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Remaining Menopause Care in India: From Taboo to Policy Priority

Nandini Varshney

London School of Economics

News Medical

India is home to more than 150 million menopausal women, a number larger than most countries' entire populations, yet menopause remains one of the most neglected subjects in the country's public health and legal discourse. While hard-won campaigns around menstrual health have steadily entered mainstream, the other end of the reproductive arc: menopause, is still shrouded in silence, stigma and spectacular legislative indifference. The article argues that menopause in India is not merely a medical event but a rights issue: one that intersects with workplace dignity, healthcare equity, and constitutional guarantees of life and liberty. Drawing on existing research, international comparisons and recent developments in India's Femtech sector, it makes a case for urgent and multi-pronged policy action.

1. INTRODUCTION

The struggle to make menstruation visible in India has been a long, contentious and, in important ways, a successful movement. From the landmark judgment of Sabarimala temple to Zomato's period leave policy, a growing body of advocacy has forced menstrual health onto the public agenda. Law schools, corporations and state governments have begun to respond, yet in the very moment of this partial victory, the other half of the menstrual arc, menopause, remains almost entirely absent from policy, law, and public conversations.

About the Author(s)

Nandini Varshney
Course: Masters of Law (LLM), London School of Economics and Political Science, 2026
Research Interests: Women's Reproductive Health Reform, Medical Law and Ethics, Human Rights Law, IT and Data Privacy Law

Menopause, the permanent cessation of the menstruation cycle of the women, typically occurs between the ages of 45 and 55. It affects most biological women who lives long enough to reach mid-life. In India, the average age of natural menopause is around 46.6 years, nearly five years earlier than the global average which stands at 51, and considerably earlier than women in high-income countries. This earlier onset compounds both the medical risks and the socio-economic consequences: women enter menopausal transition at a stage when they are often at the height of their professional lives, embedded in family duties and caregiving responsibilities and are mostly unprepared for this drastic change in their bodily autonomy, because of lack of awareness and public discourse on this topic, most of the women at this stage of life are unaware of the consequences of menopause.

The silence around menopause in India is the product of deeply entrenched patriarchy, an absence of legislative care and imagination, inadequate health infrastructures and a cultural taboo that treats the ageing female body as something to be privately managed with endured silence. This article examines these forces, maps the legislative vacuum they have created, surveys what other countries have begun to do and puts forward a framework for bringing menopause from the margins to the center of Indian health and labour policy.

BACKGROUND

The term menopause was coined by French physician Dr. C.P.L de Gardanne in 1821. Historically, medicine treated it as a form of pathology: nineteenth-century psychiatrists believed menopause caused mental disorders and proposed remedies ranging from herbal opium to hysterectomy and asylum admissions. Even today, menopause is often framed as a crisis, a loss of femininity and a gateway to old age, rather than a natural physiological transition in a woman's life. In India, this medicalized stigma intersects with existing social taboos around ageing women and reproductive health.

The reproductive lifecycle of every biological woman moves through four broad phases: menarche (the onset of menstruation), the reproductive years, perimenopause (the transitional phase) and menopause (the termination of the menstruation cycle). Advocacy in India has majorly focused almost entirely on the first two stages. The result is that menarche is discussed (however imperfectly) in schools, in parliaments

and in courts, but menopause, the biological bookend, has no equivalent public presence. This asymmetry is not biologically determined, it is politically created, and discriminative. India's population data underlines the scale of this issue. According to the UN ESCAP figures women between the ages of 40 and 59, the primary menopausal cohort, account for tens of millions of the country's female population. A 2024 Springer GeoJournal study using NFHS-5 data estimated the average menopausal age in India at 46 years, with Bihar recording the lowest at 44 years and Kerala the highest at 47.6 years. A 2024 Scientific Report analysis found that over 16% of Indian women between 40 and 44 years of age experience early menopause; the main reasons: poverty, low education and rural residence. These are not statistics at the margins; they describe a massive, disproportionately vulnerable, and policy-invisible population.

The communities most affected by inadequate menopause support include: working women in both formal and informal sectors, who face productivity loss and discrimination with no legal recourse; rural women who have limited access to healthcare, education and face greater exposure to nutritional deficits linked to early menopause; women from lower socio-economic groups for whom the physical and psychological toll of unsupported menopause intersects with economic precarity; and women in professions requiring physical endurance for whom menopausal symptoms such as joint pain, fatigue and cognitive disruption create compounding occupational disadvantage. Cherry on top is the deeply embedded patriarchal thinking and social stigma of 'menstrual impurity' that affects all the above discussed categories of women in one way or the other, with a great or even greater intensity resulting in a paralyzed reform movement.

ANALYSIS

The central argument of this article is straightforward: menopause is a rights issue and India's failure to address it is a failure of constitutional obligations, legislative imagination and public health governance. The evidence for this failure is overwhelming and depressing. There is no dedicated legislation on menopausal healthcare. There are no standardized clinical guidelines for menopause management in government health facilities. There is no legal protection against workplace discrimination on menopausal grounds. And despite India's rectification of CEDAW, which explicitly obliges state parties to address the specific health needs of older women, including

menopause, domestic law remains eerily silent.

In fact, India's Apex court recently rejected a petition seeking menstrual leave for working women and female students. The two-judge bench headed by the CJI Surya Kant concerning claim that mandatory menstrual leaves would make young women think they are not "at par" with their male colleagues and would be "harmful for their growth" and that "no one will hire women" feels like another reiteration of the taboo around menstruation and rights that we have failed to address as a democratic and welfare-based country. How does one undergoing a natural phenomenon become "unattractive" to employers and is met with emphatic silence from the society at large in this modern age?. This silence has medical consequences. Menopause is accompanied by a dramatic hormonal restructuring: androgen production falls by approximately 50%, estrogen by around 34%. The downstream effect of these hormone deficiencies includes osteoporosis, cardiovascular risks, urogenital atrophy, depression, anxiety, sleep disruption, hot flushes and diminished libido. In India, where awareness is low and healthcare access is uneven, most of these symptoms go unaddressed and are misdiagnosed, or simply ignored. Women often attribute menopausal depression to personal weakness; hot flushes to climate; joint pain to ageing etc. Without a clinical framework that names and treats menopause, women cannot seek targeted help and providers cannot give it.

Indian courts have not been entirely silent on the broader question of women's bodily autonomy. In the Suchita Srivastava case, the Supreme court explicitly recognized that a woman's right to make reproductive choices is a dimension of personal liberty under Article 21. While this case concerned abortion, the principle it articulates, that a woman's body is not subject to state indifference, applies with equal force to the menopausal transition. Similarly, the apex court has repeatedly held that the right to life under Article 21 encompasses life with human dignity not mere biological survival.

The economic consequences are equally stark. Globally, menopause-related absenteeism and reduced productivity cost economies billions annually. In the United States, studies show that 17-20% of women either leave employment or consider leaving when menopausal symptoms become severe and women undergoing menopause account for nearly 30% of the US labour force. In the United Kingdom, two-thirds of working women aged 40 to 60 who

experience menopausal symptoms report a negative impact on their work and one in six leave the workforce entirely due to insufficient support. India has no comparable data because surveys have not been conducted, which itself is neglect but given the population of India and middle aged working women in the formal and informal sectors of the country, with little to no menopausal awareness, healthcare, or support, the statistical data, if gathered, would be astonishingly upsetting.

- 150 Million+ Indian women currently experience menopause (2024)
- Average age of menopause in India: 46.6 years v. 51 years globally
- 16.2% of women ages 40-44 experience early menopause (NFHS-5, 2024)
- 0 dedicated pieces of central legislation on menopausal health in India
- 0 standardized clinical guidelines in government health facilities
- India signed CEDAW (1993), which mandates menopause health support, yet has no implementing law
- Only 52% of Indian women can name up to 10 menopausal symptoms (Menoveda Survey, 2024)
- Indian FemTech market projected to grow at 17%+ CAGR 2025-2030

This infographic captures a profound contradiction at the heart of India's approach to women's health: a vast, medically underserved population of menopausal women exists alongside a complete absence of targeted policy. The 150 million figure is not an abstraction, it represents colleagues, mothers, voters and workers who are managing a significant physiological transition without institutional support of any kind. The disparity between India's average menopausal age (46.6) and the global average (51) suggests specific nutritional, socio-economic and environmental vulnerabilities among Indian women that further compound their need for a targeted public health response.

This legislative vacuum is compounded by a specific set of institutional failures.

First, India has no comprehensive menopausal health law or policy framework even though it has enacted the "Maternity Benefit Act (1961), the Medical Termination of Pregnancy Act (1971), and the Surrogacy (regulation) Act (2021)", demonstrating both the capacity and political will to legislate on reproductive health, selectively.

Second, the Mental healthcare Act (2017) which might have been an opportunity to address menopause-linked depression and anxiety contained no menopause-specific provisions.

Third, the Indian Medical Association Act (1956) and associated professional standard frameworks make no specific reference to menopausal care, leaving clinical management ad hoc individual practitioner judgment.

Fourth, commissions such as the National Commission for Women and Ministry of Women and Child Development lack the infrastructure, and by political priority, to conduct systematic research on menopause.

However, the claim that there is nothing to account for menopausal care in India might be an overstatement. The more precise and defensible claim is that there is no dedicated legislation or standalone menopause policy. For example, The National Health Policy (2017) gestured towards a life-course approach to women's health needs beyond the age of forty. Similarly, India's strategy for Women, Adolescents and Child Health (I-WACH) articulates the principle that women's sexual and reproductive health needs must be met across the entirety of their lives, not merely during their childbearing years. On the clinical side, the Indian Menopause Society published comprehensive Clinical Practice Guidelines in 2019-2020, covering hormone replacement therapy, osteoporosis management, vasomotor symptoms and perimenopausal care.

Taken together, these might appear to constitute a framework, but the appearance can be deceptive. The NHP and I-WACH offer aspirational language without enforceable obligations, dedicated budgetary allocations or implementation mechanisms specific to menopause. The IMS guidelines, meanwhile, are the product of a private professional society with no statutory authority; they bind no hospital, no employer and no government facility. There is no central legislation that names menopause, no standardized protocol that government primary health centers are required to follow and no grievance mechanism through which a menopausal woman can seek redress for neglect or discrimination. The gap between policy rhetoric and legal reality is not a technicality, it is a space in which over 150 million Indian women are left to manage a significant physiological transition entirely on their own.

COUNTER ARGUMENTS AND LIMITATIONS

The most commonly cited objections to menopause-specific policy in India fall into four categories:

The concern that such policies would be

misused: that women might falsely claim menopausal symptoms for illegitimate leave or to lodge bad-faith discrimination complaints. This argument, which mirrors the fears raised about menstrual leave policies everywhere, conflates the problem with its small-scale potential for abuse. The solution is rigorous clinical verification, not legislative inaction. An ethical, comprehensive medical assessment framework, similar to those used in disability determinations, can provide sufficient safeguards without denying relief to the vast majority acting in good faith.

Equity concerns: some argue that menopause-specific protections create a hierarchy among health conditions or may disadvantage non-menstruating employees. This criticism has merit at the margins but cannot justify wholesale inaction. The appropriate response is comprehensive occupational health legislation covering all chronic and episodic health conditions, not the continued exclusion of menopause from any protection at all.

Cost to employers: the implementation of reasonable workplace adjustments- flexible hours, rest facilities, access to occupational health consultations, does involve costs and resources. However, the evidence from the UK and elsewhere consistently shows that retaining experienced menopausal workers is far more economical than losing them and replacing them. One in six women leaving the UK workforce due to unaddressed menopause represents a talent and productivity loss that dwarfs the cost of a desk fan and a flexible schedule.

Broader systematic failures inadequate healthcare infrastructure, low public health funding, and other health priorities:mean menopause cannot currently be addressed. India's laboratory systems strengths and quality ranking of first among 195 counties in the 2021 Global Healthcare Security Index demonstrates that scientific capacity exists. What is missing is not capacity with political priority and awareness. This is not a reason to defer; it is a reason to begin.

IMPLICATIONS

The most immediate implication of India's menopausal policy failure is a healthcare one: millions of women are navigating hormonal disruption, bone density loss, cardiovascular risk and mental health deterioration without clinical guidance, without legal protection and without social support. The downstream costs, in hospitalization, in lost productivity, in the secondary psychological effects of shame and silence are borne by women, families and ultimately the healthcare system itself.

The international landscape offers instructive models. Japan enshrined menstrual and menopause-related leave in its post-war labour codes as early as 1947. Spain became the first European country to legislate paid menstrual leave in 2023. The United Kingdom, despite rejecting a dedicated menopause equality law in 2023, has nonetheless developed extensive employer guidance through the EHRC and in 2026, the government urged large employers to publish voluntary menopause action plans, with mandatory reporting expected by 2027. The most consequential international judicial development came in the Rooney case where a UK appellate tribunal upheld that severe menopausal symptoms can constitute a disability under equality law, entitling employees to legal protection against discrimination. While foreign judgments carry no binding force on Indian courts, decisions from common law jurisdictions have historically served as persuasive authority, and Rooney is particularly instructive because it demonstrates that existing legal frameworks around “disability, equality, and dignity” are already capacious enough to accommodate menopause without requiring entirely new legislation. India’s own constitutional guarantees under “Articles 14, 15, and 21” are no less capable of reaching the same conclusion if the judicial and legislative will exists to apply them.

The United States, while lacking federal menopause leave, has seen the Mayo Clinic publish a landmark 2024 consensus on menopause and the workplace, establishing the menopause is an occupational health issue. None of these counties have perfectly solved the problem but each has moved menopause from a private matter to a public policy concern. India has not.

The rise of FemTech offers both a partial solution and an urgent warning. Indian companies such as Elda Health and Gytree have pioneered digital menopause care, Elda has served over 50,000 women through at-home testing, personalized coaching and community-based menopause circles. A 2024 survey by Menoveda found that only 52% of Indian women could name up to ten menopausal symptoms, despite there being over forty. But digital health solutions primarily reach urban, higher-income women. For the rural, the poor, and the less educated precisely those experiencing the earliest and most severe menopause, only a state-led public health response will suffice.

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Jindal School of Government and Public Policy, O.P. Jindal Global University
Sonipat Narela Road, Near Jagdishpur Village, Sonipat, Haryana 131001, India
Email: info@jgu.edu.in · Instagram: instagram.com/jindalpolicyresearchlab

Website: jgu.edu.in/jsgp/jindal-policy-research-lab