2026 Global 50/50 Bodies at Work Series

THE UNACCOMMODATED BODY



GLOBAL 50 50
Advancing gender justice

ACKNOWLEDGEMENTS

Global 50/50® is an independent think tank. Global 50/50 (G5050) was co-founded by Professors Sarah Hawkes and Kent Buse. It is staffed by a collective of researchers, strategists and communications experts, most of whom work in the global health and development sphere while also contributing to the work and aims of G5050. Collective members who contributed to Bodies at Work: The Unaccommodated Body include: Isis Buse, Alexandra Cordeiro, Grace R Namugambe, Unsia Hussain, Kate Onursal, Jiwon Lee, Victoria Olarewaju, Zoe Old, Aishwarya Rajeev, Lynsey Robinson, Lydia Sloof, Emily Swanson and Sonja Tanaka.

The initiative is guided by a diverse independent Advisory Council and charity oversight is provided by a Board of Trustees. We are deeply indebted to the members of both bodies.

Global 50/50 is grateful to the many people who shared their expertise, insights and experiences in the development of this Report, and to the 71 organisations who validated their data with us.

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Suggested citation: Global 50/50, Bodies at Work: The Unaccommodated Body, Cambridge, UK, 2026.

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This report is the second release from Bodies at Work. The first report, **Working through it?**, examined organisations' provisions to support women during menopause and what employers can do now whether or not the law requires it. Two reports will follow: The Caring Body covers care responsibilities and The Body at Risk covers harassment, violence and safe working spaces (both forthcoming).

global5050.org Global 50/50

Cover photography:

San Salvador, El Salvador. 2023. Mahé Elipe

Abortion accompaniers in El Salvador where abortion is considered a crime. Faced with this reality, women's groups have organized to help women have safe abortions, providing physical and emotional assistance to women who wish to have an abortion.

About the photographer

Mahé Elipe is a French photographer based in Mexico City. Her documentary work focuses on the human condition, with a particular interest in the place of women in society.

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WORD FROM THE COLLECTIVE

The myth of the universal body

Of the 198 organisations in this report, 30 told us they have some provision for an employee who has an abortion. Not one of them says so in public. That silence runs through this report, the second in a series we have named Bodies at Work. Workplace provision for the sexual and reproductive body is rarely written down as a policy of its own, and those who need it are left to work out what applies to them, and whom to ask.

This series takes its name from the concept of the "disembodied worker",[1] an employee imagined as if their body makes no demands on the working day. Workplaces built on that assumption treat one bodily experience as universal, and have historically designed their policies and practices around male bodies and men's lives.

> **Accommodating the embodied worker is not a favour, a perk or a sign of a progressive employer. It is a condition of equal participation in work, which is to say, of gender justice.**

Its counterpart, and the subject of this series, is the embodied worker: a person whose body menstruates, conceives or cannot, carries and sometimes loses a pregnancy, and reaches menopause while employed. Most women* will have several of these experiences across a working life. Men are affected too, through infertility, through the shared loss of a pregnancy or a stillborn child, and as partners in abortion care, fertility treatment and antenatal care, a role increasingly recognised in policy and practice.[2;3;4]

These experiences carry costs to individuals, to families, to workplaces, and to economies. Women who reach menopause early are more likely to leave the workforce than those who do not, and for organisations that means losing experienced staff at the point of greatest seniority. For a woman with painful periods or endometriosis, or returning to work after a miscarriage, what an employer provides or withholds can decide whether she stays in the job, is passed over for promotion, or has a fair chance of reaching her career goals.

Over a life course, leaving work early or cutting hours widens gender pay gaps and erodes savings and pensions, and where social protection is limited, those costs fall directly on women and their households (see Part 1, *"Why sexual and reproductive health and rights matter in the workplace"*).

A gendered space, in a time of opposition

We write at a time of deep uncertainty, as the countermovement against many of the issues in this report, and gender justice efforts globally, continues to grow. The US administration's global gag rule has been reinstated and expanded, constraining what organisations receiving US federal funding can provide, and even say, on sexual and reproductive health and rights. These rights were hard won, and they are defended, in part, by naming what is missing.

The disembodied worker is an outdated model. Women's participation in paid, formal work has grown over the last century, particularly in high-income countries,[5] and men increasingly take part in reproductive care, from fertility treatment to antenatal appointments. Yet, as this report shows, the everyday experiences of the workforce are still largely met with silence. Alvaro Bermejo, then Director General of IPPF, described seeing those gaps set out on the page: "as an SRHR organisation, that was a real mirror moment." IPPF now has dedicated policies on menstruation, menopause and abortion. This report holds up the same mirror to all organisations.

This report covers one part of a larger picture.
We have reviewed policies on a few of the many sexual and reproductive health conditions people experience across a life course. We have not examined whether those policies take intersectionality into account, or whether they reach all employees across all contract types, from salaried to precarious. Those questions remain.

What organisations can do

Employers do not act in a vacuum, and the law is often the strongest predictor of whether a policy exists. Where a statute is clear, as with leave after stillbirth in some countries, we are more likely to find one; where the law is silent, organisational provision is patchy. But these policies do not need the law to justify them. They follow from rights already recognised to health, to non-discrimination, and to safe and healthy working conditions. Acting on those rights does not have to wait for new law, however welcome that law would be.

Organisations shared internal policies and information with us that prospective employees and the public cannot see, and we are grateful for that openness. It also points to where to start. Where it is safe to do so, organisations can publish what already exists. Organisations can also write policies that name the experience instead of routing it through sick leave, which accommodates the need but treats an ordinary bodily experience as an illness. That support can be offered without requiring anyone to disclose more than they choose.

Accommodating the embodied worker is not a favour, a perk or a sign of a progressive employer. It is a condition of equal participation in work, which is to say, of gender justice.

The Global 50/50 Collective
November 2026

How we use 'women' and 'men' in this report

We use 'women' and 'men' to include all people who identify as such. We recognise, however, that most people impacted by the issues within the report are women with female reproductive bodies. But men are affected too, including directly as people who are suffering from infertility, or indirectly as the partners of women who are attending antenatal appointments, experiencing adverse pregnancy outcomes, or women who are experiencing the symptoms of menopause. Likewise, many of the issues in the report impact trans men, non-binary, intersex and gender-diverse people. We recognise that much of the underlying evidence is drawn from a limited research base that is not fully inclusive of a diverse workforce.

KEY MESSAGES

Provision is higher when supported by legal mandates.

Antenatal care is the issue we found most provision for (64 organisations). Stillbirth often has legal statutes at national level, and we found provision in 59 organisations. The law less commonly covers miscarriage, and we found provision in 44 organisations.



Provision is available but is generally not in the public domain.

Of the 198 organisations, we found some provision for at least one issue in 92, but for every issue most of what we found came from internal documents: 2 of 31 publish online for menstruation, 0 of 30 for abortion, 8 of 37 for menopause.



Dedicated policies are rare.

Across 198 organisations we found 3 dedicated menstrual policies, 1 abortion policy and 5 menopause policies.



The default is sick leave.

It is the most common form of leave for menstruation, abortion, menopause and miscarriage: an ordinary bodily event, met as an illness,



*Bars count organisations; one organisation can have several types of provision.

*Menopause excludes external accreditation (6 for-profit organisations accredited, 1 non-profit working towards accreditation), which is reported separately.

FINDINGS BY ISSUE

Policies published online

Non-public policies shared with G5050

ISSUE	ORGANISATIONS WHERE WE FOUND PROVISION	DEDICATED
Menstrual health	 **31** 2 public · 29 internal (+2 in development) Three dedicated policies, one of them published online; 2 organisations, both in Japan, offer named menstrual leave.	**3** (+1 in dev.)
Abortion	 **30** 0 public · 30 internal (+1 in development) No organisation publishes its provision online.	**1**
Fertility treatment	 **53** 22 public · 31 internal (+1 in development) We found financial or medical coverage in 36, and access tied to a diagnosis of infertility in 6, which can exclude same-sex couples and single people. This is the issue organisations are most willing to publish.	n.a
Antenatal care	 **64** 20 public · 44 internal (+1 in development) We found paid leave for appointments in 36 (1 more offers unpaid leave), and reliance on sick leave in 15 (+1 in development).	n.a
Pregnancy loss	 **62** 20 public · 42 internal (+1 in development) We found policies after stillbirth in 59 and after miscarriage in 44 (41 both), with an additional policy in development; where policies distinguish the two, miscarriage is met with sick leave (12 of 13); and support extended to partners in 15.	n.a
Menopause	 **37** 8 public · 29 internal (+1 in development) 5 dedicated policies; 6 for-profits hold external accreditation.	**5**

WHAT CHANGED BETWEEN 2023 AND 2026

The number of organisations that validated their data was relatively consistent across the two time periods: 73 in 2023 and 71 in 2026. What changed between the two time points was the sharing of internal policies. In 2023, 30 organisations shared internal policies with us, and in 2026 this rose to 47 organisations. This means that while we can show the difference between 2023 and 2026, some of the change is likely to reflect more organisations sharing internal documents with us.

This is seen in the case of menstrual health and abortion, the differences between what we found in 2023 and 2026 are likely explained by more organisations sharing internal documents with us – for abortion policies the only information we have is from internal documents as none were available in the public domain (**see Annex Table 1**).

For other findings, differences between the two time points are less obviously due to an increase in sharing internal documents.

