartum recovery.
- Present a summary of current practices and recommendations regarding the duration of health-related maternity leave in the antepartum and postpartum period.

Background

The issue of health-related maternity leave was identified through legal judgments, namely a 1989 ruling by the Supreme Court of Canada (*Brooks v. Canada Safeway Ltd.*) and a subsequent court case in Alberta (*Alberta Hospital Association v. Parcels*) which held that some portion of every woman's maternity leave is health related, and that for this period, the employee must be compensated by her employer as generously as she would be if she were sick or disabled. Even if a woman has voluntarily stopped working to prepare for the birth of her child, and/or remains off work to care for her newborn, she is entitled to have her absence reclassified from a voluntary leave to a health-related leave for the period of time in which she is deemed unfit to work due to pregnancy, childbirth and recovery postpartum.

Women may be entitled to different compensation and benefit provisions during health-related maternity leave than during voluntary leave, and therefore rely on their health practitioner to accurately determine the duration of health-related leave.

Currently there are few guidelines or standards governing the timing or duration of health-related maternity leave in Alberta, particularly for uncomplicated pregnancy and childbirth. The lack of standards and clinical protocols is reflected in a 2007 survey of Alberta physicians and midwives, in which only 21% of respondents felt somewhat or completely confident that physicians across Alberta apply similar practices and standards in determining womans' medical leave requirements during pregnancy, childbirth and postpartum.

Information included in the guide is based on a review of current legislation; a comprehensive review of the literature; an online survey of Alberta physicians and midwives; and consultation with stakeholders.

Overview – A Review of Maternity Leave Entitlement and Benefits

Practitioner awareness of the social and legal context surrounding maternity leave in Alberta may enhance clinical decision-making and patient communication.

In Canada, a woman's entitlement to a maternity leave of absence from work is treated separately from entitlement to financial benefits[4]. Employees may be entitled to both a protected leave period and financial benefits; to financial benefits without protected leave; or to neither.

Leave of Absence

There are two distinct leave of absence periods during the maternity and postpartum period: maternity leave and parental leave (Figure 1.1). Both are available to women who have worked full-time or part-time for a single employer for at least 52 continuous weeks. Eligible women who become pregnant are entitled to be off work for up to 52 weeks (15 weeks of maternity leave plus 37 weeks of parental leave) to prepare for childbirth, recovery, and care for their newborn.

Women, who have **not** worked full-time or part-time for the same employer for at least 52 continuous weeks are not entitled to either maternity or parental leave, unless the employer has a collective bargaining agreement or policy indicating otherwise. These women are only entitled to be off work for the health-related portion of pregnancy, and once they have recovered from labour and delivery, they must return to work or resign[4].

Maternity leave in Alberta is granted exclusively to birth mothers and is comprised of the following components:

- **Voluntary leave** refers to the period of time during which a pregnant or postpartum woman is capable of working, but chooses to be off work to prepare for childbirth or to care for her newborn. The timing of voluntary leave is at the discretion of the employee: it may begin up to 12 weeks prior to the estimated date of delivery, and must end no later than 15 weeks following delivery.
- **Health-related maternity leave** is the period of time during which a woman is considered unable to work, or is advised not to work, for maternity-related health reasons at any time during pregnancy, childbirth or postpartum.
  - Every woman has some period of health-related leave immediately before or upon the EDB and following delivery[2]. This period may interrupt the voluntary leave period.
  - Some women may require a health-related maternity leave prior to commencement of, or following, their voluntary leave period.
  - Establishing the need for, and duration of, health-related maternity leave rests with the employee's physician or midwife.

Parental leave refers to the 37-week period of time off work granted to either parent in order to bond with and care for the child.

Financial Benefits

While both maternity leave and parental leave are considered **unpaid** leave, many working women have access to employer-sponsored benefits programs or federal Employment Insurance (EI) benefits to replace their income for part or all of their maternity leave period[6].

Women who do not have the financial resources to support themselves for food, clothing and shelter may qualify for Income Support if they meet eligibility criteria. Pregnant women with low household income, who do not have access to a health benefits plan, may qualify for the Alberta Adult Health Benefit program which provides coverage for prescription drugs, nutritional products, dental care, optical services, diabetic supplies and emergency ambulance services.

Figure 1.1

Maternity Leave Components for Employed Women

Maternity Leave: Maximum 15 weeks + Parental Leave: Maximum 37 weeks

Health-Related Maternity Leave

Employment Period	Voluntary Antepartum Maternity Leave	Antepartum	Labour and Birth Postpartum	Voluntary Postpartum Maternity Leave	Employment Period	
Woman's Health Status and Ability to Work						
Pregnant woman is employed and qualifies for Employment Insurance Maternity Leave Benefits. Women not qualifying for Employment Insurance can contact Alberta Works at 1-866-644-5135 regarding criteria for income support and Alberta Adult Health Benefits at 1-877-469-5337 for dental, optical, prescription drugs. On line information at www.employment.alberta.ca	**At the woman's choice:** Pregnant and able to work, but chooses not to work in order to prepare for the birth. May begin as early as 12 weeks prior to EDB.	**Pregnant woman:** Assessed as unable to work due to work conditions or environment; pregnancy complications; or maternal/fetal health.	**All women:** Unable to work due to labour and birth and postpartum recovery. In Alberta, a minimum of six weeks following birth is required by Alberta Employment Standards. Earlier return to work requires medical certificate and consent of employer.	**At the woman's choice:** Assessed as able to return to work but chooses to remain off work.	**Woman chooses to take parental leave** Assessed as able to work.	Return to work.
Practitioner Role						
Determine if work environment is a risk to maternal or fetal health in pregnancy. Assess woman's health status and pregnancy risks.	Monitor pregnancy and need to start antepartum health-related leave. Recommend job modifications.	Recommend health-related leave based on assessment of need due to work environment and/or woman's health status and risks to maternal/fetal health.	All women are on health-related leave for labour and birth. Postpartum – Assess woman's recovery from birth and ability to return to work.	No further role unless new health problems arise.		
Entitlement to Salary, Benefits and/or Employment Insurance During Leave Period						
Regular salary.	Employment Insurance (EI) benefits income.	Employer sick/disability benefits, if available or Employment Insurance (EI) benefits.		Employment Insurance (EI) benefits.	Employment Insurance (EI) benefits.	Regular salary.

Antepartum Period

Factors Influencing Ability to Work During Pregnancy

Evidence suggests that working during pregnancy contributes to the "healthy worker effect", a term used to describe the favourable socio-demographic and behavioral characteristics that are generally associated with women in the paid workforce[7].

There is evidence, however, that a woman's ability to continue working during pregnancy may be compromised by complications of pregnancy, pre-existing maternal medical conditions, risk of exposure to environmental toxins or hazards, physical or ergonomic demands, working conditions, and problems associated with changes occurring during pregnancy, ranging from minor stress or discomfort to significant disability.

Pre-Existing Maternal Medical Conditions

The *Preconception Health Framework* [8], *Healthy Mother, Healthy Baby User Guide*[10] and the *Alberta Prenatal Record* [9] identify a range of pre-existing conditions and illnesses which may become more difficult to manage during pregnancy, such as diabetes, hypertension, bleeding/clotting disorders, cardiac conditions, and psychiatric disorders. Certain risk factors (tobacco use or substance abuse) may also adversely affect fetal or maternal outcomes.

In cases where work duties or conditions exacerbate maternal health problems, a modification, reduction or cessation of work duties may be indicated.

Complications of Pregnancy

The *Alberta Prenatal Record* [9] and *Healthy Mother, Healthy Baby User Guide*[10] identify a number of pregnancy-related complications, such as preterm labour and gestational hypertension, which may significantly affect a woman's ability to continue working. To reduce the risk of complications or to manage diagnosed complications, a modification, reduction or cessation of work duties may be indicated.

