

Menstrual and Menopausal Health at Work in India



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About IWWAGE

The Institute for What Works to Advance Gender Equality (IWWAGE) was established in 2018 with an aim to build and deepen evidence around the low participation of women in the economy to find solutions to support the development of gender inclusive policies and programmes.

IWWAGE is an initiative of LEAD at Krea University, an action-oriented research centre housed at the Institute for Financial Management and Research (IFMR), a not-for-profit society which is also the Sponsoring Body of KREA University.

About MHAi

Menstrual Health Action for Impact (MHAi) is a think tank and strategic advisory organisation that leverages menstrual health and systems strengthening to improve the health and well-being of girls and women in low and middle income countries.

We inform and bolster menstrual product markets, facilitate the intentional integration of menstrual health into health systems, advance responsive WASH and menstrual waste management, and spotlight menstrual and menopausal health for women at work.

About the 'Future of Work' Series

Various factors are changing the employment landscape, from skilling demands and sector-specific job creation to fertility rates and women's health. And while more women are gradually entering the workforce, their workplace experiences are far from on par with those of men. In their Report "Women in the Workplace 2024", McKinsey & Co. estimates that globally it will take nearly 50 years for women to achieve parity. Achieving gender equality is hindered by social dimensions that shape women's experiences in the workplace. Imminence lies in creating a workplace experience that is inclusive and equitable for everyone. Against this backdrop, what strategies can keep women in India's workforce as we confront a constantly evolving future of work? IWWAGE's Future of Work series seeks to answer this question through roundtable consultations and secondary research focusing on emerging sectors. The series highlights gender-responsive principles in various thematic areas to enable and enhance women's workforce participation.

Abbreviations

ASHA – Accredited Social Health Activist

DALYs – Disability Adjusted Life Year(s)

EMAS – European Menopause and Andropause Society

FLFPR – Female Labour Force Participation Rate

HUL – Hindustan Unilever Limited

IBM – International Business Machines

IFMR – Institute for Financial Management and Research

ILO – International Labour Organization

ISO – International Organization for Standardization

ISODIS 45010 – Draft International Standard 45010 Workplace Menstruation Menopause Standard

IWWAGE – Institute for What Works to Advance Gender Equality

LEAD – Leveraging Evidence for Access and Development

LFPR – Labour Force Participation Rate

LMICs – Low- and Middle-Income Countries

MHAI – Menstrual Health Action for Impact

MMH – Menstrual and Menopausal Health

NHM – National Health Mission

NGO/NGOs – Non-Governmental Organisation(s)

OSH – Occupational Safety and Health (from OSH Code 2020)

PCOS – Polycystic Ovary Syndrome

PLFS – Periodic Labour Force Survey

PMS – Premenstrual Syndrome

RoI – Return on Investment

WASH – Water, Sanitation and Hygiene

WEE – Women’s Economic Empowerment

WHO – World Health Organisation

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01

Background and Context

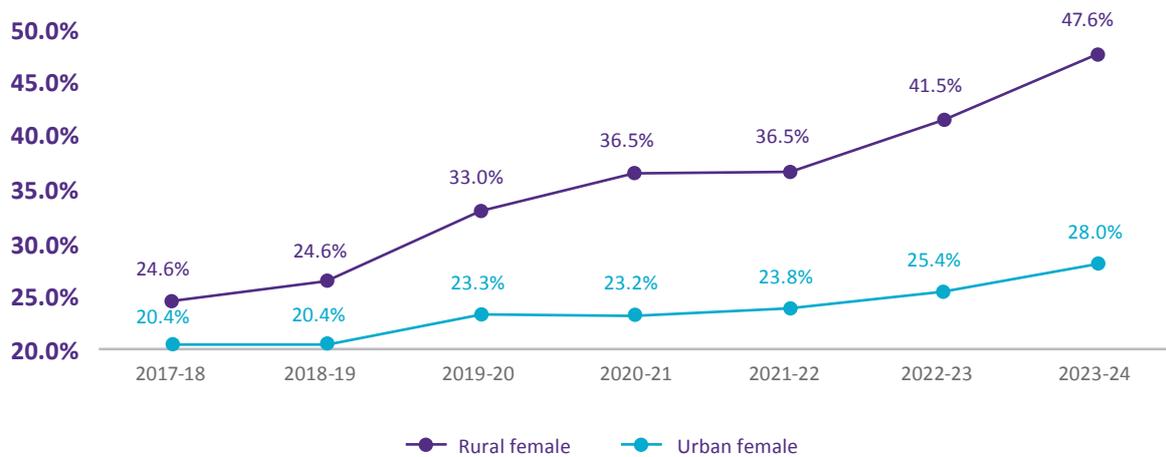


1.1 Women at Work in India

Women's workforce participation in India has evolved significantly in recent years, having implications for their economic, social, physical, and mental health and wellbeing as well as broader societal progress and inclusive development. National surveys indicate

a marked rise in female labour force participation rates (FLFPR), reflecting a positive shift in social norms and economic transitions. The Periodic Labour Force Survey (PLFS) highlights that the proportion of women engaged in the workforce sharply rose from 23.3% in 2017-18 to 41.7% in 2023-24, more notably in rural than urban areas¹ (Figure 1).

Figure 1: Increasing FLFPR in urban and rural India



Despite this progress, India lags behind globally. International Labour Organisation (ILO) modelled estimates (2024) place India's female Labour Force Participation Rate (LFPR) at 33%, compared to the world average of 49%.² This is partly due to the nature of women's employment in the country being deeply fragmented and informal. Only an estimated 15.7% of working women are in regular salaried employment. The vast majority are self-employed, daily wage earners or engage in casual work - spread across sectors such as agriculture, domestic service, street vending, gig and platform work, and small-scale manufacturing. Self-employed women are majorly engaged in own-account work which has typically low-productivity and meagre earnings.³ Among women in regular salaried jobs, informality prevails. More than half of regular salaried women (57.3%) had no written job contract, 45.9% were not eligible for paid leaves and 58.0% had no specified social security benefit.

Moreover, women's entry into the workforce is profoundly shaped by social determinants such as caste, religion, class and education. While more women are joining the workforce, they continue to face persistent demand-side or individual level barriers (e.g., time poverty, caregiving responsibilities, health challenges) and supply-side or workforce related hurdles (e.g., wage disparities, occupational segregation, workplace safety, limited growth, discrimination at workplace). Recent policy narratives have started paying attention to participation rates, unpaid care work, worker rights, and occupational health and safety.⁴ Across the domains, working women's health remains a neglected dimension, especially for the vast segment in informal and unpaid work.

1.2 Menstrual and Menopausal Health in India

MENSTRUAL & MENOPAUSAL HEALTH

Menstruation is a natural, monthly biological process experienced from puberty to menopause, that involves the shedding of the uterine lining.

- In India, girls and women experience menstruation over a ~33-year period (from 13.5 years - 46.6 years)

Menopause is a natural life transition marking the end of menstruation. A person is considered to have reached menopause when they have had 12 consecutive months without a menstrual period. The phase before menopause - perimenopause - can last between a few months to 10 years, and is typically accompanied by a host of symptoms like hot flashes, brain fog, sleep disruption, and mood changes.

- The average age at menopause in India is 46.6 years (Prasad et al., 2021)⁵

Menstrual and Menopausal Health (MMH) are integral aspects of women's health.⁶ In India, approximately **393 million people menstruate, and an estimated 124 million women aged 40–49 years are in the menopausal transition.**^{7,8} Menstruation and menopause are natural, normal⁹ physiological processes for this large and growing population of menstruators and women in menopause. Yet their menstrual health experiences, including routine menstrual management, are challenged and undermined by social, cultural and economic factors throughout their lives. Illustratively, only 23% of reproductive age women are aware of their fertile period¹⁰ and nearly 188 million struggle to get the menstrual products they need.¹¹ Gaps in infrastructure persist - 19% of household lack access to basic toilets,¹² and 60.4% of women are unable to change menstrual material when away from home.¹³ Socio-cultural norms are pervasive, with over 83.4 % of women reporting restrictions on visiting religious spaces, and constraints on socialisation and engaging in daily routines.¹⁴ Menstrual health concerns are prevalent (e.g., heavy menstrual bleeding experienced by 17.8%¹⁵ and Polycystic Ovary Syndrome (PCOS) by 19.6%¹⁶), but are grossly neglected in healthcare services. Additionally, research indicates that over 80% of Indian women experience menopausal symptoms, with over 50% having severe or disruptive symptoms, with deeply entrenched socio-cultural norms hindering open conversation, timely care and social support for this transitional phase.¹⁷

Poor MMH undermines women's overall health and wellbeing, negatively influencing their ability to fully participate in all aspects of their lives - including education and work. When women lack access to quality and affordable menstrual products, they may use unsafe materials (like rags) or use safe

products (like sanitary pads) unhygienically - making them susceptible to reproductive tract infections.¹⁸ Low levels of awareness about menstruation, the menstrual cycle, menopause, and atypical symptoms combined with unsupportive socio-cultural norms prevents girls and women from understanding their bodies, seeking care for menstrual concerns and symptoms (e.g., menstrual pain, abnormal vaginal discharge) and disorders like heavy menstrual bleeding and PCOS - posing a risk for long-term discomfort, pain, healthcare costs, and wider health implications (like anaemia, cardiovascular disease).¹⁹ For instance, anaemia is highly prevalent among Indian girls and women of reproductive age and heavy menstrual bleeding can further exacerbate this condition having negative implications on their health and participation in school and work. Furthermore, menopause increases the risk of non-communicable diseases in women as a result of significant hormonal changes. Indian women already have a high burden of developing cardiovascular disease, with menopausal women at even greater risk.²⁰ Research alludes to the profound effects of menstrual concerns and disorders across the life course - endometriosis is estimated to have caused a loss of approximately 56.61 disability-adjusted life years (DALYs) for every 100,000 people and PCOS is associated with 0.43 million DALYs respectively.^{21,22}

As millions of Indian women shoulder paid and unpaid work, the intersection of MMH and workforce participation becomes critically important. This brief spotlights MMH, a vital yet often overlooked aspect of women's health emphasising that challenges and needs extend across the entire reproductive lifespan and beyond, with direct and indirect consequences for women to enter, remain and excel in the world of work.²³

The Interplay of MMH and Workforce Participation



The interplay of **MMH and workforce participation is multi-faceted, bi-directional and poorly understood**. Poor MMH has implications on women's presence at work, and also the quality of engagement and productivity. At the same time, workplace environments and occupational hazards can adversely impact MMH and wellbeing.

2.1 Impact of MMH on Work: Key Dimensions

Table 1: Impact of MMH on Work

Effect	Insights
Work Absenteeism	Nearly one in five girls and women in South Asia report missing school or work due to menstruation. ²⁴ On average, women can lose about 1.5 hours of work during their periods. ²⁵
Reduced Quality of Participation	<p>Conditions like pain, heavy bleeding, PCOS, and endometriosis are associated with severe pain, fatigue, and mental health challenges.²⁶ Women in perimenopause and menopause may experience bothersome and disruptive symptoms (ranging from anxiety, fatigue, hot flashes, insomnia, and brain fog) that can affect the quality of work.^{27,28,29}</p> <p>A study in Hyderabad shows that working women in menopause report lower overall quality of life (physical, psychosocial, sexual) than non-working counterparts.³⁰</p>
Psychological Impact	Around 42.5% of peri and postmenopausal women in India experience depression, affecting workplace engagement and productivity. ³¹

Table 1 alludes to immediate and long-term implications for women's participation and engagement in the workforce if their MMH needs are unsupported. Adverse implications are more pronounced for those in the informal sector (directly affecting their daily wages), having consequences for their overall health and even their family's wellbeing (if they are sole or significant contributors to the family income). Platform and gig workers experience different challenges, having varied and changing worksites, lacking social protection and safety measures to support their needs.³² Women engaged in such work lack access to sanitation facilities to change their menstrual products safely and in privacy, and their menstrual health can be affected by heat stress in the summer months. In the formal work sector, women held only 12.7% of middle and senior management positions (as of 2023); menopausal challenges can hinder career advancement during crucial professional phases.³³ Despite the clear significance, there is limited data on MMH's effects on work in India and other low- and middle income countries (LMICs) in general. Emerging lessons from high-income countries offer critical insights into how MMH affects women's labour market outcomes, and while focused on the formal work sector, clearly highlighting the need for attention and action.