Organisations in the sample

2023 → 2026

197 → 198

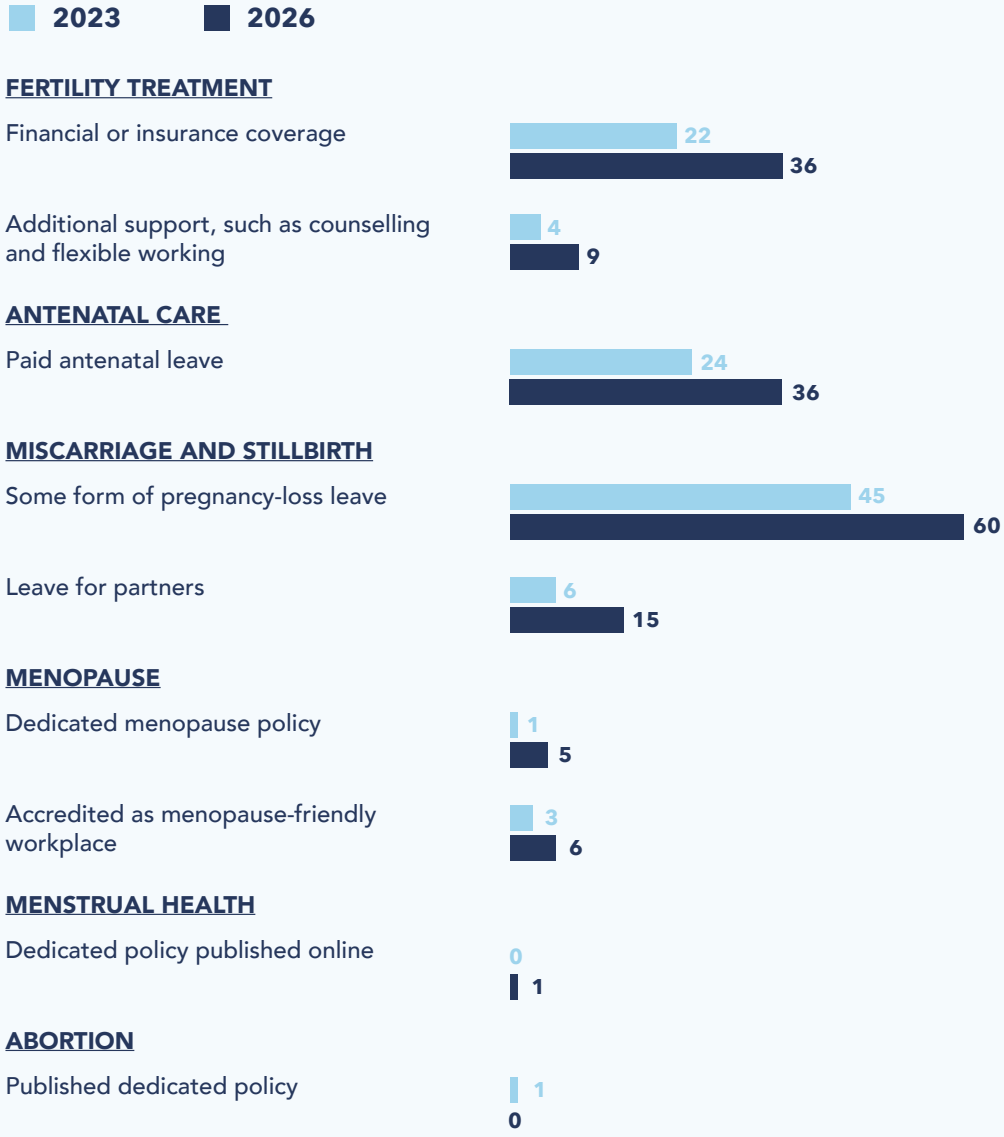
Shared internal policies with G5050

30 → 47

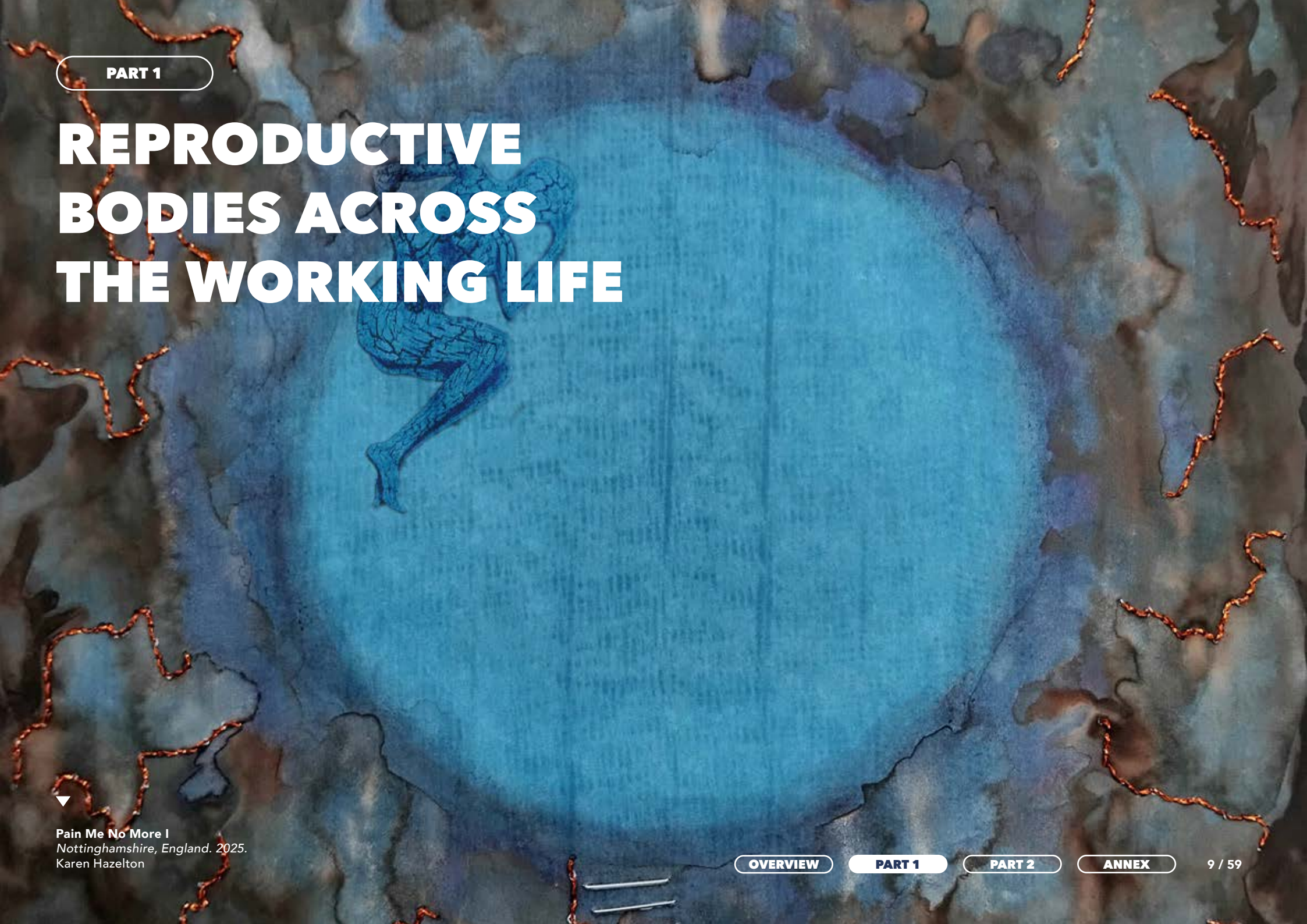
Validated their data

73 → 71

WHAT WE FOUND IN 2023 AND 2026, SELECT FINDINGS



REPRODUCTIVE BODIES ACROSS THE WORKING LIFE



Pain Me No More I
Nottinghamshire, England. 2025.
Karen Hazelton

Bodies at Work: About the report and series

Fifty years of campaigning and law reform have brought women closer to working on equal terms with men, with equal workplace rights and equal pay in many countries, though still not everywhere.[6] Much of this effort has focused on people's rights to enter and be treated equally in the workplace. But other aspects of engaging in the workplace have remained unchanged and unsuited to the people who work in it.

Across a working life, the body makes demands that a workplace either meets or fails to meet. Women menstruate, carry a pregnancy, lose one or end one, and in time reach menopause. Women and men experience infertility, starting a family, and domestic responsibilities, and at both home and work they may be exposed to harassment and violence.

Still, most workplaces are designed around the "disembodied worker":[7] an employee free of the conditions of having a body, of belonging to a family, a community and a society, and of the power relations, shaped by gender, that people carry to work with them. Yet the frequent narrative of women and work is one of leadership: the pipeline to the top and the few who reach it.

This series, Bodies at Work, asks a wider question: *do workplaces accommodate the working body for the whole workforce and the whole working life?*

About The Unaccommodated Body

Reproductive health is not a marginal concern for the workforce – it is a near-universal feature of women's working lives. Every stage of the reproductive life course, from menstruation through to menopause, carries potential consequences for workforce participation, performance, and career continuity.

For some stages, most women need nothing from their employer most of the time: for example, most women manage menstruation without accommodation, but the availability of provision matters for the minority who suffer with severe symptoms. For other stages and conditions, every woman who experiences them needs something: no one attends antenatal appointments or recovers from a stillbirth without time away from work. Fertility treatment, abortion and miscarriage are different again: only some women will experience them, but those who do need accommodation to be recognised and provided.

Figure 1 (over the page) sets out what the evidence shows for the six stages covered in this report.

BODIES AT WORK ASKS:

Do workplaces accommodate the working body for the whole workforce and their whole working life?

The Unaccommodated Body



What can workplaces do to accommodate women's sexual and reproductive health needs?

The Body at Risk



What are workplaces doing to support employees affected by sexual harassment, bullying and violence?

The Caring Body



When unpaid care falls to employees, how do workplaces recognise and support them?

Figure 1. Reproductive events across a working life



Provision for these issues is shaped at three levels. At the macro level, international standards set expectations of states, and national law turns these into enforceable entitlements, or does not. At the meso level, organisations provide, or fail to provide, on top of whatever the law requires. At the micro level, a manager's discretion and a colleague's response shape experiences in the workplace.

This report reviews the macro level (legal measures) as well as the meso level – i.e. the policies each employer has in place. Legal measures and organisational policies underpin some aspects of whether and how stringently (or not) policies are implemented, but much of that also depends on organisational culture, and we do not work at that level.

Figure 2. Nested levels of protection



BOX 1. THE UNITED STATES: FIFTY-ONE JURISDICTIONS, ONE WORKFORCE

In the US, leave laws are set independently by our 50 states and Washington, DC. Multi-state employers navigate a patchwork of ever-changing leave laws. At EngenderHealth, we offer various types of leave to meet all the requirements in the states in which we have staff. We offer 'safe, sick, and care leave' both to meet requirements and to put our values into practice: giving staff flexibility to care for themselves and others, recognizing that employees' personal and family circumstances vary.

Employer-sponsored health insurance in the US presents a different challenge, again varying by geography. Our coverage is governed by requirements in Washington, DC (where we have our registered home office), and relevant laws and plan options change from year to year. Smaller employers have limited bargaining power to tailor coverage, so supporting staff means annually reviewing what is covered and where we can fill gaps.

Traci L. Baird, President & CEO, EngenderHealth and Global 50/50 Advisor



Mahreen Zain

Why sexual and reproductive health and rights matter in the workplace



Women fighting for life without pain
Quito, Ecuador. 2022.
Karen Toro

Figure 1 follows women's experiences at work stage by stage. This section traces the costs of those experiences: on women, on their partners and families, on the organisations that employ them and on the wider economy.

It matters for women

Rights to sexual and reproductive health are not 'benefits' chosen to be granted by employers; these are enshrined in global commitments and in many cases underpinned by national legal frameworks. When women's rights go unrealised they do not simply 'get on with it'. At every stage in Figure 1, the same three responses recur: they leave their jobs, cut their hours or work at reduced capacity – with implications for women and their partners, families and employers.

- The right to protection of health and safety at work, "including the safeguarding of the function of reproduction", is written into the Convention on the Elimination of All Forms of Discrimination against Women,[23] and sexual and reproductive health is part of the right to health under the International Covenant on Economic, Social and Cultural Rights;[24] ILO Convention 183 requires maternity protection to include prenatal care.[25]
- 1 in 10 UK women who worked through the menopause left a job because of symptoms;[26] 17% considered leaving for lack of support.[27]
- Menopause before 45 is associated with employment rates around 9 percentage points lower in a woman's early fifties.[28]
- 8% of women in fertility treatment in Japan had left a job because of it.[29] Women with endometriosis lose 10.8 hours of work productivity a week.[30]
- Around 54,000 women a year in Britain lose their job because of pregnancy or maternity, and 77% report a negative or possibly discriminatory experience.[31]
- 12.3% of women in a nationally representative UK sample had been sacked, constructively dismissed or made redundant while pregnant, on maternity leave or within a year of returning, which, if scaled up, could mean as many as 74,000 women a year.[32]

It matters for partners and families

Earnings lost after each reproductive event compound over a working life into lower household income, smaller savings and smaller pensions, and where social protection is limited that cost falls directly on women and their families. Men are part of this too: they experience infertility, share pregnancy loss and accompany partners to care.

- Long-run "child penalties" in women's earnings run from 21 to 26% in Denmark and Sweden, 31 to 44% in the UK and US, and 51 to 61% in Germany and Austria.[33]
- The gender pension gap averages 23% across OECD countries, is above 35% in the UK, and reaches 47% in Japan, driven by women's careers being about 6 years shorter and around 13% fewer hours.[34] Analysis of Norwegian register data show earnings 3.3% lower on average across the four years following a menopause diagnosis, rising to 7.4% by the fourth year.[35]
- An estimated 1 in 6 adults worldwide experience infertility in their lifetime.[36] Only 15 organisations in our sample extend pregnancy-loss support to partners.

It matters for organisations

Menopause arrives when women are at their most senior – meaning when women are unsupported at work and leave their jobs they take their experience and expertise with them. Organisations active in global health should be modelling good SRHR policies for their own employees alongside their programmatic work in this area.

- Replacing a departing employee costs UK employers an average of £30,614, most of it lost output while the new employee reaches full productivity.[37]
- 1 in 4 women who worked through the menopause took time off and 18% considered reducing their hours;[38] 53% could recall a time they were unable to go into work because of symptoms.[39]
- Employees who have experienced pregnancy loss report returning before they are ready and are more likely to leave or change career (**see Figure 1**).
- Across the 198 organisations in our sample, where more than 4 million people are employed, we found 3 dedicated menstrual policies, 5 menopause policies and 1 abortion policy.

"As an SRHR organisation, that was a real mirror moment" (Alvaro Bermejo, then Director General, IPPF, speaking to Global 50/50 in 2026.)

It matters to the whole economy

As more women enter and stay in work and societies age, workplaces need to adjust: there is a cost to ignoring the needs and realities of a workforce that is more female and older than the one the policies were designed for. Conversely, there are economic opportunities in making workplaces fit for everybody.

- Across the OECD, the employment rate of women aged 55 to 59 rose 18.5 percentage points between 2000 and 2024, and the gender gap in employment at ages 55 to 64 narrowed from 23.2 to 13.1 points; 48% of women aged 60 to 64 are now in work.[40]
- The gender gap in hourly wages still averages 11.4% across OECD countries.[41]
- The World Bank estimates that closing the gender gap in women's economic participation could raise global GDP by more than 20%.[42]

PART 2: WHAT ORGANISATIONS PROVIDE ON REPRODUCTIVE HEALTH AND RIGHTS ACROSS THE LIFE COURSE



Mother bone
Brazil
Maliza Bernard

What the report covers

We assessed the 198 organisations in our annual sample for the presence of workplace policies or provisions on six issues across the reproductive life course: menstruation, abortion, fertility treatment, antenatal care, pregnancy loss and menopause.

Our framework looks at provisions, which include time (e.g. leave, flexibility and protected time off), money (e.g. paid versus unpaid time, insurance cover and direct financial support), and conditions (e.g. facilities, adjustments). The six reproductive-health issues examined here are not included in the Gender and Health Index but were first reported on in our 2023 report, Workplaces: worse for women?

Who we assessed

The 198 organisations assessed in this report are those Global 50/50 monitors each year through the Gender and Health Index. The Index tracks two linked inequalities: inequality in opportunity in career paths inside organisations, and inequality in who benefits from the work of those organisations and from the global health system overall.

Of the 198 organisations, 192 have been monitored continuously since 2020. They are highly heterogeneous, each with its own purpose and governance, and together employ more than 4 million people. We classify them as non-profit or for-profit, because a company with an interest in health and an organisation whose core mandate is to advance health differ in role and motivation, and that difference may shape their organisational culture and policies.

Figure 3. Organisations assessed, by type



How we collect and report data

We reviewed each organisation's publicly available information, with two reviewers per item and a third verifying, and shared results with organisations for validation before publication. We also invited organisations to share internal information, so policies or provisions not visible on public websites could be captured. Where we reference these in the report, we do so with the organisation's consent. Throughout the report, 'published' refers to any provision publicly available online, and 'non-public' refers to provisions found in internal information organisations shared with us directly. Some organisations that shared internal information opted not to be named, and their findings are counted in the aggregate figures, but their names do not appear in the report. Organisations may appear under more than one form of provision, so the counts do not always sum to the number of organisations.

The absence of a finding means we could not identify a provision in the public domain and that it was not shared with us; it does not necessarily mean that the organisation does not offer that provision. As with all Global 50/50 findings on organisations, a published policy is not evidence of practice and we acknowledge this as a limitation.

71 organisations validated the data we collected on them. 54 organisations shared non-public information relevant to this report, 41 of them as policy documents and 13 by providing information during validation. We found policies or provisions in the public domain for 46 organisations.

Full details of our methodology are in the Annex.

Alongside our findings, each section includes examples of workplace policies. They are drawn from organisations outside our sample. We include them because they are in the public domain and illustrate the kinds of provision organisations can adopt. Inclusion is not an endorsement or a judgement that they represent best practice.



Dora
Brazil. 2023.
Maliza Bernard

1. MENSTRUAL HEALTH POLICIES

Why it matters

Menstrual symptoms are unpredictable and many women work through them. In a Dutch survey of 32,748 women, 80.7% reported reduced productivity while at work or school during their periods, while 13.8% had taken time off. Of those who had called in sick, only 20.1% told their manager or school why.[43] Stress, embarrassment and an inability to disclose recur across the literature.[44] Conditions related to menstrual health, among them endometriosis, uterine fibroids and polyendocrine metabolic ovarian syndrome/polycystic ovary syndrome (PMOS/PCOS), bring reduced hours and can negatively affect career progression.[45;46;47]

What the law provides

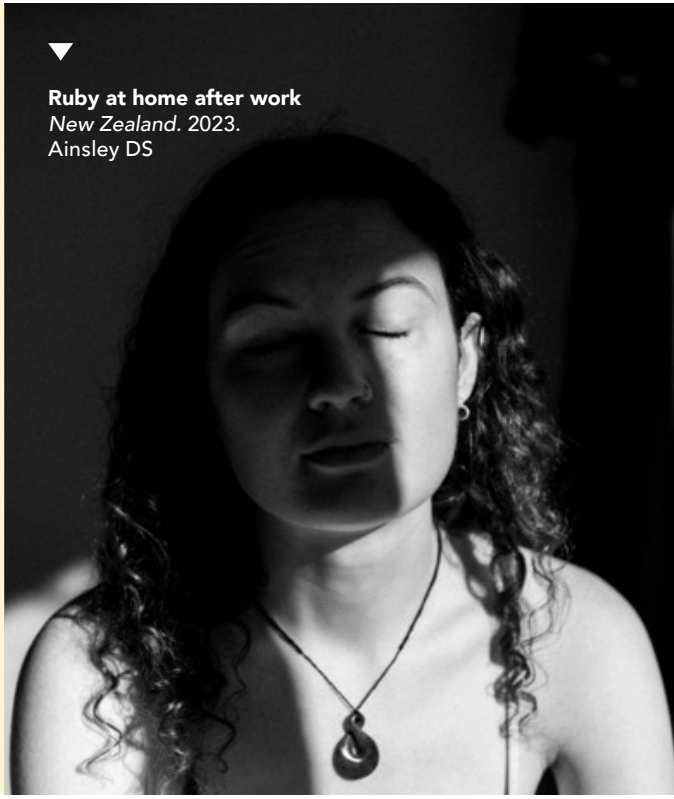
Menstrual leave policies have been in existence in some parts of the world since the early twentieth century, though national and international protection remains extremely limited (**see Box 2**). Discussion, however, has gathered pace since the mid-2010s.[48]

BOX 2. MENSTRUAL LEAVE IN LAW

The 2023 Global Health 50/50 Report, Workplaces: worse for women?, traced the history of and debates around menstrual leave policy, finding "a distinct lack of consensus over the role of states and employers above and beyond the guarantee of a safe, supportive workplace equipped with good sanitation facilities".[49]

There is no international convention or standard governing menstruation at work. Statutory entitlements exist in only a handful of countries and are not equivalent: Japan's and South Korea's carry no statutory pay, while Spain's and Portugal's are gated on a clinical diagnosis. A patchwork of sub-national measures also operates in China, India, Mexico and Argentina, most of them executive policy rather than statute.

Spain's law, which the 2023 report recorded as newly passed, came into force in June 2023. Uptake has been small enough that there is still no evidence either way on whether it has affected women's position in the labour market.[50]



Ruby at home after work
New Zealand. 2023.
Ainsley DS

What we found

2 **state publicly what menstruation provisions they make available for employees.**

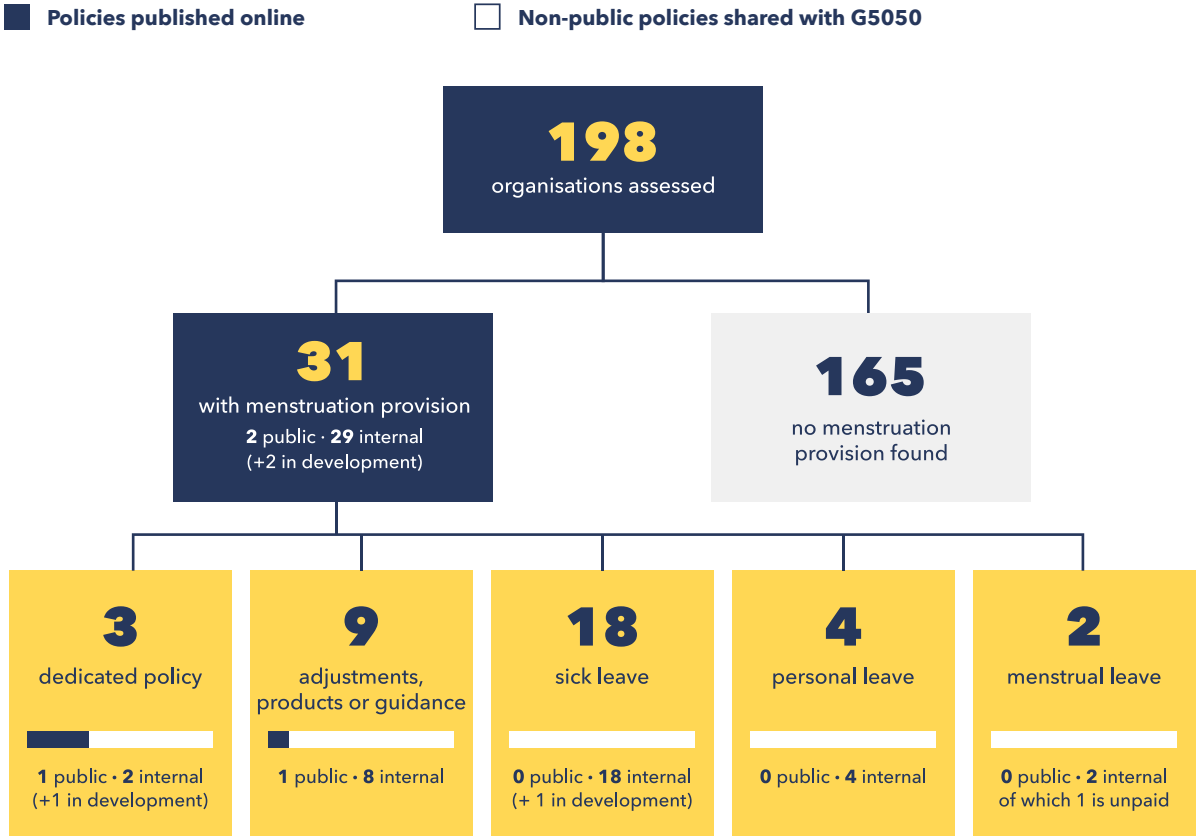
16% **of organisations were found to have provision for menstruation (31/198), with a further 2 whose only provision is in development**

Of these, two publish the provision online and 29 shared non-public information with us. Across organisations:

- **3** have a dedicated policy in place for menstruation, one of which is available online, with a fourth in development;
- **18** allow sick leave to be used, with one more in development;
- **4** allow personal leave to be used;
- **2** provide leave that names menstruation (both are headquartered in Japan, where the entitlement has existed since 1947); and
- **9** provide products, adjustments or guidance, one of which publishes its provision online.