Occupational Risks and Hazards

While Alberta workers are protected from occupational hazards through the Occupational Health and Safety Act, there is no specific protection afforded to women who are pregnant or who may become pregnant[11]. Therefore, physicians and midwives should counsel pregnant women regarding their critical role in identifying potential occupational hazards. In the United Kingdom, employers are required to conduct a full, written assessment on all pregnant workers regarding the possibility of occupational hazards such as working conditions, physical exertion, and biological and chemical agents[12, 13].

At the low birth weight consensus development conference in Alberta in 2007, the *Consensus statement on healthy mothers, healthy babies: how to prevent: low birth weight* addressed the need for public policy which may have a positive affect on pregnancy outcomes and work place policies[14].

Environmental Toxins and Hazards

Environmental toxins or hazards are well documented in the literature[7, 10, 15-21] and include chemical and biological hazards and radiation (Table 1). Note that second-hand smoke is also considered an environmental toxin due to its association with low-birth weight and preterm birth[10, 22, 23]. Risk may vary depending on timing, duration and length of exposure, means of transmission, concentration levels and combinations with other chemicals[7, 24]. In cases where risk cannot be assessed with certainty or eliminated through workplace modifications, a complete cessation of work may be indicated and the woman placed on health-related maternity leave.

Table 1 [7, 9]

Environmental Toxins and Hazards
Chemical Hazards
• Metals (lead, mercury, cadmium and copper) • Gases (carbon monoxide and anesthetic gases) • Tobacco smoke, including second-hand • Pesticides, herbicides and insecticides • Organic solvents used in dry cleaning and electrical appliance manufacturing (such as isopropyl alcohol, methyl ethyl ketone, glycol ethers, benzene and polychlorinated biphenyls [PCBs]). • Disinfecting agents such as ethylene oxide • Chemicals used in manufacturing such as epichlorohydrin and vinyl halides • Exposure to metallic (inorganic) mercury
Biological Hazards
• Blood-borne pathogens such as Hepatitis B, Hepatitis C, HIV • Typhoid, Tuberculosis • Toxoplasmosis, Cytomegalovirus • Human parvovirus B19 • Rubella, Varicella
Radiation
• Ionizing radiation

Physical Demands and Ergonomic Factors

Evidence regarding the impact of physical and ergonomic stressors on pregnancy outcomes ranges from compelling to inconclusive. Not surprisingly, a survey of Alberta physicians and midwives[3] revealed that respondents feel less confident in their ability to assess for ergonomic risks (15.8% completely confident) and work schedule stressors (26.2% completely confident) than for complications of pregnancy (54.6% completely confident).

Lack of employer understanding and compliance was also noted by workers in Calgary, Alberta who reported quitting their jobs during pregnancy due to ergonomic and physical stressors such as lifting and standing, as well as affects of common ailments of pregnancy on their ability to work, such as nausea[7]. In Quebec, the *For a Danger-Free Pregnancy* prevention program found that of the 6,000 evaluations conducted on behalf of pregnant workers, 81% involved the investigation of ergonomic risks reported by the employee[25].

A review of the literature suggests that certain occupational demands or conditions alone may be associated with adverse perinatal outcomes, while some conditions may pose a risk when combined with other factors. Prolonged walking or standing (>3 to 4 hours per day), either alone or in combination with other risk factors, is associated with increased risk of preterm labour[26, 27], preterm birth[27], low birth weight[28], or a small for gestational age (SGA) infant[29]. Heavy (>23 kg) or repetitive lifting[26, 28, 29] or carrying[26] is also associated with SGA, preterm labour, preterm birth and low birth weight. Evidence suggests eliminating heavy lifting by the 20th week of pregnancy[30], and eliminating excessive standing by the 24th week of pregnancy[29, 30] restores the risk of adverse perinatal outcomes to those of unexposed women.

Working Conditions

Noise and Vibration

Evidence suggests that exposure to noise in pregnancy may be associated with low birth weight[31], preterm birth and intrauterine growth restriction[32], as well as high frequency hearing loss in newborns[32, 33]. There is also some evidence that whole-body vibration may contribute to miscarriages and stillbirth[19, 34].

Shift Work, Shift Length and Scheduling

There is evidence that shift work, night work, and an irregular work schedule all contribute on their own to an increased risk of preterm birth[28] and small for gestational age (SGA)[29, 35], and that the risk is significantly reduced if the work schedule risks are eliminated by 24 weeks gestation[29, 35].

Some evidence suggests that long work hours, exceeding 35 to 40 hours per week, are associated with adverse perinatal outcomes[10]. There is even stronger evidence suggesting that when accompanied by other risk factors (standing, lifting, noise, high psychological demand)[35, 36], long work hours or shift length contribute to an increased risk for low birth weight, miscarriage and preterm delivery.

Potentially Disabling Conditions During Pregnancy

There are many conditions commonly associated with pregnancy (stress, nausea, fatigue, sleep disruption, back and pelvic pain) that are not necessarily predictive of a woman's ability to continue working.

However, depending on the individual woman, the nature and demands of her job, the demands in other areas of her life, and her domestic and psychosocial situation, these conditions may have the potential to **become disabling** during the antepartum or postpartum period.

Sleep Disruption

Sleep disruption affects up to 97% of pregnant women during pregnancy[37] and is significantly associated with mood disorders and depressive symptoms in the perinatal period[38]. Sleep disruption late in pregnancy followed by unresolved sleep disturbances through the postpartum period may develop into depression[39].

Evidence specifically linking sleep deprivation with a woman's fitness to work during the antepartum period is minimal. There is, however, considerable evidence to indicate sleep deprivation in the general population has a negative effect on cognitive function and performance, motor function, mood, attention and memory; and that sleep deprivation increases the risk of injuries caused by human error[40].

Depression

Evidence is emerging to suggest an association between untreated depression and poor fetal outcomes such as low birth weight, intrauterine growth restriction, preterm birth, low Apgar scores, and small head circumference[41, 42].

Yet symptoms commonly associated with depression in all populations (poor sleep, low energy, weight changes), are difficult to distinguish from the normal effects of pregnancy and newborn care [43], causing antenatal and postnatal depression to be under-recognized and under-treated [42, 44]. An estimated one-quarter of women are diagnosed with depression during pregnancy [42, 44].

Healthy Mother, Healthy Baby User Guide[10] cites a large body of evidence to identify more than 35 risk factors which may help health professionals identify women at risk of antenatal depression, including sleep problems, partner conflict, complications of pregnancy, and lack of social support.

Stress, Anxiety and Psychosocial Factors

Evidence surrounding the impact of stress and anxiety on fetal outcomes is not conclusive, although there is sufficient emerging evidence to warrant further study regarding maternal stress and low birth weight, small for gestational age (SGA), preterm birth, birth complications, low birth weight, and low Apgar scores[45].

A number of studies[10, 46] suggest that birth outcomes may be influenced by social conditions such as unplanned/unwanted pregnancy, recent stressful events, and problematic relations, lack of social support, poverty, social isolation, and past physical or sexual abuse.

Back and Pelvic Pain

Back pain is experienced more often by pregnant women than by men and non-pregnant women[47], with an estimated 50%[48] to 67%[49] of maternity patients reporting back pain during pregnancy. Women experiencing back pain report significantly higher on measures of their disability rating and impairment of their functional ability when compared to women without back pain [50].

There is evidence to suggest that back and pelvic pain may be triggered or aggravated by ergonomic stressors such as standing, lifting, postural problems and general fatigue[51-54]. Women with a pre-pregnancy history of regular leisure physical activity tend to have a reduced risk of low back and pelvic pain during pregnancy[54].

Assessing Ability to Work During Pregnancy

In assessing fitness to work during pregnancy, practitioners should carefully assess the impact of the above factors, and the prevalence of exacerbating conditions. The following points should be considered:

- The benefits for women to continue working through pregnancy if feasible and safe.
- Priority on optimizing and protecting fetal health. Assess for conditions which may compromise fetal health or fetal outcomes. Conditions affecting maternal health may also directly or indirectly influence fetal health or outcomes.

- The unique circumstances and health needs of each woman. There may be significant variation in the degree of risk posed to individual women, or the degree to which women are affected by routine changes that occur during pregnancy, ranging from minor stress or discomfort to significant disability.
- Endeavour to obtain accurate and complete information from the woman regarding occupational exposures. Counsel women about potential risks and hazards, and encourage them to enforce their legal right to obtain complete and accurate information from their employer regarding the potential for workplace exposure.
- If maternal or fetal health is at risk, first recommend modifications at work (reduction of workload; change in work schedule or shifts; elimination of specific hazards or stressors; reassignment). Complete cessation of work should be considered when appropriate modification or reduction of duties or hazards is not considered likely, practical or efficacious.
- Be aware of a Supreme Court of Canada ruling that employers are obligated to accommodate the health needs of pregnant workers to the point of undue hardship[55]. An employer cannot refuse to modify the work environment, reduce workload or minimize risks unless doing so will cause undue hardship to the employer.
- Employees who cannot be accommodated through workplace modifications are entitled to a health-related absence from work upon the recommendation of the physician or midwife.

Cessation of Work Prior to Childbirth

The Supreme Court of Canada[1] held in 1989 that in the absence of fetal or maternal conditions necessitating an earlier absence from work, all pregnant women are deemed unfit to work at least upon the onset of labour. Current practices and medical opinion suggest that some women may be able to work until labour is imminent; others may need a health-related absence days, weeks or months prior to the EDB. A summary of practices and recommendations for uncomplicated pregnancies is shown in Table 2.

Postpartum Period

Factors Affecting Ability to Work Post-Partum

While six weeks is traditionally held as the time required for reproductive organs to return to their non-pregnant state[56, 57], there is evidence to suggest that recovery of reproductive organs is a single but incomplete measure of postpartum recovery[58]. The World Health Organization[59, 60] reports that there is more maternal morbidity in the postpartum period than most caregivers are aware of, including infection, incontinence, hemorrhoids, constipation, fatigue, perinatal and pelvic pain, breast problems, anemia, backache, headaches, and sexual problems. Two other studies[61, 62] suggest that none of the 300 mothers studied had resumed full functional status (domestic, work and self-care activities) at six weeks postpartum.

Mode of Delivery

Delivery method has a moderately large impact on postpartum recovery, and women who have had an assisted vaginal birth (primarily forceps) experience more health problems at eight weeks postpartum, and continue to report more problems at six months, 18 months and five years postpartum, than women who experienced a spontaneous vaginal birth[63]. Caesarean deliveries are also associated with significantly worse physical function, role limitations and vitality at five weeks postpartum than unassisted vaginal births[63, 64].

Sleep Disruption

There is evidence to suggest that sleep disruption and accompanying fatigue are significant in the first month postpartum[38, 65], and these may last as long as three to six months postpartum[56, 66, 67]. The impact on psychosocial function and job performance is less clear and warrants further research.

Depression

Evidence suggests that postpartum depressive symptoms may affect between 4% and 16% of postpartum women[68, 69] and are closely associated with a woman's physical, social and role functioning during the postpartum period[70]. While depressive symptoms are often linked to fixed maternal characteristics and risk factors, such as age, race and marital status, there is compelling evidence linking them to the burden

of the woman's physical symptoms[70] (breast, back or incision-site pain; and headaches, hemorrhoids and urinary incontinence) or having an infant rated by the mother to be in poor to fair health[68]. The effects of postpartum depression can be long lasting, and the offspring of mothers with untreated postpartum depression are more likely to have behavioural problems and sub-optimal development through early childhood[71].

Breastfeeding

Establishing or maintaining breastfeeding is not considered sufficient reason for a postpartum worker to remain off work on health-related leave. However, under the Alberta Human Rights Act, employers are required to accommodate the needs of breastfeeding workers to the **point of undue hardship**. This may include offering flexible hours, breaks and a quiet space to accommodate breastfeeding; or arranging for the employee to work from home or have her infant brought to work for breastfeeding[72].

Breastfeeding can be associated with certain illness such as mastitis that may necessitate an assessment of the woman's ability to work and may consequently deem a breastfeeding woman unfit to work.

Assessment for Fitness to Return to Work During the Postpartum Period

In assessing a woman's fitness to return to work postpartum, it is important to note that a majority of women may not actually return to work upon recovery from childbirth. Many will be entitled to remain off work for up to 52 weeks. In these cases, the declaration of a woman's recovery is the point at which compensation and benefits are reclassified from a health-related leave to a voluntary leave.

Women who do not qualify for health-related or EI benefits are uncompensated during maternity leave and are therefore likely to return to work when compelled financially to do so. Regardless of economic circumstance, Alberta employment standards state that women must take at least six weeks off work postpartum unless she is deemed fit to work by her health practitioner and there is mutual agreement between her and the employer to an earlier return to work.

Determining Duration of Health-Related Maternity Leave

Uncomplicated Pregnancy

There are no presumptive periods or definitive clinical standards regarding the duration of health-related maternity leave. A summary of current practice and policy follows.

Antepartum

The duration of the antepartum health-related absence is based primarily on the extent of complications, occupational hazards and pre-existing maternal conditions. In the absence of conditions or complications warranting an earlier cessation or reduction of work, the policies and practices shown in Table 2 and Alberta survey results may offer some insights for practitioners.

Postpartum

The duration of the postpartum health-related absence is based primarily on the pace of maternal recovery, including the extent of complications during birth and recovery. A recent study of 661 postpartum women found that at 11 weeks postpartum 50% of participants had returned to work. The findings supported the need for women to be evaluated for fatigue levels, mental and physical symptoms. Better preconception health was associated with better postpartum health at 11 weeks after childbirth across all measures[73]. The policies and practices shown in Table 2 and Alberta survey results may offer some insights for practitioners.

Survey of Alberta Physicians and Midwives

In a 2007 survey of Alberta physicians and midwives[3], 186 respondents were asked to estimate the proportion of the women who need the following length of time off work for medical reasons immediately following birth: two weeks or less; three to five weeks; six to eight weeks; nine to 13 weeks; and more than 13 weeks. Respondents were asked to use the same scale to report on three categories of postpartum women: uncomplicated vaginal birth; uncomplicated Caesarean section delivery; and complicated (including Caesarean) birth. A summary of responses follows.

Uncomplicated Vaginal Delivery

A six to eight week postpartum recovery period was reported most often as the length of time required by a majority of women who have an uncomplicated vaginal delivery. Whereas,

- 80% of respondents reported that less than 10% of the women need two weeks or less time postpartum for medical recovery.
- 42% of respondents reported that more than half of the women require six to eight weeks postpartum for medical reasons.
- 76.2% of respondents reported that 25% or fewer women need nine to 13 weeks recovery time.
- 67.1% of respondents reported that fewer than 10% of the women need more than 13 weeks for recovery.

Uncomplicated Caesarean Section Delivery

A six to eight week postpartum recovery period was reported most often as the length of time required by a majority of women who have an uncomplicated Caesarean section delivery. Whereas,

- 91.2% of respondents reported that less than 10% of the women need two weeks or less time postpartum for medical recovery.
- 82.8% said fewer than 25% of women need three to five weeks recovery time.
- 45.6% of respondents reported that more than half of the women require six to eight weeks postpartum for medical reasons.
- 21.5% of respondents reported that more than half of the women need nine to 13 weeks recovery time; and 22.9% reported that more than half of the women need more than 13 weeks for recovery.

Complicated (Including Caesarean) Delivery

A nine to 13-week postpartum recovery period was reported most often as the length of time required by a majority of women who had a complicated delivery. Whereas, 68.6% of respondents reported than half or fewer of the women need six to eight weeks postpartum for medical recovery.

- 31.3% of respondents reported that more than half of the women require six to eight weeks postpartum for medical reasons.
- 36.1% reported that more than half of the women need nine to 13 weeks recovery time; and 32.5% reported that more than half of the women need more than 13 weeks for recovery.

Factors Physicians and Midwives Consider when Assessing for Readiness to Return to Work

A survey of Alberta physicians and midwives[3] indicates that when assessing women for fitness to work during the antenatal period, on scale of 1 to 4, respondents place the most weight on complications of pregnancy (3.85), singleton vs. multiple pregnancy (3.75) and the possibility of environmental hazards (3.74). Respondents place the least weight on women's concerns about lack of employer support/ empathy (2.84) and pain or discomfort during the pregnancy (3.10).

When assessing women for fitness to return to work postpartum, on scale of 1 to 4, respondents place the most weight on the impact of infant health problems (3.75), additional demands related to multiple births (3.71) and physical recovery from labour and delivery (3.70). Respondents place the least weight on the woman's ability to maximize income/support programs (2.73), the impact of sleep loss or disruption (3.24), and problems establishing or maintaining breastfeeding (3.26).

Working with Insurers and Employers

Health providers are deemed to be the authority in determining the unique period of health-related maternity leave for pregnant/postpartum workers. Insurers and employers may vary considerably in the extent of medical evidence required to substantiate health-related maternity leave. Some organizations may employ minimum or presumptive periods during which time all pregnant/postpartum workers are assumed to be unfit to work; in these cases, practitioners are only required to provide evidence to substantiate a health-related absence that extends beyond the minimum or presumptive period. Practitioners should be aware that many health benefits plans are underwritten by third-party insurers and not directly managed by employers. The insurer may assess the employee's health-related maternity leave claim without the benefit of an

established relationship with the worker and without the involvement of the employer. In the event of disputes regarding the terms or duration of health-related maternity leave recommended by the health practitioner, women may be advised to seek input from their employer as an additional source of support and advocacy.

Table 2

Summary: Health-Related Leave Recommendations or Policy for Uncomplicated Pregnancy and Birth

Source	Antepartum	Post Partum Recovery
Alberta Human Rights Commission Board of Inquiry Decision (1991)[3]	Medical evidence suggests four to six weeks prior to EDB	Medical evidence suggests six to nine weeks following birth.
Alberta Employment Standards Code (legal requirement in Alberta)	No specific recommendations	Six weeks, or must provide medical certificate of fitness for earlier return to work.
College of Physicians and Surgeons of Alberta[4]	Two weeks prior to EDB	Up to 11 weeks.
Saskatchewan Council of the College of Physicians and Surgeons[5]	Two weeks prior to EDB	Up to 13 weeks.
European Union directive[15]	Two weeks prior to confinement	
Medical Disability Advisory[6]		Mean actual recovery: 7.6 weeks. Insurance industry provision: four weeks minimum; six weeks optimal.
United Kingdom Health and Safety Executive[7]		Two weeks for office work. Four weeks for factory work.
International Labour Office (ILO) Convention 183[8] and Recommendation 191[9]		• Convention 183 (mandatory): 14 weeks total, which must include at least six weeks postpartum. • Recommendation 191 (recommended): 18 weeks total ante/intra/postpartum.
International Labour Office[10] database of 56 countries in Africa, Americas, Asia Pacific, Central Asia, and Europe		Six postpartum weeks recommended by half of all countries requiring compulsory leave.
Survey of 186 Alberta physicians and midwives regarding actual practices	Mean: 3.58 weeks prior to EDB Reported range: 0 to >6 weeks Mean low: 2.2 weeks Mean high: 4.96 weeks	Six to 13 or more weeks postpartum, with uncomplicated vaginal deliveries skewing slightly toward 6 to 8 weeks and complicated deliveries skew toward 9 to 13 weeks or longer.

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