Insights from high-income countries foretells the implications of menopause on work

A study in Norway and Sweden documented the multi-dimensional impacts caused by menopause on women's lives. It showcased that while menopause caused a short-lived but sharp increase in specialist doctor visits, primary care, and drug utilisation (hormonal replacement therapy and antidepressants), there is a large and persistent decline in employment and earnings, with a greater reliance on social transfers – more commonly experienced by women belonging to lower socio-economic groups.³⁴

Riach and Jack (2021) called out menopause at work as a simultaneous health, social and cultural experience often compounded by fears of discrimination and long-term health conditions, such as the perception of 'weaknesses' at a workplace.³⁵

A survey revealed that approximately **460,000** Japanese women aged 40-50 years had experienced "menopausal resignation." The economic losses incurred due to resignations amounted to approximately \$ 2.8 billion. Around 73% of working women in their 40s or 50s were prone to insomnia – one of the hindering menopausal symptoms – impacting their productivity at the workplace.³⁶

The World Economic Forum underscores that inadequate menopause support leads to **14 million** lost working days annually in the UK, costing employers more than **£30,000** per lost employee—highlighting a compelling economic rationale for action.³⁷



2.2 Occupational risks affect MMH

Emerging evidence points to occupational hazards such as working conditions, tasks, and nature of work contributing to poor health, adversely affecting sexual and reproductive health, including menstrual health directly and indirectly across a worker's life course. Table 2 below presents some salient occupational hazards and their relevance for menstrual and menopausal health.

Table 2: Occupational hazards and MMH

Type of occupational hazard/risk		Implications for menstrual and menopausal health
Physical hazards	<ul style="list-style-type: none"> • Extreme heat and extreme cold • Radiation 	<p>Over time, exposures to extreme heat, extreme cold can affect the menstrual cycle and menstruation.³⁸</p> <p>Radiation exposure can also affect the menstrual cycle and ovarian function through their effects on the ovaries.</p>

Chemical hazards	<ul style="list-style-type: none"> Exposure to heavy metals and toxic chemicals, dust especially among those engaged in agriculture, manufacturing, and even health care industries 	<p>Heavy metals, chemicals, dust can affect menstruation and the menstrual cycle by disrupting the endocrine system.³⁹</p> <p>A study found that exposure to disinfectants among nurses was associated with menstrual disorders.</p> <p>Women engaged in agriculture are exposed to pesticides, which have been associated with adverse reproductive outcomes, including disruptions to the menstrual cycle and menstruation.</p>
Psychosocial or workplace hazards	<ul style="list-style-type: none"> Working hours Shift work Work load Workplace violence Emotional labour Lack of support Poor workplace infrastructure Changing work environments 	<ul style="list-style-type: none"> Shift workers have significantly higher odds of menstrual disorders, dysmenorrhea, and early menopause. Shift work, irregular work schedules can cause changes to women's circadian rhythms, affecting menstruation and the menstrual cycle.^{43,44,45} Working environments, workplace stress and anxiety - affect the menstrual cycle.⁴⁶ Heavy manual labour can cause pelvic floor stress and associated complications.⁴⁷ Women engaged in daily wage labour and heavy manual labour who experience menstrual pain, heavy menstrual bleeding may undergo hysterectomies as a solution (to menstruation related missed work days and lost wages). The adverse implications of this surgery are significant in terms of their physical and mental health, and finances.⁴⁸ Physical infrastructure for menstrual management - Safe and functional toilets are needed for menstrual management, and to manage symptoms of disorders and menopause (that may require more frequent changing due to heavy bleeding, or incontinence). The absence of safe and private toilets can also place women workers at increased risk for gender-based violence at the workplace.
Ergonomic or mechanical hazards	<ul style="list-style-type: none"> Manual and heavy labour 	<ul style="list-style-type: none"> Such exposures can contribute to menstrual pain, heavy bleeding, in combination with other exposures.
Biological hazards	<ul style="list-style-type: none"> Virus and bacteria 	<ul style="list-style-type: none"> Exposure to certain viruses (e.g., COVID-19) may affect the menstrual cycle. Hence health care workers who are more likely to be exposed to these biological hazards may be at risk - though this is poorly understood.

Case studies from India highlight occupational hazards for women workers

A study on female waste pickers noted that **17.6%** had no access to sanitation facilities, **37.3%** missed their work during their periods, **63.7%** did not change their menstrual absorbents while working and over **60%** had workplace toilets located at significant distances from their work site.⁴⁹

In the sugarcane belt of Maharashtra, reports have revealed that thousands of women have undergone unnecessary hysterectomies, often in their twenties or early thirties to stop menstruating and avoid wage loss during the harvest season.⁵⁰ Without access to sanitation or menstrual support at work, and under undue pressure from labour contractors, these women resort to drastic surgical interventions, often without understanding the long-term health implications of the same.

These insights demonstrate the deep interconnection between MMH and women's workforce engagement. MMH challenges, ranging from pain and fatigue to long-term disorders, undermine attendance, performance, earnings and even career progression. Concurrently, unsupportive workplace environments, occupational exposures, and inadequate infrastructure can exacerbate poor MMH, perpetuating a cycle of disadvantage. This results in wage losses, stalled careers, and significant social and economic costs. Recent evidence from the Global North suggests that menopause-related disruptions impose a significant economic cost on the global workforce, with estimated annual losses of £1.5 billion in the U.K., \$1.8 billion in the U.S., \$3.3 billion in Canada, \$9.9 billion in Germany, and \$12 billion in Japan.⁵¹ In addition to the economic costs for individuals and their families, organisations, and nations, poor MMH has pervasive impacts on a person's health and wellbeing.

2.3 The Case for Menstrual and Menopausal Health at Work

As India and other economies invest in expanding women's workforce participation, there is growing recognition that efforts must go beyond enabling women's entry into the workforce and address other aspects of work including employee retention, wellbeing, and dignity at work. Adopting a life course approach to MMH can offer a strategic lens to support women not just as workers, but as individuals

navigating physiological experiences and transitions that intersect and shape their presence at work, productivity, agency, and rights.

Acknowledging and addressing MMH needs for working women brings health, economic and social returns, with limited, though promising insights and directions, offered by ongoing interventions in India and across the world. Integrating menstrual and menopausal health into workplace policies delivers economic returns, improves health outcomes, and advances gender equity and rights.

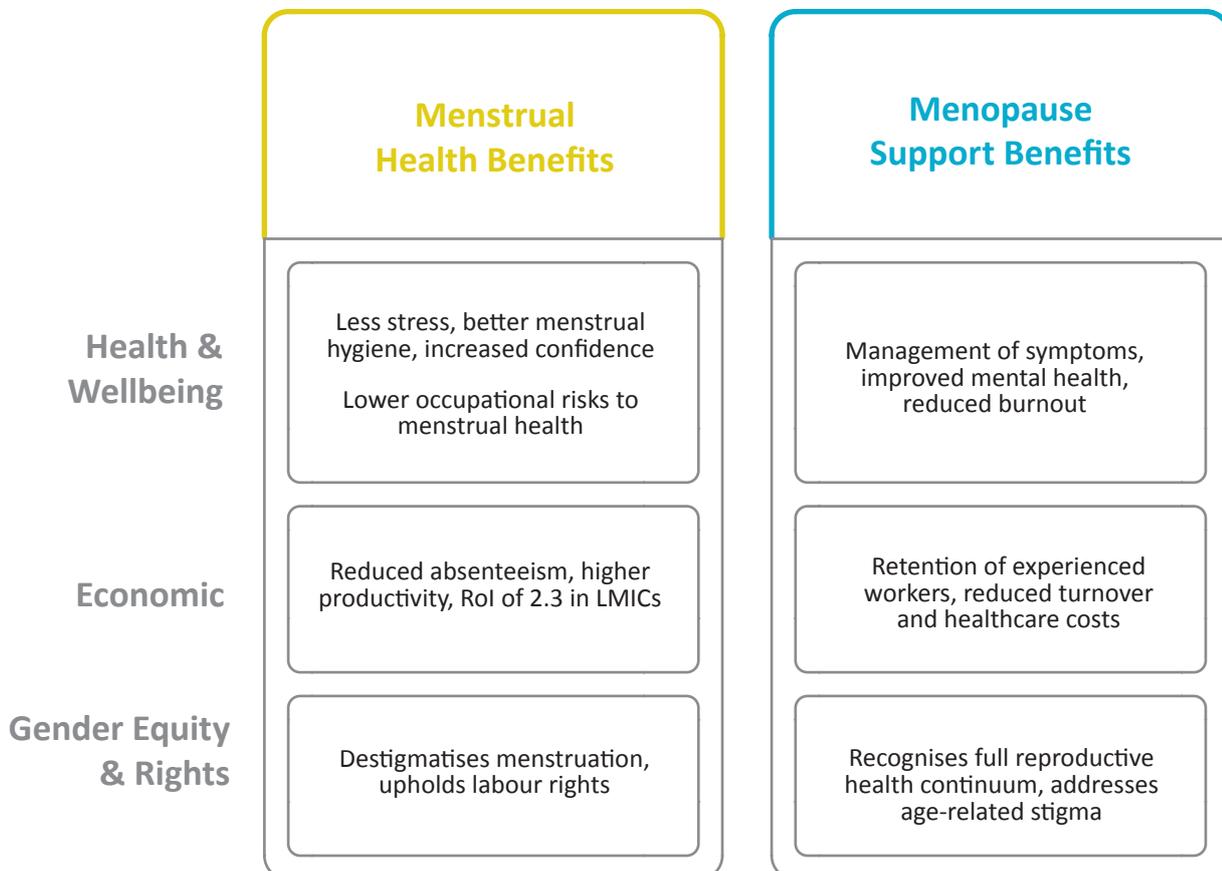
Economic benefits: Addressing MMH in workplace settings can significantly reduce absenteeism, presenteeism (working while unwell), and staff turnover, improving productivity and long-term workforce engagement. A study in Burkina Faso found that improving menstrual hygiene reduced absenteeism by 21–24 percentage points, enhancing income and labour participation.⁵² Supporting employees through MMH accommodations (such as flexible work schedules, leave options, and access to healthcare) helps retain experienced staff, reduce recruitment/training costs, and foster long-term workforce continuity. Return on Investment (RoI) assessments in Kenya and Nepal indicate that comprehensive workplace menstrual hygiene interventions comprising the provision of products and sanitation infrastructure, behaviour change initiatives with employers and employees, and workplace guidance and policies for improved

menstrual hygiene are cost-effective. For every \$1 invested, there was \$1.54 and \$1.25 in benefits in Kenya and Nepal respectively.⁵³ Similar estimates for low- and middle-income countries do not exist, and neither does estimates for economic losses incurred when women’s participation in the informal labour force is affected by MMH.

Health and wellbeing benefits: Improving MMH in workplace settings is strongly associated with better physical, psychological, and social wellbeing for women workers. Existing research, though sparse (especially in LMICs) indicates that access to menstrual products, safe and private sanitation facilities, and opportunities for rest supports overall workers health through reduced risk for urogenital infections, mitigates discomfort, and lessens anxiety linked to stigma and concealment.⁵⁴ Among female garment factory workers in Bangladesh, menstrual hygiene interventions that provide menstrual products and menstrual health education led to improved health outcomes, though there were limited impacts on labour outcomes, including attendance at work and income.⁵⁵

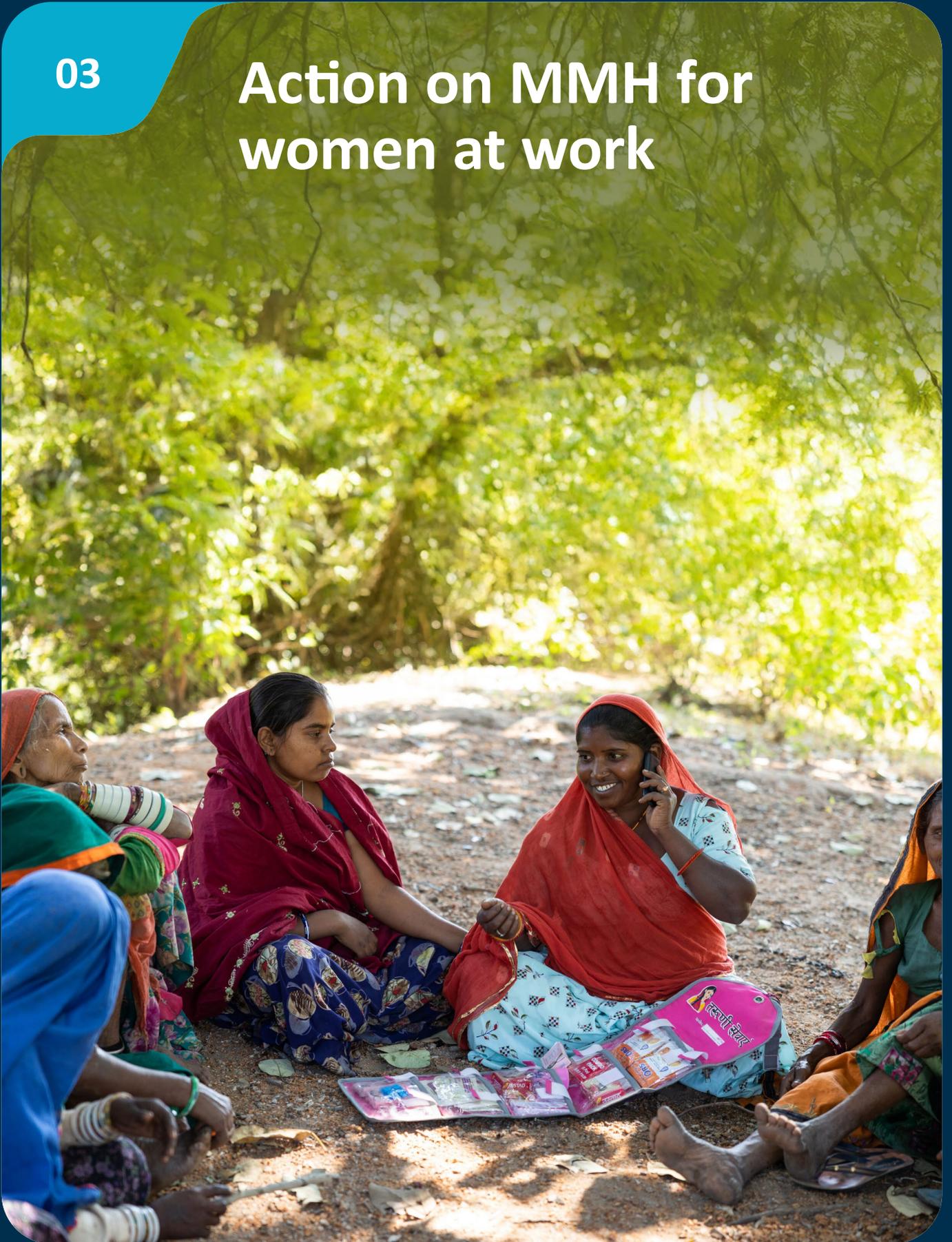
Gender equity and rights for women workers: Recognising both menstruation and menopause as workplace issues is relevant for to advancing gender equity, inclusion, and labour rights. Women's right to work is integral to their right to access and occupy public spaces with dignity. Workplace provisions for menstrual and menopausal health gives women the choice and ability to exercise the right to participate fully in public life. Menstrual stigma and inadequate infrastructure function as deliberate mechanisms of spatial exclusion that restrict women's mobility, choice, economic contribution, and public engagement particularly for informal and low-wage women workers, who are least likely to have voice or legal protections. When workplaces proactively support menstrual and menopausal health, they promote a shift from tokenistic inclusion to structural changes that meaningfully engender women's workforce participation, affirming women's right to work under conditions of dignity and safety in alignment with international labour standards and human rights principles.⁵⁶

Figure 2. Addressing MMH at work brings health, economic and social benefits



03

Action on MMH for women at work



3.1 Global Initiatives for MMH at Work

Globally, efforts to support MMH at work are nascent, primarily focused on formal workplaces, with no comprehensive framework yet established to address the diverse needs of working women across sectors and settings. Some notable initiatives are illustrated in the next section

- **Global guidance on MMH at work:** The International Organization for Standardization (ISO) is developing a standard for menstruation, menstrual health and menopause in the workplace (ISO/DIS45010). This document guides organisations on developing policies and practices that are supportive of MMH experiences of workers in the workplace. It does not provide medical guidance or clinical options outside of the workplace, but includes references to qualified sources where such information is available.⁵⁷
- **Training and certifications for organisations:** The Period Positive Workplace initiative promotes menstrual health through three feasible workplace actions- provision of free menstrual products in bathrooms, adherence to toilet facility standards, and clear communication about menstrual product availability.⁵⁸ Organisations meeting these criteria earn certification, laying foundation support for MMH at work. Over 100 organisations across North America, Europe, Asia and the Pacific region have been certified as a Period Positive Workplace.⁵⁹ The Bloody Good Employer initiative offers a four-step accredited programme for organisations seeking to be more responsive to the needs of their menstruating employees.⁶⁰ Through a comprehensive process, the initiative tailors the programme to meet the needs of companies and their employees.
- **Menstrual leave policies:** Various countries (Spain, Japan, Taiwan, Indonesia, Zambia) have introduced menstrual leave, with differing approaches on paid/unpaid leave and eligibility. For example, Spain allows people up to three days of leave for period pain if they provide a medical certificate; Taiwan offers a half-paid day off.⁶¹
- **Menopause focused initiatives:** Some companies provide specific support ranging from menopause specific policies, sessions with medical experts, flexible work, and changes in physical work environments to support symptom management. The European Menopause and Andropause Society (EMAS) advocates for removing stigma, fostering inclusive policies and collaborative workplace decision-making.⁶²
- **Advocacy networks for working women's health:** United Nations Population Fund (UNFPA) and partners launched the Coalition for Reproductive

Justice in Business to “advance and mainstream the reproductive-health agenda for women and girls in corporate strategy and operations and to ensure the provision of adequate maternal-health support, access to family-planning information and response to gender-based violence in the workplace”.⁶³ Furthermore, MMH can be positioned as an entry point for sexual and reproductive health and rights at work across women’s working lives, and as a lever for sustained gender responsive actions.

3.2 Workplace MMH initiatives in India

When it comes to menstrual and menopausal health and women’s work, India’s policy landscape reflects both progress and gaps. While national and state provisions have advanced adolescent menstrual hygiene, workplace-specific support remains fragmented and limited.

3.2.1. Government led initiatives

While menstrual health and hygiene has been part of government programming, the focus has primarily remained on adolescent girls and on promoting safe and hygienic menstrual practices, often through product provision and awareness campaigns. MMH at the workplace has received sparse attention and skewed attention.

Menstrual health and hygiene schemes in India: India has pioneered multi-sectoral menstrual hygiene schemes, primarily targeting adolescent girls through subsidised sanitary products and improved sanitation infrastructure. For example, Pradhan Mantri Janaushdhi Pariyojana provides single-use Suidha sanitary pads at INR 1 per pad in Jan Aushadhi kendras.^{64,65} In 2018, the Ministry of Housing and Urban Affairs issued an advisory on public and community toilets, with recommendations for states, ranging from adequate lighting to provisions for the disposal of sanitary napkins for women. It also suggested ways in which gender-sensitive toilets can be constructed. Safety, privacy and location selection have also been given specific emphasis.⁶⁶

To ensure that girls are effectively transitioning from school to work, it is imperative to place equal or more importance on addressing their menstrual and menopausal needs to mitigate the loss or productivity and other factors.

Menstrual leave initiatives: In parallel, parliamentary debates on workplace menstrual rights have gained momentum. The Right of Women to Menstrual Leave and Free Access to Menstrual Health Products Bill, 2022.⁶⁷ proposed legal entitlements including paid menstrual leave and universal access to menstrual

products within work and educational institutions. The bill sparked debate over practical challenges and risks of reinforcing stereotypes that could negatively impact hiring or promotion. Employers may grapple with the operational challenges of managing varying leave schedules while maintaining workforce productivity. Balancing the needs of both employees and the business itself requires a delicate equilibrium. Given these nuanced challenges, addressing menstrual health in the workplace needs to go beyond standalone policies like menstrual leave but including integration with broader labour laws and workplace standards, ensuring that there are support mechanisms across India’s diverse employment sectors.

Some states have proactively addressed menstrual leave for working women, launching formal initiatives (see Table 3). However, in the absence of assessments, it is unclear whether these leave focused initiatives have actually supported MMH at work for all categories of workers, across the formal and informal sectors.

Table 3: Government-initiated menstrual leave initiatives in India

Policy/Practice	Coverage/Details	Year/Status
Bihar	2 days of paid menstrual leave per month for state government women employees	1992
Odisha⁶⁸	1 day paid menstrual leave for women workers in both public and private sectors	2024
Kerala	Menstrual leave for female students in universities and institutions	2023
Karnataka	Women employees in the public and private sector entitled to one day of paid leave during their menstrual cycle	2025

Occupational health initiatives: At present, there is no core National Labour Law that mandates provision of menstrual hygiene facilities or support in the workplace. The Factories Act, 1948 mandates that every factory must provide separate, conveniently situated, adequately lighted and ventilated sanitation and toilet facilities.⁶⁹ The state government can prescribe the number of toilets, based on the proportion of male and female workers. Additionally, the Occupational Safety, Health and Working Conditions (OSH) Code, 2020 extends the sanitation provisions to transgender employees mandating separate and adequate arrangements for all genders.⁷⁰ The OSH Code applies to all establishments with 10 or more workers requiring employers to maintain a hygienic workplace, with violations subject to penalties. Despite such provisions, ground level implementation often falls short. Many women workers continue to lack access to basic sanitary facilities highlighting ongoing gaps in enforcement and awareness.⁷¹

3.2.2 Civil society and private sector led initiatives

Civil society, especially NGOs working on menstrual health, have started incorporating attention to MMH at work. Actions range from awareness sessions with

women workers, distribution of menstrual products, and ensuring access to female friendly toilets in worksites, to menstrual and menopausal policies for workplaces. Initiatives such as “Flow at Work” and Bleed Equal provide support to organisations to address MMH at work.⁷²

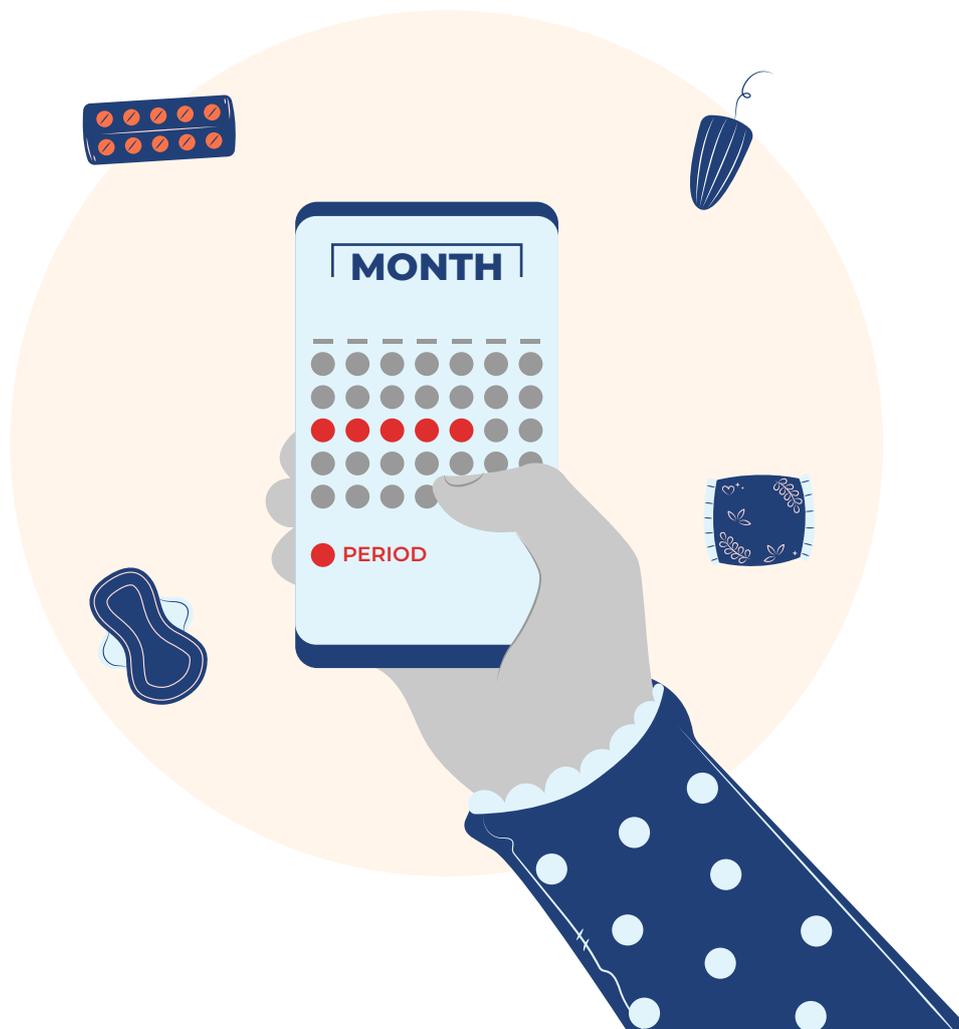
Several Indian employers, such as Zomato, have introduced menstrual leave policies, ranging from one day per menstrual cycle to up to 10 days annually. These actions have been framed as an effort to destigmatise menstruation, though concerns remain about unintended impacts on hiring and career progression. Some universities have also piloted menstrual leave in limited ways; for example, Punjab University offers one day of leave per month per semester for female students from 2024–25. By contrast, there is currently no formal menopause policy for women employees in either government or the private sector. Nonetheless, a growing number of organisations, including HSBC India, International Business Machines (IBM), Hindustan Unilever Limited (HUL), Standard Chartered Bank, NatWest Group, and Intuit, are beginning to normalise menopause through awareness campaigns, expanded medical coverage, access to menopause specialists and mental health support, as well as flexible leave and work policies to help women navigate this life stage.

Innovative initiatives for MMH at work in India

Humm Care is a health-tech platform that provides end-to-end support to organisations in responding to healthcare needs of its employees and their families. It also tailors health-care solutions for women across every life stage including PCOS, thyroid, endometriosis and menopause support.

Cranberry, a women's health company offers a combination of curated supplements, digital care journeys, and personalised guidance to address individual concerns particularly those related to menstrual cycles, Premenstrual Syndrome (PMS), and related conditions.

MIROR, a Bengaluru-based FemTech startup, has built India's largest WhatsApp community for menopause care, connecting over 1,500 women. The platform offers comprehensive support for women navigating perimenopause and menopause. It has also extended its impact through awareness programmes in all 11 police divisions of Bengaluru and rural outreach via a partnership with the National Health Mission (NHM). Through this, over 4,000 ASHA (Accredited Social Health Activist) workers have been trained to spread menopause awareness in rural communities.⁷³



04

Insights from the Roundtable



MMH are relevant for women's participation and well-being at work. However, research on MMH in Indian workplaces remains scarce. To begin addressing this gap, IWWAGE and MHAi have consolidated early insights from a roundtable consultation held in May 2025. These are initial, indicative findings and are shared here to spark continued conversation and future evidence generation.

The roundtable aimed to gain insight from civil society and development sector experts and researchers into women's experiences of menstruation and menopause, and the multifaceted implications for their work. The roundtable also touched on the differences across various professions and contexts, including young and older women, at early stages, mid-career, and in leadership positions, in both formal and informal work settings.

4.1 Structural and Institutional Inequities

Discussions from the roundtable revealed a deeply inequitable landscape in which caste, class, location, and type of employment interact to shape women's access to MMH resources and their ability to experience dignity in the process. Informal women workers, such as domestic workers, street vendors, gig workers, and factory labourers, face distinct challenges in managing menstruation and menopause due to the nature of their work, working environments, and existing labour policies. Many lack access to basic sanitation facilities in public spaces and markets, heightening their vulnerability to urogenital infections and related complications. Platform-based gig workers described avoiding breaks during work hours because of algorithmic surveillance and performance pressures, which prevent them from changing menstrual hygiene products when needed.

In factory settings across India, women over the age of 40 can be pushed out of employment, not due to declining ability or productivity, but because of entrenched ageism and gendered assumptions. Employers frequently perceive older women as less efficient, more prone to health issues, or as liabilities owing to their reproductive and menopausal transitions. In the absence of protective labour provisions, many of these women are silently edged out of the workforce without formal dismissal, severance, or benefits. Their years of experience and contribution are devalued, and their health needs, particularly those related to menopause, are viewed as burdens rather than legitimate grounds for workplace support or accommodation.

In urban India, where large number of women are employed as domestic workers, access to sanitation facilities is mediated by social hierarchies and caste-based norms. Women from lower castes are often

denied the use of their employers' toilets and must wait until returning home, often after long workdays, to manage their menstrual needs. This not only exacerbates the risk of infections and discomfort but also reinforces the historical segregation of menstruating bodies as 'impure' or 'dirty'. For these workers, access to sanitation becomes a daily negotiation that compounds the insecurity and indignity of informal work.

In agricultural sectors, particularly in parts of Maharashtra, Andhra Pradesh, and Telangana, experts noted a troubling normalisation of unnecessary hysterectomies among women labourers. These surgeries are often performed prematurely and without fully informed consent, under the pretext of improving productivity by eliminating menstrual pain or irregularities. Here, the uterus is treated less as a part of a woman's body and more as a workplace impediment, removed in the name of uninterrupted labour. The long-term health consequences of surgically induced menopause from hysterectomies, including the increased risk for chronic and metabolic diseases (e.g., osteoporosis, diabetes) and psychological distress, are seldom recognised and addressed.

In rural workplaces, the transition into menopause is marked by isolation, misinformation, and silence. In the tea gardens of Assam for example, limited health infrastructure and the absence of targeted educational resources mean that menopause is rarely acknowledged as a stage requiring support. Instead, it is framed as a private ordeal, something to be endured quietly, even as women continue to shoulder physically demanding labour. Many lack both the vocabulary and the space to articulate their experiences, as well as basic information about common symptoms such as hot flashes, fatigue, joint pain, and mood changes. Within families and communities, these symptoms are often misunderstood or trivialised, eroding women's self-esteem and reinforcing their social marginalisation.

4.2 Evidence and Data Gaps

Current discussions on MMH reveal how uneven and incomplete the existing body of research remains. Most studies continue to focus on adolescent girls and menstrual hygiene, leaving significant gaps in understanding women's experiences through adulthood, from the reproductive years to menopause, and beyond. Little is known about how menstrual needs and challenges shape the lives of young women as they enter and navigate the workforce, or how the menopause transition, often shrouded in silence and stigma, affects women's participation, productivity, career progression, and wellbeing at work. The mental health and social dimensions of menopause (such as feelings of vulnerability, identity loss) and

that associated with menstrual disorders experienced by some during the reproductive age, remain largely unexplored in general, including in the context of work.

Women in the informal economy, who make up a large proportion of India's workforce, are almost entirely missing from the MMH evidence base. Despite facing severe infrastructure gaps and difficult working conditions, their realities are rarely documented. There is also limited economic data to highlight the true cost of inaction. The impact of unmanaged or poorly managed MMH on productivity, absenteeism, presenteeism, and workforce turnover remains poorly captured, making it difficult to build a strong case for workplace investment or policy attention.

Another concern that emerged from conversations was the prevalence of early hysterectomies among women labourers, particularly in states such as Andhra Pradesh and Telangana. With the average age reported to be around 38 years, these surgeries are often linked to workplace pressures for uninterrupted work, and economic vulnerabilities. Yet, the long-term consequences for women's health, livelihoods, and labour force participation are still not well understood.

4.3 Workplace Inclusion and Policy Gaps

Despite some progressive steps, such as the introduction of menstrual leave policies by a few corporates and the pioneering of period leave in Bihar in the 1990s, to the recent policy approved by the Government of Karnataka, which allows all working women, across industries and sectors, to take one day's paid leave every month, many women are hesitant to avail these benefits. Fear of stigma, reduced promotion opportunities, and surveillance by supervisors prevent uptake. Moreover, private sector HR systems are yet to meaningfully institutionalise MMH support. Few organisations have inclusive health policy templates that acknowledge and accommodate menstrual or menopausal health needs across different roles, seniorities, and work cultures. We also lack evidence on how menstrual leave policies and other accommodations are received and utilised by organisations who implement them and those who they are intended for.

Most critically, women in the unorganised sector, who make up more than 90 per cent of India's female workforce, remain excluded from any formal protection. Labour rights frameworks overlook MMH, and existing occupational health provisions, including those recommended by the ILO, remain unimplemented at scale.

4.4 The Need for Intersectional, Life-Course-Centred Action

Underlying all of these challenges is the absence of an intersectional, life-course-based approach to MMH. Menstrual and menopausal health cannot be treated as isolated issues relevant only to health departments or adolescent-focused programmes; the interventions limited to water, sanitation, and hygiene, and product provision solutions. The menstrual and menopausal health discourse is deeply tied to overall physical and mental health, economic participation, productivity, dignity, and equity. The roundtable emphasised that women's experiences are not uniform. Young and older women, those in early-career roles and those in leadership, and those across formal and informal sectors face distinct MMH-related challenges that must be understood and addressed in context.

There is an urgent need for systemic thinking that integrates MMH into health, labour, education, and gender equality policies. This includes developing robust evidence frameworks, investing in workplace infrastructure, building inclusive organisational cultures, and dismantling the stigma that continues to define how menstruation and menopause are treated in public discourse and policy.

Conclusion and Future Considerations

Menstrual and menopausal health is a critical but under-recognised dimension of women's workforce participation in India. It shapes both individual wellbeing but also collective economic outcomes. Poor MMH contributes to absenteeism, reduced productivity, stalled career progression, and in some cases, premature workforce exit. At the same time, workplace environments, occupational hazards, and inadequate infrastructure can intensify these challenges. Ignoring MMH perpetuates cycles of ill-health, wage loss, attrition, and the underrepresentation of women at work. This comes at a significant cost to women, their families, businesses, and the broader economy. Addressing MMH therefore requires a holistic approach that integrates health, labour, and gender policy frameworks.

Future learning and action should prioritise the following areas:

1. Strengthening the Evidence Base

India lacks comprehensive data on how MMH affects women's labour market outcomes across sectors. Future research must capture both direct impacts (absenteeism/presenteeism, wage

loss, productivity decline) and indirect effects (career stagnation, mental health, long-term health costs). Disaggregated data by age, sector, and employment type (especially for informal and platform workers) will be essential to design responsive interventions.

2. Workplace Practices and Occupational Health

Workplaces must move beyond ad hoc initiatives to embed MMH into occupational health and safety standards. This includes ensuring responsive WASH infrastructure, flexible work arrangements, and employer-supported health benefits. For informal and gig workers, portable solutions and community-based support systems are critical. Lessons from global contexts show that menopause-related disruptions can impose significant economic costs; India must proactively address this to safeguard women's participation.

3. Policy and Financing Pathways

MMH should be positioned within national labour, social protection, and gender equality policies. Dedicated budget lines, convergence across ministries, and feminist financing approaches can ensure sustainability. Linking MMH to broader agendas (such as care economy, workplace inclusion, and social protection) will strengthen its legitimacy and impact.

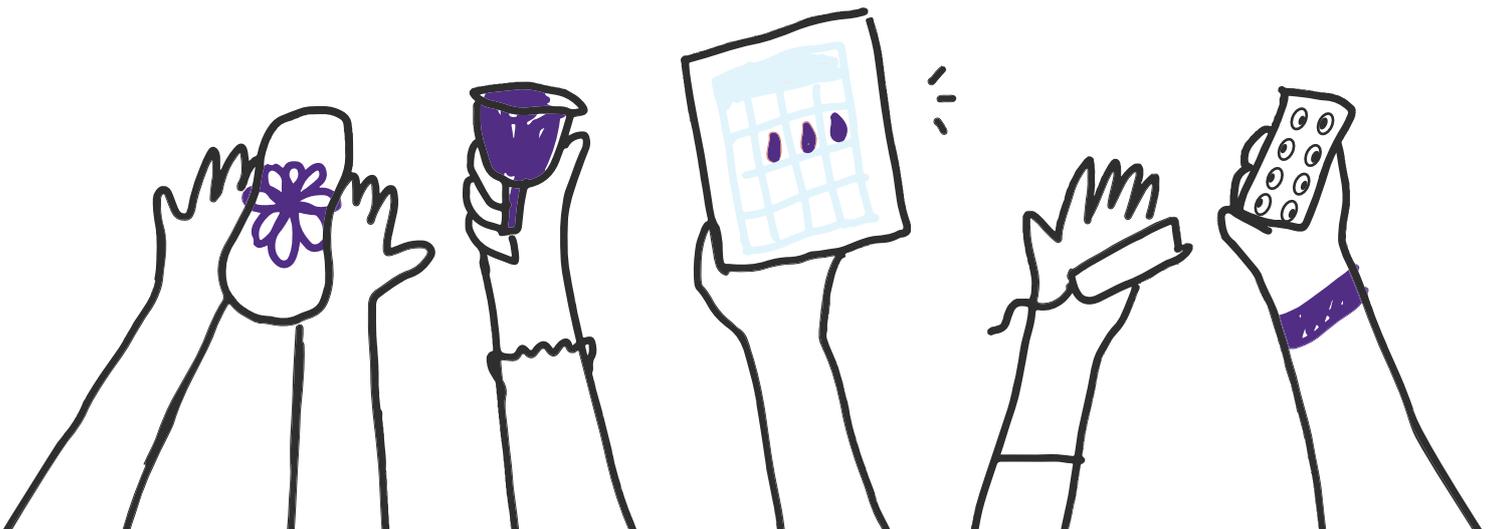
4. Narrative and Norm Change

Persistent stigma and silence around menstruation and menopause continue to undermine women's ability to seek care and support. Future work must invest in shifting workplace cultures, building awareness among employers and peers, and normalising conversations around MMH as part of gender-responsive workforce inclusion.

Advancing women's workforce participation in India demands that we move beyond rhetoric to embed MMH within workplace practices, labour policies, and national agendas. More pertinently, aligning MMH with the broader agenda of Women's Economic Empowerment (WEE) under *Viksit Bharat@2047* underscores how augmenting WEE can accelerate India's economic gains.

Menstrual and menopausal health, therefore, must be addressed holistically with interventions enabling access to accurate information, affordable menstrual products, responsive WASH infrastructure, and quality healthcare, alongside the elimination of stigma and discrimination across the life course. Such a comprehensive approach will enable those who menstruate to achieve good menstrual health and participate fully and equitably in education, work, and public life.

As India confronts the future of work, centering MMH within economic inclusion agendas is imperative. By emphasising health, rights, and dignity, MMH can be a contributor to women's empowerment and national development. IWWAGE, together with MHAi and other partners, will continue to build this narrative by bridging evidence, practice, and policy to ensure that MMH is recognised as integral to women's full and equal participation in the economy.



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⁷² Learn more about [Flow at Work](#) and [Bleed Equal](#)

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