See **Annex Table 2** for the list of organisations and the provisions we found.

Figure 4. Where provision for menstruation was found, published online and internal



The 2 organisations whose provision is in development are shown under the 31 but counted in neither total. Organisations may appear under more than one form of provision, so the five types sum to more than 31.

Tools for change: policy examples

Examples of policies to support menstrual health, drawn from organisations outside the 2026 sample.

FIND MORE POLICY EXAMPLES HERE

Victorian Women's Trust Australia
Menstrual and Menopause Wellbeing Policy

> **"The policy is designed to be flexible depending on the employee's needs, providing for the following options: the possibility of working from home; the opportunity to stay in the workplace under circumstances which encourage the comfort of the employee (e.g. resting in a quiet area); or the possibility of taking a day's paid leave."**

> **"In the case of paid leave, employees are entitled to a maximum of 12 paid days per calendar year (pro-rata, non-cumulative) in the event of inability to perform work duties because of menstruation and menopause, and their associated symptoms. A medical certificate is not required."**

Source: Victorian Women's Trust

Finance Sector Union Australia
Menopause and menstrual leave policy framework

> **"It is essential that the workforce has a good understanding of the benefit and that managers will start to see improvements in morale and culture."**

1. An employee is entitled to up to twelve (12) days of paid menopause/menstrual leave per year.
2. Employees may access menopause/menstrual leave when they are unable to work due to symptoms associated with menopause or menstruation.
3. The employee shall give the employer notice as soon as reasonably practicable of their request to take leave under this clause.
4. Employees can use their menopause/menstruation leave without providing a medical certificate.
5. In addition to menstrual leave, employees are entitled to work from home on an ad hoc basis or stay in the workplace under circumstances which encourage the comfort of the employee e.g. resting in a quiet area.
6. Menopause/menstrual leave is not cumulative and, like the other forms of personal leave provided for in this Agreement, unused menopause/menstrual leave will not be paid out at any time.

Source: Finance Sector Union

FROM POLICY TO CULTURE CHANGE AT ICRW ASIA

In 2023 we featured ICRW Asia (Part of ICRW Global Network), where two colleagues had noticed staff using sick leave to cope with severe menstrual pain and took a proposal to management. A six-month trial began in April 2023. This year we went back to ask what had happened since:

"Having the option to take leave without having to justify or explain these needs has been an important step towards making the workplace more responsive to different bodily and health needs, and we'd encourage other organisations to develop a policy. It's an important step in reshaping workplaces around women's bodies. But a policy is the first step, not the last, and the aim should be building a period-positive workplace. That means creating a culture where menstruation can be spoken about without embarrassment, ensuring access to appropriate facilities and menstrual products, providing flexibility when someone is experiencing period-related difficulties, and building greater awareness among managers and colleagues. It also means recognising that people experience menstruation very differently, and avoiding a one-size-fits-all approach."

ICRW Asia

BOX 3. MENSTRUAL-FRIENDLY FACILITIES AND RESOURCES

A growing number of organisations provide free pads and tampons in their workplace toilets. The Period Positive Workplace standard asks employers to stock products in or near employees' bathrooms.[51]

Other menstrual-friendly facilities and resources include:

- Reliable, nearby toilet access, with private cubicles, hand-washing facilities and specialised disposal bins (and biodegradable disposal bags where possible).
- Access to a quiet rest space and to pain relief when needed.
- Manager training and menstrual-health champions, so support is consistent and stigma-free.
- Review of uniforms and PPE where these are worn (e.g. darker, looser or stretch fabrics, and spare sizes).
- For very large organisations, an on-site health clinic or occupational-health pathway for gynaecological care.

Sources: HOPE, Menstrual friendly workplace (Centre for Reproductive Health, University of Edinburgh); Period Positive Workplace).

Further information

For further information and resources on menstrual health in the workplace, see the Global 50/50 resources page.

RESOURCES PAGE



Remains of a home
USA. 2023.
Trevor Coopersmith

2. ABORTION POLICIES

Why it matters

Abortion care is a component of comprehensive SRHR, and a core principle of the realisation of bodily autonomy for women and girls.[52] Legal provision of abortion services, however, continues to be highly contested across much of the world. Gender equality advocates face increased pressure as opposition has become more coordinated at both global and national levels, permeating multiple spaces and institutions and narrowing the accessibility of safe abortion services.

Abortion provision is largely absent from research on reproductive health at work and from workplace guidance. An all-Ireland survey of 3,200 workers, commissioned by five trade unions, found around one in five had direct experience of abortion while at work, and theorises the workplace as a site of abortion 'surveillance', where disciplinary power and a normalising gaze produce silence and self-censorship and anti-abortion norms may go unchallenged.[53]

What the law provides

Abortion laws vary widely across the world. According to the Center for Reproductive Rights, a third (33%) of women of reproductive age live in the 77 countries that allow abortion on request, and a further 23% in the 12 countries and territories that allow it on broad social or economic grounds. Some 12% live where it is permitted when pregnancy poses a risk to health, 20% where it is allowed only to save the pregnant person's life, and 6% in the 21 countries that prohibit it altogether. A further 6% live in the U.S. and Mexico, where abortion laws vary at the state level.[54]

These differences shape what an organisation can safely provide to employees, and even what it can say. In the most restrictive settings, criminal liability can extend beyond the person having an abortion to those who assist or provide information.

What we found

0 abortion policies or provisions for employees found in the public domain.

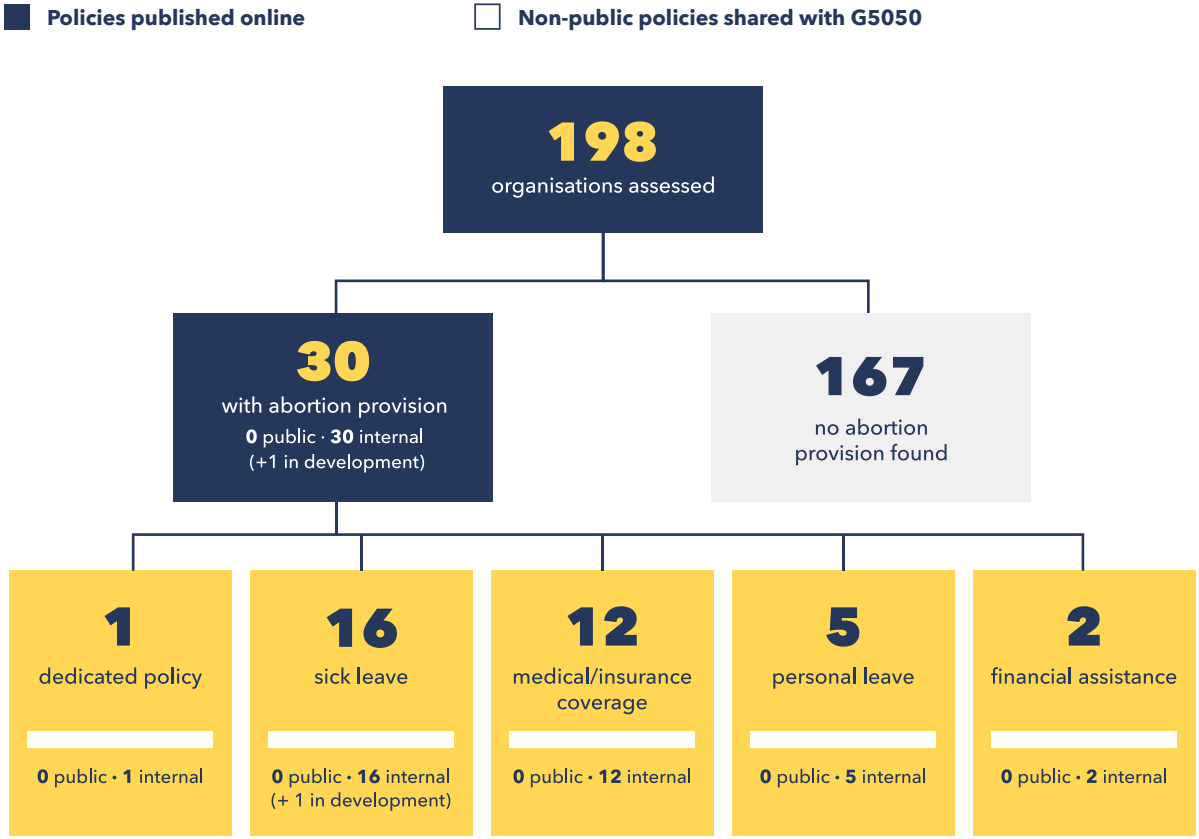
15% of organisations were found to have provision for abortion (30/198), with 1 more whose only provision is in development.

Despite this level of counter-pressure, we found abortion provision for 15% (30/198) of organisations, with 1 more whose only provision is in development. None publish the provision online and all 30 shared non-public information with us. Across these organisations:

- **1** has a dedicated policy that names abortion;
- **16** allow sick leave to be used with 1 further policy in development;
- **12** cover care through an employer plan or through national or state insurance, where the service is legal;
- **5** allow personal leave to be used; and
- **2** offer financial assistance towards the cost of care.

See **Annex Table 3** for the list of organisations and the provisions we found.

Figure 5. Where provision for abortion was found, published online and internal



The organisation whose provision is in development is shown under the 30 but counted in neither total. Organisations may appear under more than one form of provision, so the five types sum to more than 30.

Tools for change: policy examples

Examples of policies to support abortion care, drawn from organisations outside the 2026 sample.

FIND MORE POLICY EXAMPLES HERE

Channel 4 United Kingdom
Pregnancy Loss Policy, April 2021

The policy's definition of pregnancy loss includes abortion, alongside miscarriage, stillbirth, ectopic pregnancy, molar pregnancy and neonatal loss.

Leave "a minimum of two weeks' leave on full pay. Self-certified.

Appointments Paid time off for appointments relating to the loss, including scans, tests and mental health appointments, and to accompany a partner.

Flexible working Phased return, more breaks, working elsewhere in the building, earlier start and finish times, temporarily reduced hours, camera off on video calls.

Who to talk to Line manager, or People Partner, or a named Pregnancy Loss Champion in the People Team, for employees who would rather not raise it with their manager.

Counselling Employee Assistance Programme, 24 hours; signposting to organisations specialising in each type of loss.

On recovery "Emotional and physical recovery from a pregnancy loss does not have a time limit… Employees should not feel judged or discriminated against when requesting time off to recover from loss."

Source: Channel 4

NHS England United Kingdom
National Pregnancy and Baby Loss People Policy Framework

> "The aim of this policy is to provide the support people need during this difficult time in their life, and to help managers and colleagues know how to support people affected, with kindness and understanding. This policy includes, but is not limited to: miscarriage, ectopic pregnancy, molar pregnancy, and termination of pregnancy."

> "We would like to offer colleagues up to 10 days paid leave for the mother (or parent who was pregnant), and up to 5 days paid leave for the partner. Leave days are given on a pro-rata basis and pay is calculated on the basis of what the individual would have received had they been at work. This includes, but is not limited to: miscarriage, ectopic pregnancy, molar pregnancy, and termination of pregnancy.

> This is not dependent upon gestation of pregnancy (how long someone has been pregnant for) or length of service with the organisation. A 'Fitness for Work' statement from the GP is not required, unless additional time off from work is needed. This paid time off will not be used for 'sickness trigger' purposes. In addition, colleagues are offered paid time-off for appointments linked to pregnancy or baby loss, for example, medical examinations, scans and tests and mental health related interventions, if this stretches beyond the time outlined above ... We also promise that all requests to work flexibly following a loss will be treated with understanding and sensitivity. This may include home working for a period of time (where practical) or changing someone's hours of work or shift pattern."

Source: NHS England

BOX 4. IN CONVERSATION WITH MSI

A dedicated policy that names abortion makes this form of healthcare more visible and helps to destigmatise it. At the same time, naming abortion may imply that employees should disclose what can be a sensitive and personal topic, and it may presume a level of understanding among managers and colleagues that cannot be taken for granted. The conversation below sets out some of these tensions.

What can organisations do to support personal abortion experiences of employees?

It could be assumed that a dedicated abortion policy is the clearest form of support. We have considered that approach, but we have also reflected on the importance of privacy and personal choice. As an organisation whose mission and name is centred on the principle of reproductive choice, we are conscious that choice extends beyond reproductive decision-making alone. It also includes the choice over whether, when, and with whom to share our personal decisions. We never want our team members to feel that they need to disclose information they may regard as personal or not relevant for their employer to know about in order to receive support.

Our approach is therefore to make support available through flexible leave arrangements which include up to 5 days' paid leave for personal reasons, health-related absence policies, and access to services when needed. The underlying principle is that support should be available without requiring disclosure.

Just as we champion everyone's right to make informed choices about their reproductive lives, we believe colleagues should be able to choose what they wish to share with us as their employer, and access support on terms that feel right for them.

Much of your work is in contexts where abortion is restricted or contested. How can organisations support employees' personal abortion experiences?

In contexts where abortion is restricted or heavily contested, many women are forced to seek an unsafe abortion as they're denied access to safe care. So, in these contexts we provide post-abortion care, which is a life-saving procedure following an unsafe abortion. In these settings, our teams can be impacted by anti-choice stigma, so we seek to build a pro-choice environment.

This goes beyond formal policies and includes training, peer support, mentoring, practical guidance, and opportunities for reflection.

Through initiatives such as provider-share workshops, MSI team members can learn from one another, process the challenges of their work, and build supportive professional networks. Reducing stigma and normalising abortion are important objectives. Whilst policies can certainly provide an essential and useful foundation, meaningful support also depends on the wider ecosystem of support networks, resources, and organisational culture.

> **We had policies that existed, but we weren't practising them as we should. And then Global 50/50 highlighted gaps that were so obvious once you saw them on the page. For example, you pointed out we didn't have a suite of reproductive justice policies – menopause, menstruation, abortion – and as an SRHR organisation, that was a real mirror moment. We didn't say 'well, nobody else has them.' We said, 'No – we need to have them.' And now we do.**
>
> *Alvaro Bermejo, then Director General, IPPF, speaking to Global 50/50 in 2026*

Further information

For further information and resources on abortion in the workplace, see the Global 50/50 resources page.

RESOURCES PAGE

3. FERTILITY TREATMENT POLICIES



Hormone cake
Lincolnshire, UK. 2023.
Chiara Luxardo

Why it matters

An estimated one in six adults worldwide experience infertility in their lifetime,[55] and treatment brings frequent, short-notice appointments and considerable physical and emotional strain.[56] In a survey of women attending 18 fertility clinics in Japan, around 90% felt treatment could hinder their work and 8% had left a job because of it.[57]

What the law provides

The right to decide when and how many children to have is established in human rights law, but statutory provision for assisted reproductive technologies and infertility treatment varies widely.[58] Some states fund it publicly, often with limits on who can access and how many cycles, whereas in many others it is purchased privately.[59] Dedicated statutory leave to attend fertility treatment is rare.[60]

BOX 5. FERTILITY BENEFITS AND THE WIDER FERTILITY MARKET

Assisted reproductive technology has expanded quickly and unevenly. In 2000, roughly one quarter of countries had IVF services, and by 2010 more than half did.[61;62] In a 2024 review, IVF was estimated to account for around 9 per cent of births in some high-income countries.[63] Treatment is delivered largely by a for-profit private sector, backed by private equity[64] and frequently priced beyond most people. In the UK more than 60 per cent of IVF is privately funded and a cycle can cost £5,000 or more. In more than half of low- and middle-income countries a single cycle can cost more than the average annual income.[65]

Egg freezing provides an example of how those forces coalesce at a cost of around US$7,000 a cycle in the United States, plus annual storage fees.[66] It is increasingly offered as an employer benefit and popularly understood as support for women building careers, although the evidence for this is contested.[67]

Van de Wiel (2022) argues that employer fertility benefits tend to appear in workplaces that penalise having children at what is viewed as the 'wrong time'.

Fertility benefits address the cost of treatment rather than the structural and economic conditions that shape when people have children, such as secure work, housing and childcare. In other words, a benefit does not change how work is organised. It can, though, increase access to treatment and technologies that have made parenthood possible for many more people, and that access should not rest on a benefit but should be viewed as an integral part of sexual and reproductive health and rights.[68]

What we found

Organisations are more likely to publish their provisions for fertility treatment online than for any other variable we assessed.

27%

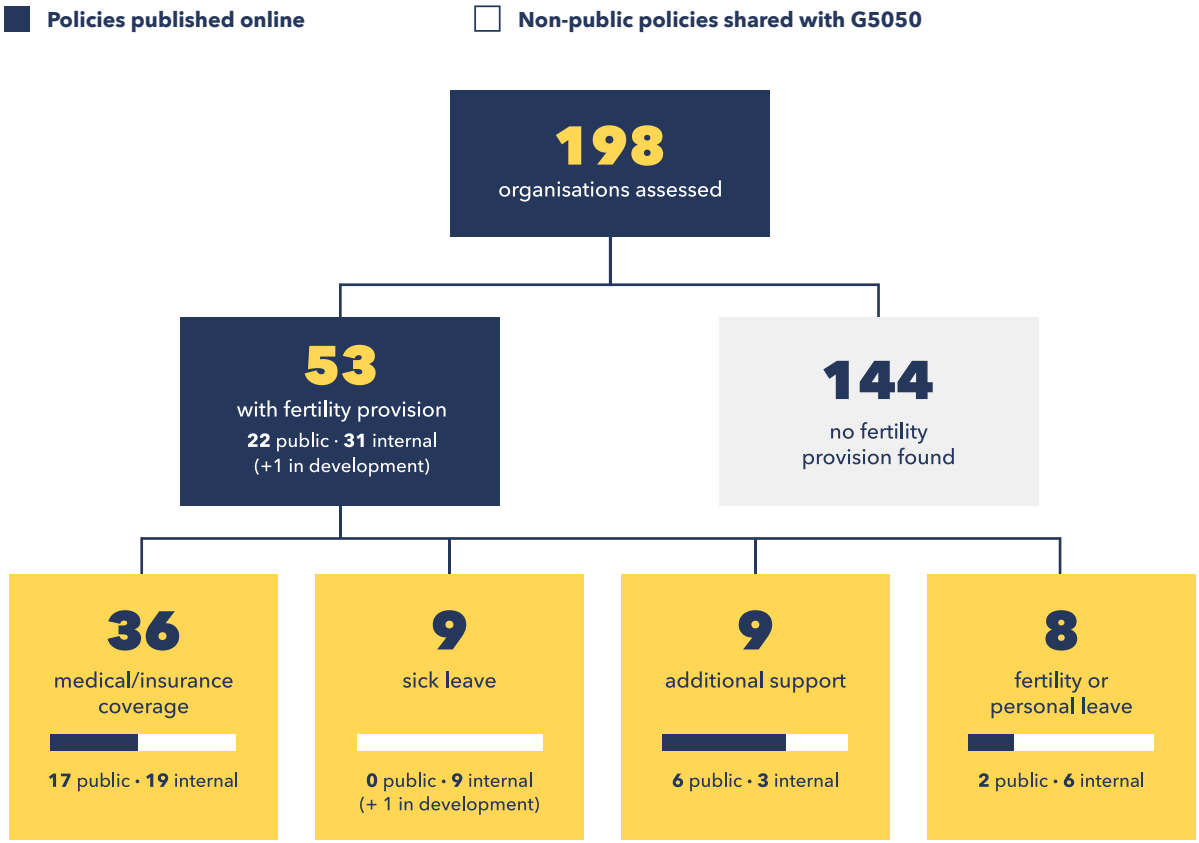
of organisations were found to have provision for fertility treatment (53/198), with 1 more whose only provision is in development.

Of these, 22 publish the provision online, and 31 shared non-public information with us. Across these organisations:

- **36** provide financial and/or medical coverage for treatment;
- **9** allow sick leave to be used, with one more in development;
- **8** offer fertility leave or other leave that can be used for fertility treatment, such as personal leave;
- **5 of the 17** organisations with leave in place mention the partner of the person undergoing treatment;
- **9** provide additional support such as counselling or flexible working;
- **6** are explicit about provisions being available to same-sex couples or people without a partner;
- **6** link access to a diagnosis of infertility, a criterion that can exclude same-sex couples and single people, as definitions of infertility are often based on a period of unprotected heterosexual intercourse without conception.[69] Some jurisdictions are moving away from this; for example, since January 2026, California has defined infertility to include anyone unable to reproduce without medical intervention, alone or with a partner.[70;71]

See **Annex Table 4** for the list of organisations and the provisions we found.

Figure 6. Where provision for fertility treatment was found, published online and internal



The organisation whose provision is in development is shown under the 53 but counted in neither total. Organisations may appear under more than one form of provision, so the four types sum to more than 53.

Tools for change: policy examples

Examples of policies to support fertility treatment, drawn from organisations outside the 2026 sample.

FIND MORE POLICY EXAMPLES HERE

Co-op United Kingdom
Fertility Treatment Policy

> "As a guide, we'll generally give paid leave for up to ten appointments per cycle, for up to three cycles of fertility treatment but some situations may need more or less."

> "It doesn't matter how long you've worked here or how many hours you work; all colleagues are entitled to use this policy."

> "'partner' refers to the partner of the person undergoing treatment and includes same sex partners, intended parents and colleagues who have a surrogate or co-parent undergoing treatment."

Paid leave covers attending a partner's, surrogate's or co-parent's appointments, not only your own.

The policy sets out that pregnancy rights, including protection from unfair dismissal and unfair treatment, begin at embryo transfer, and that the employee need not tell their manager at that stage.

The pregnancy loss policy applies from the point of embryo transfer onwards.

24-hour colleague helpline, open to family members who do not work for the company; virtual GP and psychologist-led mental health support; signposting to fertility support networks.

Source: Co-op

A separate manager's guide is published here.



Two mothers
Trieste, Italy. 2023.
Mara Scampoli

Further information

For further information and resources on fertility treatment in the workplace, see the Global 50/50 resources page.

RESOURCES PAGE

4. ANTENATAL CARE POLICIES



Embarazo sin tabúes
Mexico City, Mexico. 2025.
Jenny Bautista Media

Why it matters

Antenatal care is an essential component of promoting healthy pregnancies and positive pregnancy outcomes for mothers and babies. WHO recommends a minimum of 8 antenatal contacts, the first within the first 12 weeks and the rest at set points through to 40 weeks, in addition to scans, tests and any specialist referrals.[72] Almost all of these fall within working hours. Time off for antenatal care is therefore not an occasional accommodation but a structural feature of any pregnancy occurring while employed, and in many workplaces it is also the first point at which a woman discloses she is pregnant.

Attendance matters for outcomes. Eight or more contacts can reduce perinatal deaths, and antenatal care is where the risks of a woman's own job, from night work to lifting, are identified and adjusted; yet in 2015 only 64% of women worldwide received antenatal care 4 or more times, and 2.6 million babies were stillborn.[73] Where time off is not protected, appointments are traded against pay and job security. In a US study of pregnant workers at high risk of preterm birth, fewer than a third were eligible for paid leave, women described choosing between an appointment and a full pay cheque, and 2 were dismissed after asking for accommodations their doctor had recommended.[74]

In Britain, 1 in 10 mothers reported being discouraged from attending antenatal appointments, and qualitative research describes pregnant workers managing secrecy and silence to avoid penalty.[75;76;77] Partners are affected too: men's attendance at antenatal appointments is increasingly recognised as part of good care, and is only possible where their employers allow it.[78;79]

What the law provides

Antenatal care as part of a broader package of maternal health care provisions in the workplace is underpinned by a number of international conventions and treaties. ILO Convention No. 183 on maternity protection sets minimum standards for maternity leave and requires that medical benefits include prenatal, childbirth and postnatal care.[80]

Yet of 185 countries with available information, 132 do not provide time off for prenatal medical examinations. Among the 53 countries where the right to time off is available, 46 specify that this entitlement is paid.[81]

What we found

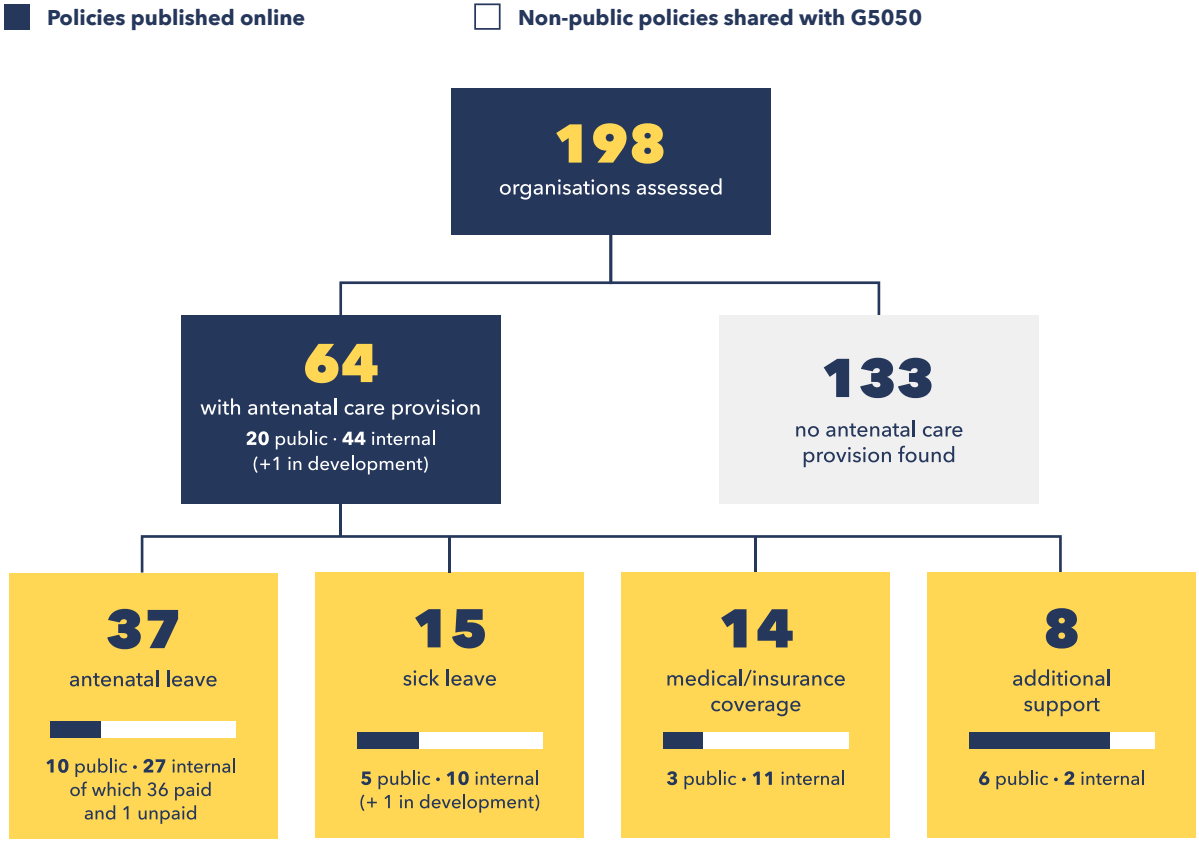
32% **of organisations were found to have provision for antenatal care (64/198), with 1 more in development.**

We found antenatal care provision for 32% (64/198) of organisations, with 1 more in development. Of these, 20 publish the provision online, and 44 shared non-public information with us. Across the 64 organisations:

- **36** offer paid leave for antenatal appointments, and one further organisation offers unpaid antenatal leave;
- **14** cover antenatal care through employer or national or state health insurance;
- **15** make general sick leave available for appointments, with one more in development; and
- **8** provide support beyond leave, such as flexible working or employer-provided services.

See **Annex Table 5** for the list of organisations and the provisions we found.

Figure 7. Where provision for antenatal care was found, published online and internal



The organisation whose provision is in development is shown under the 64 but counted in neither total. Organisations may appear under more than one form of provision, so the four types sum to more than 64.

Tools for change: policy examples

Examples of policies to support antenatal care, drawn from organisations outside the 2026 sample.

FIND MORE POLICY EXAMPLES HERE

NHS Scotland United Kingdom
NHS Scotland Workforce Maternity Policy, guide for employees

Antenatal care

> **"Your manager is asked to take a person-centred approach depending on your individual circumstances. You are entitled to paid time off to attend antenatal care. This may include relaxation and parentcraft classes that your doctor, midwife, or health visitor has advised you to attend, in addition to medical examinations. You should provide reasonable notice of appointments. Except for the first appointment, you may be asked to provide evidence of the appointment where available. You are encouraged to arrange appointments outside working hours or at the start or end of the working day. However, this may not always be possible, and your manager should be as flexible as possible."**

Source: NHS

Royal Veterinary College United Kingdom
Time off for Antenatal Appointments: Father / Partner / Other Parent

> **"An expectant father or the partner (including same sex) of an expectant mother/pregnant person, or other parent is entitled to take time off work to accompany the pregnant person to up to two of their antenatal appointments."**

> **"Although the statutory obligation is to provide unpaid leave, the RVC has chosen to go beyond the statutory minimum and provide paid leave in order to support our staff during this important event."**

Paid leave for up to two antenatal appointments, capped at six and a half hours per appointment.

No appointment card required, on the stated ground that it is the pregnant person's property.

Source: RVC

Further information

For further information and resources on antenatal care in the workplace, see the Global 50/50 resources page.

RESOURCES PAGE

5. STILLBIRTH AND MISCARRIAGE POLICIES

Why it matters

Globally there are approximately 1.9 million stillbirths every year[82] and the pooled risk of miscarriage is estimated at 15% of recognised pregnancies, equivalent to around 23 million losses a year.[83] Statutory leave after stillbirth exists in some countries, gated at gestational thresholds that vary between jurisdictions, with little workplace protection for those who experience miscarriage. Employees report returning to work before they are ready, and are more likely to leave or change career.[84;85;86;87]

What the law provides

In some countries, stillbirth is included in maternity leave, and in others it falls under bereavement leave, with protection tending to begin between 20 and 26 weeks' gestation and earlier loss commonly falling outside any entitlement at all.

In the United Kingdom, the Employment Rights Act 2025 creates a statutory right to bereavement leave following pregnancy loss before 24 weeks (miscarriage) for the first time. It is a day-one right to up to two weeks of unpaid leave, covering any type of loss, including miscarriage, termination and unsuccessful IVF embryo transfer, and extends to partners and intended parents in surrogacy.[89]

We reviewed published sources on stillbirth-related leave in 37 countries where the organisations are headquartered. In 27, we found an entitlement to leave after a stillbirth, and in the remaining 10 we found no provision in the sources reviewed.

Where leave exists, it ranges from about 4 weeks (Sweden) to 52 weeks (Australia, UK), and most is paid, at full or reduced rates. There is no common legal definition of stillbirth, and thresholds range from about 12 weeks to 28 weeks of pregnancy; some countries use birth weight instead, and five set no threshold at all.

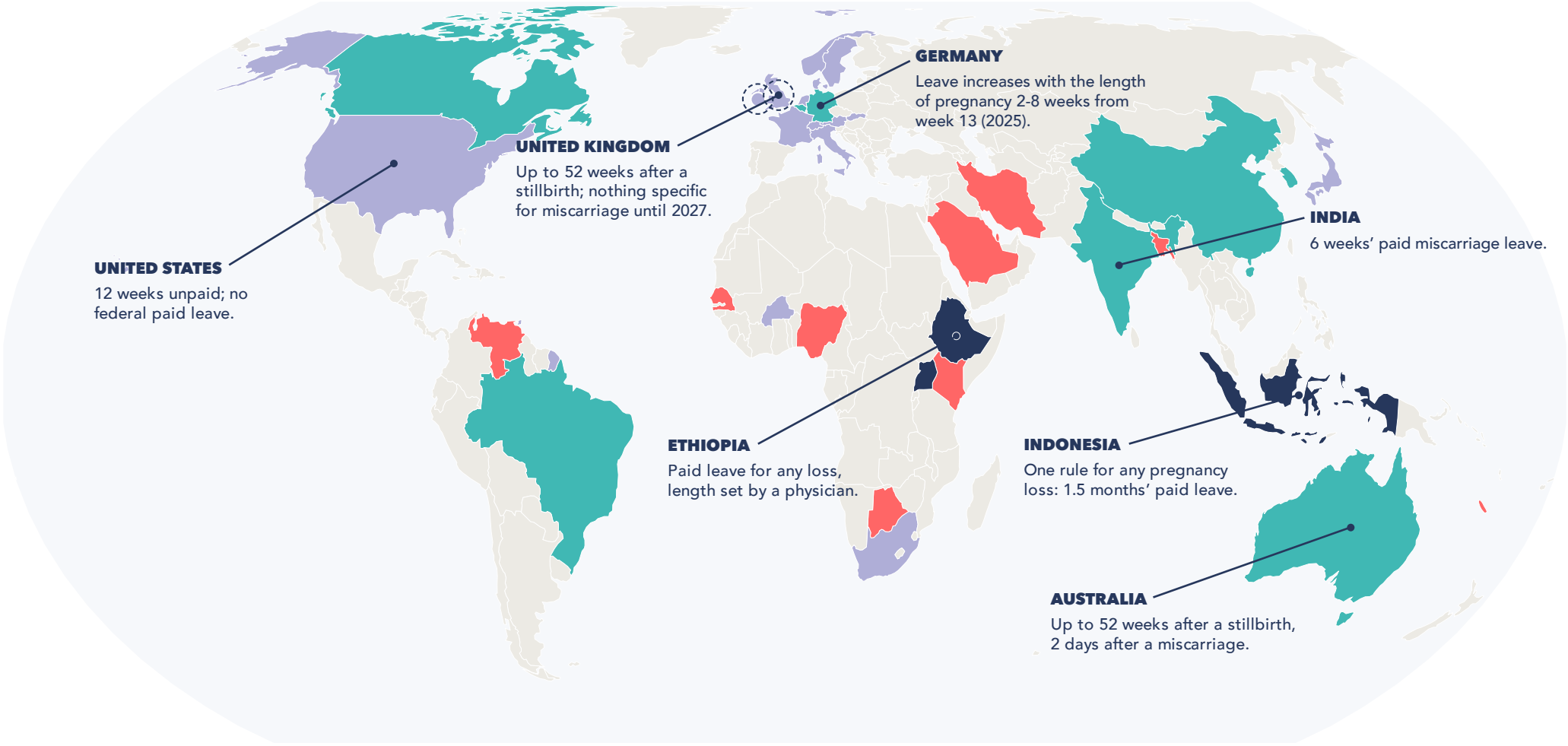
BOX 6. DEFINING MISCARRIAGE AND STILLBIRTH

A stillbirth is a baby born with no signs of life. Countries use different cut-offs for how far a pregnancy must have progressed before a loss is classified as a stillbirth, with earlier losses counted as miscarriages. Early loss carries serious and persistent psychological effects which are routinely underestimated in both health systems and workplaces. Nine months after an early pregnancy loss, a substantial minority of women still have clinically relevant post-traumatic stress, anxiety or depression symptoms.[88]

The International Classification of Diseases (ICD-11) defines a stillbirth as a baby born with no signs of life at or after 22 weeks of pregnancy or > 500g birthweight if the gestational age is not known.

The World Health Organization (WHO) recommends that a 28-week threshold be used for international comparison, while in a handful of countries losses from 20 weeks are counted as stillbirths.

Figure 8. Leave for miscarriage and stillbirth across the 37 headquarter locations



What we found

31% **of organisations were found to have provision following stillbirth and/or miscarriage (62/198), with 1 more whose policy is in development.**

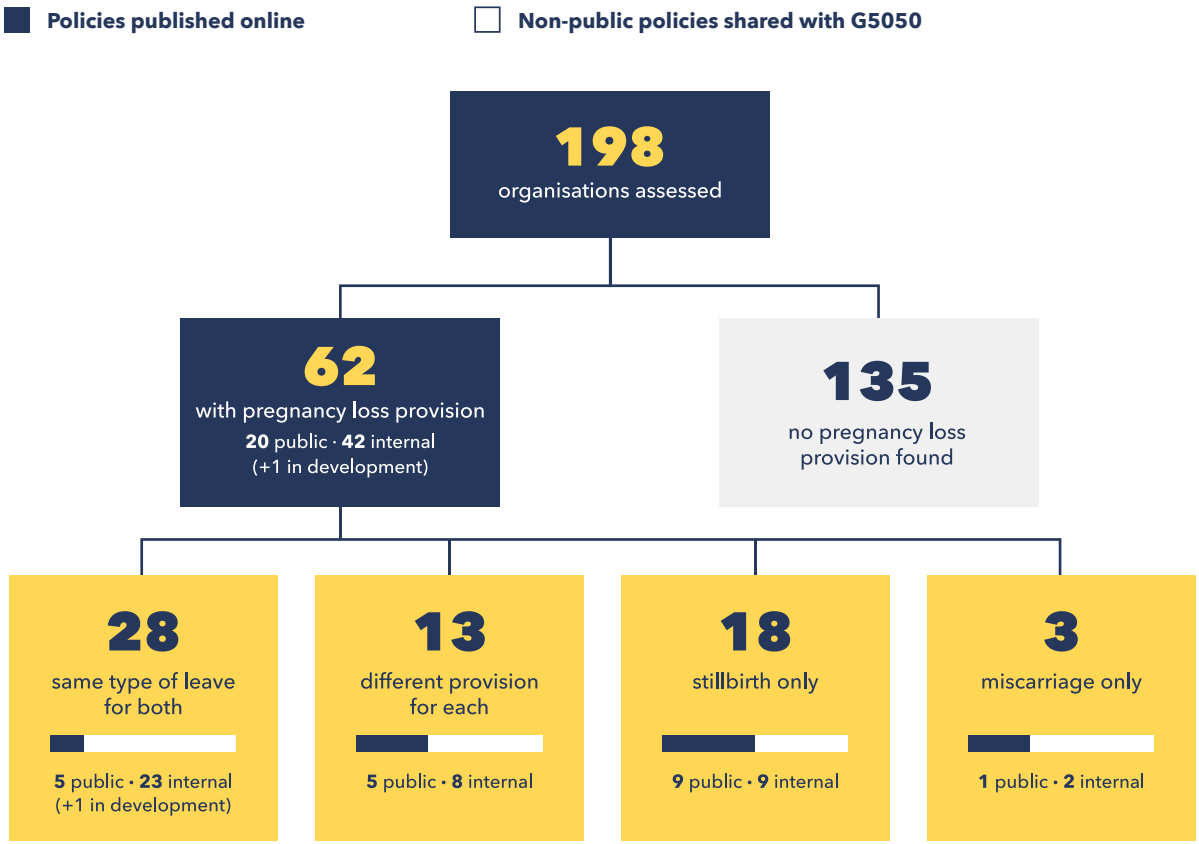
Of these, 20 publish the provision online, and 42 shared non-public information with us. Across these organisations:

- **59** provide leave or support following stillbirth and 44 following miscarriage, 41 of them following both (each with one more in development);
- **28** provide the same type of leave or support after either loss (+1 in development), 13 provide something different for each, 18 cover stillbirth only and 3 cover miscarriage only;
- where a gestational limit is given*, organisations define miscarriage as a loss before 20 weeks (3) or 24 weeks (10);
- on the same basis, they define stillbirth as a loss from 20 weeks (4), 24 weeks (13), 26 weeks (1) or 28 weeks (2);
- following stillbirth, the most common provision is maternity or parental leave (26 of 59), and following miscarriage it's sick leave (26 of 44);
- where organisations provide something different for each loss, miscarriage is met with sick leave in 12 of 13; and
- **15** provide support to partners (9 published online, 6 non-public).

See **Annex Table 6** for the list of organisations and the provisions we found.

*Where a gestational limit isn't given, we presume the provision is on top of statutory leave in the organisation's HQ country, such as maternity leave following stillbirth.

Figure 9. Stillbirth and miscarriage provision by type



The organisation whose policy is in development is shown under the 62 but counted in neither total.

Tools for change: policy examples

Examples of policies to support pregnancy loss, drawn from organisations outside the 2026 sample.

FIND MORE POLICY EXAMPLES HERE

University of Glasgow United Kingdom
Baby Loss Support Guidance

Pregnancy Loss After 24 Weeks

> **"If a baby sadly dies after 24 weeks of pregnancy (a stillbirth), or is born alive at any stage and then dies (a neonatal death), the colleague is usually entitled to full parental rights and benefits.**

We understand that by this stage in pregnancy, many parents have already begun making significant preparations and may be emotionally and practically invested in welcoming their baby. In recognition of the profound impact of such a loss, and the preparations already underway, maternity leave will begin immediately after the birth if it occurs before the intended start date or before formal notice of maternity leave was given."

Source: University of Glasgow

Further information

For further information and resources on pregnancy loss in the workplace, see the Global 50/50 resources page.

RESOURCES PAGE

icddr,b, headquartered in Bangladesh, is one of the few organisations in our sample whose provision goes well beyond the statutory minimum:

"At icddr,b, providing leave following pregnancy loss reflects our commitment to staff wellbeing, dignity, and reproductive health and rights. Setting the provision at 26 weeks recognizes that pregnancy loss can have profound physical and emotional consequences, and that recovery and individual circumstances vary. Having this provision formally documented in institutional policy is particularly important because it establishes a clear entitlement, promotes consistency and fairness, and reassures staff that they can take the time they need without stigma or uncertainty. It sends a strong message that pregnancy loss is a legitimate health and wellbeing concern that deserves compassion, recognition, and organizational support."

6. MENOPAUSE POLICIES



Dodol maker
Bogor, Indonesia. 2021.
Dikye Ariani

Why it matters

Symptoms are wide-ranging, spanning somatic, vasomotor, psychological and sexual clusters.[90] Women report holding themselves to the same standard of performance while symptoms make meeting it harder, with fear of appearing to underperform recurring across accounts.[91]

Menopause before 45 is associated with employment rates in a woman's fifties around nine percentage points lower than for women who do not experience early menopause. Norwegian register data show earnings 3.3% lower on average across the four years following a menopause diagnosis, rising to 7.4% by the fourth year.[92]

For further information see **Working through it?**.

What the law provides

Very few laws require employers to make any provision for menopause, and where binding duties exist they take different forms. Two US states, Rhode Island and Illinois, have legislated to require reasonable accommodations,[93;94] and Philadelphia has made menstruation, perimenopause and menopause protected classes from January 2027.[95] The United Kingdom has taken a different route, and under the Employment Rights Act 2025, employers with 250 or more staff will be required to publish an equality action plan covering menopause support, with the duty expected to become mandatory in spring 2027.[96]

Outside these few jurisdictions, and in the United Kingdom for individual claims, women seeking a legal remedy must fit their experience into categories built for something else, such as sex, age or disability discrimination, or health and safety. Some legal scholars argue these grounds are collectively insufficient,[97] and others propose that menstruation and menopause be recognised, as pregnancy is, in international labour law as biological attributes that produce gendered disadvantage at work.[98]

Nothing stops employers acting before the law requires them to, and guidance on what they should do is growing. The European Menopause and Andropause Society,[99] the British Standards Institution,[100] the UK Equality and Human Rights Commission and, since September 2026, the International Organization for Standardization all point to similar measures: flexible working, practical adjustments, manager training, confidential advice and naming menopause in workplace policies.[101]

What we found

19% **of organisations were found to have provision for menopause (37/198), with 1 more whose only provision is in development.**

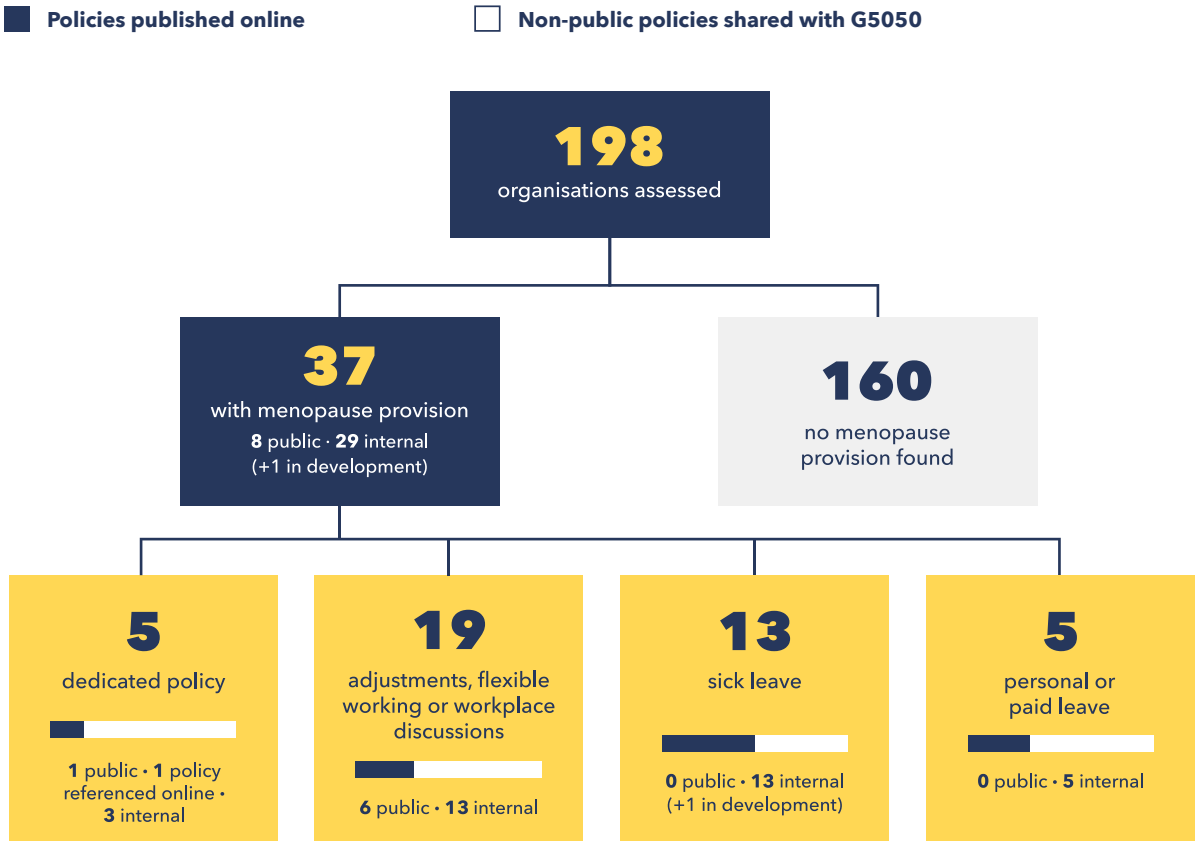
We found menopause provision for 19% (37/198) of organisations, with 1 more whose only provision is in development. Of these, 8 publish the provision online, and 29 shared non-public information with us. Across these organisations:

- **5** have a dedicated policy in place for menopause, one of which is available online;
- **13** allow sick leave to be used, with one more in development;
- **5** allow personal or paid leave to be used; and
- **19** provide adjustments, flexible working or workplace discussions (in 2023 we counted only awareness and discussions).
- **6** organisations, all in the for-profit sector, hold external accreditation from a third-party standard, with 1 non-profit organisation working towards an accreditation.*

See **Annex Table 7** for the list of organisations and the provisions we found.

*Accreditation is a third-party standard rather than organisational provision; Menopause Friendly website (Henpicked) checked October 2026.

Figure 10. Where provision for menopause was found, published online and internal



The organisation whose provision is in development is shown under the 37 but counted in neither total. Organisations may appear under more than one form of provision, so the four types sum to more than 37.

Tools for change: policy examples

FIND MORE POLICY EXAMPLES HERE

BOX 7. THREE YEARS ON: TWO ORGANISATIONS REVISIT THEIR MENOPAUSE POLICIES

Both organisations were featured in the 2023 report. Here we return to them three years on.

Medicines Patent Pool

Medicines Patent Pool featured in 2023 through Jane Caldwell, Chief Operating Officer, who shared how perimenopause nearly drove her from the workforce and how she had introduced a menstrual and menopause policy at a former employer. In 2024 MPP introduced its own dedicated menstrual and menopause policy, which includes leave and which Jane championed.

In 2023 you told us perimenopause nearly took you out of the workforce. MPP now has a menstrual and menopause policy that you championed. Why was putting that in place important to you?

There is still enormous stigma surrounding the normal, yet significant, health changes that women — half the world's population — experience. Menstruation and menopause remain irrationally taboo subjects, often treated as embarrassing and best dealt with privately, preferably in silence. But information, understanding and progress do not thrive in silence. MPP wanted to help create a workplace where these experiences could be discussed openly, without shame, and where no one felt they had to struggle alone.

What does a policy give staff that goodwill and a sympathetic manager do not?

One-to-one conversations and supportive managers are important, but collective understanding is far more powerful. A policy helps embed that understanding into workplace culture, so people feel supported rather than isolated when experiencing significant health changes. We cannot break down stigma if our only option is a private, hidden conversation.

You championed this through to approval. Who needed convincing, and what convinced them?

There were different valid concerns to address. Some women felt the subject was too personal to discuss at work, while some men questioned what we were doing about men's health. Training was key. All staff took part, focusing on the hormonal changes men and women experience throughout their lives. Starting with the science helped remove the initial embarrassment and gave everyone a shared understanding. From there, more open and constructive conversations became much easier.

How has the implementation of the policy affected working lives at MPP, or the culture more generally?

The policy has helped normalise the conversation. The more we understand the hormonal changes we may experience throughout our lives, the better equipped we are to manage their impact at work. Several colleagues have told us they now feel more comfortable speaking up. That is an important step towards creating a culture where people feel understood, supported and able to do their best work.

MPP is one of the organisations we assess and name each year. Does being externally monitored and reported on change anything internally, and if so what?

Absolutely. External assessment helps keep equality firmly on the agenda for both our Executive Leadership Team and HR throughout the year. It provides accountability, encourages us to maintain momentum and helps us measure progress against our commitments. Achieving and maintaining a strong rating is extremely important to MPP: it validates the work we are doing while reminding us that equality is an ongoing commitment, not a one-off achievement.

Jane Caldwell, Chief Operating Officer, Medicines Patent Pool

Islamic Relief Worldwide

"Islamic Relief recognises the impact menopause can have on colleagues' wellbeing, confidence, and overall work experience. In recognition of this, we introduced a Menopause Policy in 2023 to provide guidance, support, and appropriate workplace adjustments. Over the past three years, we have observed that menopause-related needs are often raised within broader health and wellbeing conversations rather than as a standalone issue. This highlights the need for greater awareness, education, and open dialogue across the organisation. We acknowledge that more can be done to ensure colleagues and managers are aware of the policy and feel confident using it. Our aim is to foster understanding, reduce stigma, and create a supportive environment where colleagues can access the appropriate support and workplace adjustments when needed."



Older not over
Nairobi, Kenya.
Anwar Sadat Swaka

Further information

See **Working through it?**, for our in-depth look at menopause in the workplace.

For further information and resources on menopause in the workplace, see the Global 50/50 resources page.

RESOURCES PAGE

ANNEX: DETAILED FINDINGS PER POLICY



Reflections of Ophelia
United Kingdom. 2025.
Daisy Warne

TABLE 1. FULL COMPARABLE COUNTS: PROVISION FOUND, NUMBER OF ORGANISATIONS (ALL FINDINGS, INTERNAL AND PUBLIC)

VARIABLE	PROVISION	2023	2026
Menstruation	Menstrual leave (paid or unpaid)	1	2
	Sick leave can be used	14	18 (+1 in development)
	Personal leave can be used	4	4
Abortion	Sick leave can be used	10	16 (+1 in development)
	Personal leave can be used	3	5
	Insurance coverage	8	12
Fertility treatment	Financial or insurance coverage	22	36
	Fertility leave	7	8
	Additional support	4	9
Antenatal care	Paid antenatal leave	24	36
	Sick leave can be used	13	15 (+1 in development)
Miscarriage and stillbirth	Any pregnancy-loss leave	45	60 (+1 in development)
	Full maternity or parental leave after stillbirth	18	26
	Sick or bereavement leave after stillbirth	26	19 (+1 in development)
	Sick or bereavement leave after miscarriage	33	32 (+1 in development)
	Maternity leave or parental leave after miscarriage	4	3
	Leave for partners	6	15
Menopause	Dedicated policy	1	5
	Sick leave can be used	12	13 (+1 in development)
	Personal leave or paid leave can be used	2	5
	External accreditation (reported separately)	3	6 (+1 working towards)

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Where an organisation is named without a tick, the finding was publicly available online, and we refer to these as "published".

- **organisations in this colour were found in both the 2023 and 2026 reports**
- **organisations in this colour are new in 2026**
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- unmarked organisations are non-profit

TABLE 2. MENSTRUATION: FINDINGS BY POLICY AND ORGANISATION, 2026

NO. OF ORGS	POLICY/PRACTICE	DETAILS
3 (+1 policy in development)	**Dedicated menstruation policy** *A named policy of its own.*	**1. International Center for Research on Women Asia** (Part of ICRW Global Network) ✓ **2. International Planned Parenthood Federation** (IPPF) ✓ **3. Medicines Patent Pool** (MPP) In addition, one organisation with a policy in development shared non-public information and asked not to be named.
2	**Menstrual leave** Leave that names menstruation (Japan, Labour Standards Act, Article 68).	**1. Global Health Innovative Technology Fund** (GHIT Fund) ✓ In addition, one organisation shared non-public information and asked not to be named.
4	**Personal leave** *General personal leave usable for menstruation.*	**1. EngenderHealth** ✓ **2. Pathfinder International** ✓ In addition, two organisations shared non-public information and asked not to be named.
18 (+1 policy in development)	**Sick leave** *Symptoms accommodated, but managed as illness.*	**1. Abt Global** ▪ ✓ **2. Drugs for Neglected Diseases Initiative** (DNDi) ✓ **3. Food and Agriculture Organization of the United Nations** (FAO) ✓ **4. Fos Feminista** (formerly IPPFWHR) ✓ **5. International AIDS Society** (IAS) ✓ **6. International Rescue Committee** (IRC) ✓ **7. International Vaccine Institute** (IVI) ✓ **8. MSI Reproductive Choices** ✓ **9. Partnership for Maternal, Newborn and Child Health** (The Partnership, PMNCH) ✓ *PMNCH is hosted by the WHO, and therefore this is a WHO policy.* **10. Pathfinder International** ✓ **11. Swedish International Development Cooperation Agency** (Sida) ✓ **12. UNICEF** ✓ In addition, seven organisations shared non-public information and asked not to be named, including one organisation with a policy in development.
9	**Products, adjustments and guidance** *Menstrual products, workplace adjustments and awareness guidance, but no time off.*	**1. BRAC** **2. Deutsche Gesellschaft für Internationale Zusammenarbeit** (GIZ) ✓ **3. Global Alliance for Improved Nutrition** (GAIN) ✓ **4. Health Action International** ✓ **5. UNICEF** ✓ In addition, four organisations shared non-public information and asked not to be named.

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Where an organisation is named without a tick, the finding was publicly available online, and we refer to these as "published".

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TABLE 3. ABORTION: FINDINGS BY POLICY AND ORGANISATION, 2026

NO. OF ORGS	POLICY/PRACTICE	DETAILS	
1	**Dedicated abortion policy** *A policy or benefit that names abortion.*	**1. International Planned Parenthood Federation (IPPF)** ✓	
2	**Financial assistance** *Employer funds towards the cost of abortion care.*	**1. Pathfinder International** ✓ In addition, one organisation shared non-public information and asked not to be named.	
12	**Medical/insurance coverage** *Care covered through an employer plan, or through national or state insurance where the law allows.*	**1. Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) (informed us that this is covered through national statutory health insurance, Germany)** ✓ **2. EngenderHealth** ✓ **3. Fos Feminista (formerly IPPFWHR)** ✓	**4. Health Action International (informed us that this is covered through national statutory health insurance, the Netherlands)** ✓ **5. i+solutions** ✓ **6. International Rescue Committee (IRC)** ✓ In addition, six organisations shared non-public information and asked not to be named.
5	**Personal leave** *General personal leave usable for abortion care.*	**1. EngenderHealth** ✓ **2. International Center for Research on Women Asia (Part of ICRW Global Network)** ✓	**3. MSI Reproductive Choices** ✓ In addition, two organisations shared non-public information and asked not to be named.
16 (+1 policy in development)	**Sick leave** *General sick leave usable for abortion care.*	**1. Drugs for Neglected Diseases Initiative (DNDi)** ✓ **2. EngenderHealth** ✓ **3. Food and Agriculture Organization of the United Nations (FAO)** ✓ **4. Fos Feminista (formerly IPPFWHR)** ✓ **5. icddr,b** ