

MENSTRUAL HYGIENE MANAGEMENT IN THE WORKPLACE

ACTIVITY OVERVIEW

All over the world, people who menstruate experience challenges managing their periods, especially those who live and work in environments that do not support adequate menstrual hygiene management (MHM). MHM is part of USAID's holistic approach to menstrual health and hygiene (MHH), which includes reproductive health; water, sanitation and hygiene; education; and social and behavior change. For working women, these challenges may have critical implications for their health and general wellbeing, as well as for their economic outcomes such as work attendance, performance, and earnings. To better understand the relationship between MHM and women's economic empowerment, the USAID Water, Sanitation, and Hygiene Partnerships and Learning for Sustainability (WASHPaLS) project conducted action research to assess the benefits and costs of improved MHM in the workplace for women workers and the enterprises that employ them.



The overall objective was to determine if providing adequate MHM in the workplace contributes to improved business and social outcomes, including women's economic empowerment.

A desk review of existing evidence on the impact of MHM in the workplace and women's economic empowerment (WEE) at the start of the project revealed a dearth of research on menstrual experiences of women in the workplace. The lack of evidence shows widespread challenges to women in managing their menstruation on the job, as well as negative effects of menstruation on earnings, productivity, dignity, and confidence. Despite these significant difficulties, very few programs sought to improve the conditions under which women manage their periods in the workplace. More information on the desk review can be found in the [full report](#).

The *MHM in the Workplace* action research implemented workplace MHM programs, conducted a cost-benefit analysis to quantify the social and financial costs of the programs, and in parallel, conducted a MHM metrics development and field testing study to support the adoption of a set of indicators in national, harmonized surveys. More information on the action research can be found in [an overview brief](#).



The workplace interventions took place in four enterprises in Nepal and Kenya, with the following components:



PRODUCTS AND INFRASTRUCTURE

Increased access to free menstrual products and improved water, sanitation, and hygiene infrastructure.



WORKPLACE POLICIES AND GUIDANCE

Encouraged a more supportive environment for menstruating employees by recommending MHM-friendly policy improvements.

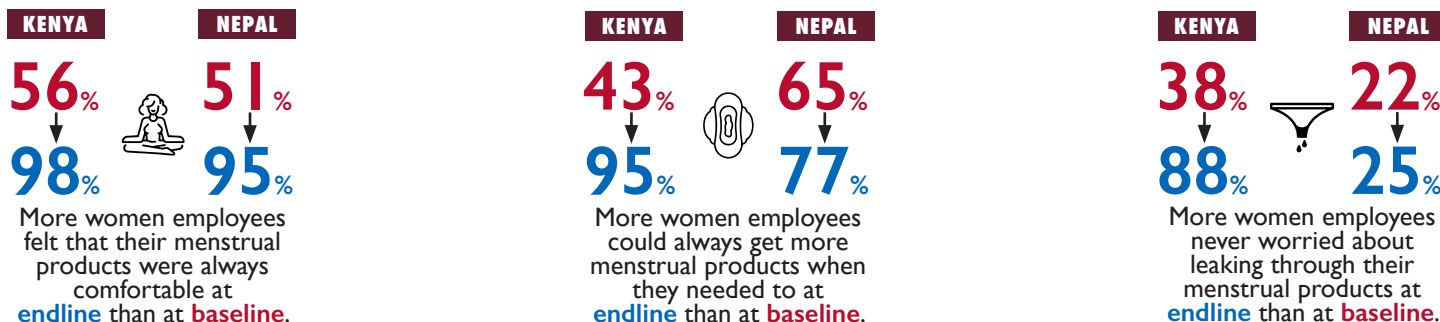


EDUCATION AND BEHAVIOR CHANGE COMMUNICATION (BCC)

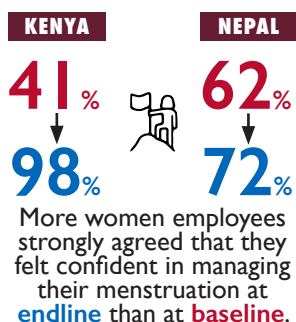
Promoted education and behavior change based on the contextual realities of each factory.

FINDINGS FROM THE INTERVENTIONS

ACCESS TO SAFE, HYGIENIC, AND ABSORBENT MATERIALS OR PRODUCTS AND SUPPLIES



CONFIDENCE REGARDING MHM

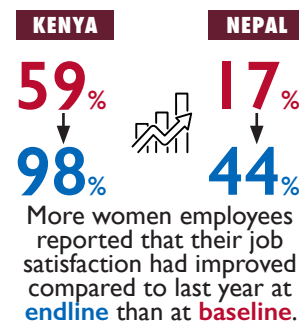


PRODUCTIVITY & WORK PERFORMANCE

"If you are not comfortable [due to menstruation-related reasons], your production can go down, but we are used to persevering because if you are slow, you will be scolded, yet you cannot explain the reason why you are slow."

WOMAN EMPLOYEE, KENYA

JOB SATISFACTION



SUPPORTIVE ENVIRONMENT FOR MANAGING MENSTRUATION WITHOUT FEAR OF STIGMA

"There has been openness to talk about [menstruation] and lack of shame. Before [the intervention] it seemed that it was something bad that happened... [Menstruation is] not a secret as before."

SUPERVISOR, KENYA



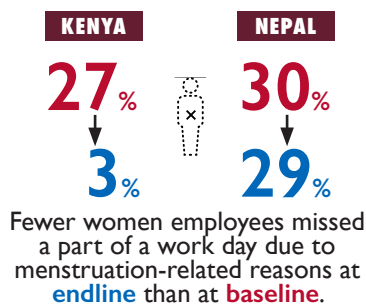
"We [have] peace of mind as we do not think what if I bleed now, what to say to colleagues, what to respond to supervisor if I am not coming to work on time, or want to go and rest. My productivity has increased."

MHM FOCAL PERSON, NEPAL

ABSENTEEISM AND PRESENTEEISM

"Less work means less money, so despite pain... we want to be present at work. Now we are confident enough to share our issue to the manager, enjoy the short rest break, and [go] back to work."

WOMAN EMPLOYEE, NEPAL



"Supervisors feel good because they are answerable for production and targets and when women are comfortable, the targets are met and supervisors feel happy and proud."

SUPERVISOR, KENYA

FINDINGS FROM THE INTERVENTIONS



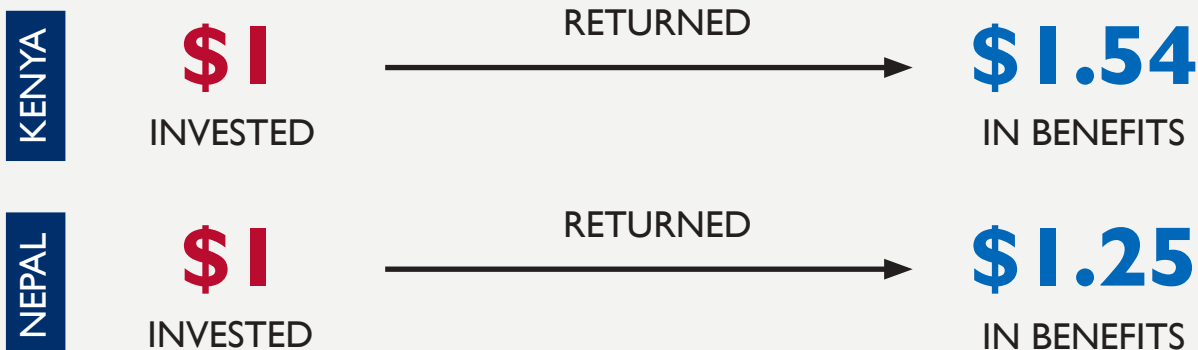
The interventions resulted in improvements in women's abilities to manage their periods at work, including their self-confidence. Increased awareness of menstruation helped normalize this taboo subject as a biological process and thus reduced stigma toward menstruating individuals*. To varying degrees, all four workplaces saw improvements in their water, sanitation, and hygiene (WASH) infrastructure. In both countries, women employees perceived a more supportive work environment, and they felt more comfortable asking for menstruation-related leave.

These improvements led to better menstruation practices. Access to free menstrual products at work meant that women were more likely to use safe, hygienic, and absorbent products and change them frequently. In one workplace in Kenya, women sometimes still faced challenges in changing products while at work because they needed permission from supervisors. Women worried less about menstruating while at work: in Kenya, there was a dramatic reduction in the anxiety relating to leakage, but in Nepal a similar proportion of women worried about leakage at baseline and endline. This difference can be explained by the greater use of disposable pads at baseline in Nepal as compared to Kenya where other menstrual materials (cloth, etc.) commonly used were more likely to leak. Another difference between countries is that, in Kenya, absenteeism declined dramatically between baseline and endline whereas in Nepal, there was no change. Because the employees in the Nepal workplaces lived on site, they were able to make up any missed hours at a different time in the day or in the week.

COST-BENEFIT ANALYSIS SHOWED THAT THE BENEFITS OF THE INTERVENTION OUTWEIGHED THE COSTS



OVER THE 10 MONTH INTERVENTION PERIOD, EVERY



A learning brief with the detailed cost-benefit analysis methodology and findings [is available here](#).

KEY LEARNING POINTS

1 Women's poor menstrual experiences at work were linked to conditions of gender inequality more broadly. Menstruation diminished women's chances of being treated as equals in the workplace; when menstruating employees called in sick regularly or needed to negotiate more frequent bathroom breaks, their performance was viewed as inferior to that of non-menstruating employees, and they were less likely to be valued or promoted.



RECOMMENDATION: Approach MHH in the workplace in a holistic manner that considers improvements of MHM infrastructure and products, knowledge, and supportive attitudes alongside broader structural barriers related to gender equality.

2 Workforce instability and turnover, lower wages, and low skill sets appeared to coincide with young age, low literacy, and higher vulnerability of women employees, further exacerbating women's difficulties in managing menstruation at work.



RECOMMENDATION: Understand and respond to age, education/literacy, and other contributing factors that exacerbate women's vulnerabilities to inadequate MHH in the workplace through formative research.

3 The intervention's primary focus was on employees who menstruate. Nonetheless, the team engaged men co-workers as a group that can potentially improve MHM conditions in the workplace. The research teams first ensured menstruating employees' comfort and safety before pursuing male engagement activities. In Kenya, guiding women to determine the circumstances under which men could be brought into the MHM space was an empowering process that resulted in the development of a volunteer Menstrual Health Committee, comprised of both men and women employees.



RECOMMENDATION: Recognize when men's roles in MHH in the workplace may be harmful, and work with menstruating employees to define the timing and content for strategies to engage men colleagues as allies and supporters of an MHH-friendly environment.

4 The intervention included a review of existing workplace policies with potential to support menstruating employees. Results demonstrated generally weak workplace operational policies related to MHH, as well as inadequate structures for implementation. The policy reviews also highlighted the complementarity of national-level policy mandates and the critical need for multi-level policy efforts to improve women employees' abilities to perform their best in the workplace.



RECOMMENDATION: Ensure that internal private sector policies are operational and aligned with national-level policy change in support of MHH to compel workplace actions where they don't already exist, and to enhance existing worksite efforts.

5 Development actors often assume that adolescents have the greatest deficit in menstrual health knowledge and body literacy, and that working women are able to manage their periods. This assumption fails to recognize that many in the workforce are not yet adults; that some may have had limited formal schooling; that menstrual health education received in adolescence may have been insufficient and inaccurate; and that menstrual health needs change throughout life stages. Relatedly, most existing BCC materials on menstruation are designed for younger audiences. BCC materials on menstruation must be presented in social contexts that are age appropriate to be relatable to adults.



RECOMMENDATION: Customize BCC materials to age and developmental contexts and in accordance with formative research findings to maximize appropriateness of content for adult workers.

KEY LEARNING POINTS

- 6** Local engagement is key to sustaining intervention efforts beyond the project timeline. The team engaged with in-country experts and stakeholders involved in MHH. Additionally, wherever possible, the activity purchased and disseminated locally produced menstrual products and services in an effort to support local businesses, empower their owners (who were often women), and facilitate sustainability.



RECOMMENDATION: Plan for sustainable MHH efforts from the start by engaging with key experts and stakeholders who are positioned to continue the work in the long run. Collaborate with local designers and producers of menstrual materials and services to ensure contextual application and support a nascent and growing market.

- 7** Managing menstruation in the workplace encompasses sanitation, products, and infrastructure issues; access to health knowledge and services; addressing stigma and isolation; unequal norms and expectations grounded in sexism and misogyny; workers' rights, representation, and voice (particularly for women); training and supervision; women's participation in the public sphere; business promotion practices and professional advancement; and more. Workplace MHH does not fit squarely into any one sector, which often results in siloed and more limited programs.



RECOMMENDATION: Approach MHH as a multi-sectoral development issue by expanding the intervention mandate and collaborating with experts from a variety of disciplines.

- 8** The *MHM in the Workplace* action research promoted accurate understanding of the biological processes of menstruation in the context of reproductive life stages, from menarche to menopause. In all four workplaces, discussions on MHM surfaced broader information needs and concerns about related sexual and reproductive health (SRH) issues. However, given the specific mandate of the action research, the teams were limited in the information and services they could provide to women in these workplaces, resulting in important missed opportunities for health information and care.



RECOMMENDATION: Create explicit and intentional linkages between MHM and SRH services by expanding the intervention's theory of change, ensuring co-funding with health resources, integrating SRH care in the workplace or implementing a system for quality referrals, and measuring both MHH and SRH outcomes.

- 9** This study pioneered efforts to quantify the social costs and benefits of MHM (through a willingness-to-pay [WTP] approach) to women and the enterprises that employ them. This approach revealed that there is a business case for implementing MHH programs in the workplace. Furthermore, it demonstrated the feasibility of applying a cost-benefit analysis methodology, while also identifying ways to improve access to company records and comparability of data.



RECOMMENDATION: Future investments should build on these efforts, recognizing that although it may be easier to work with multinational companies, it is also important to conduct these analyses in varying employment contexts. Results from economic analyses can be particularly convincing for policymakers and empower advocates to promote MHH in the workplace.

- 10** Family-owned private sector enterprises are uniquely positioned to invest in innovative menstrual health initiatives for their employees. Our research team found that participating family-owned businesses greatly valued their employees' well-being and were responsive to their needs, including those related to MHH. There was a sense of reciprocal loyalty, which motivated these business owners to implement workplace interventions with larger footprints—which is promising for future efforts. Furthermore, smaller companies may have greater flexibility to undertake corporate changes, in that they do not need multi-tier management approvals to implement workplace interventions.



RECOMMENDATION: Understand the business owners' motivations and appeal to their specific priorities and concerns.

FUTURE RESEARCH PRIORITIES

The *MHM in the Workplace* action research surfaced important gaps in knowledge. Additional research in the following areas would make important contributions to the field of MHH in the workplace:



What are best practices to improve MHH in different work sectors (e.g., agriculture, technology, manufacturing, etc.)?



Are there specific internal operational policies (e.g., paid sick leave, temporary work adjustments, etc.) that are most effective in institutionalizing positive MHH changes?



How can supervision practices and workplace incentives support MHH in the workplace?



What is the relative benefit of infrastructure upgrades and free/subsidized menstrual products to improved MHH in the workplace, compared to an MHH-friendly workplace culture and stigma reduction?



What added effect would addressing social norms in the immediate community outside the factory (e.g., among religious leaders, elders, etc.) have on improving MHH in the workplace?



Which variables most significantly contribute to better business outcomes (e.g., through fewer absences, reduced presenteeism, improved corporate reputation) when MHH is improved in workplaces?

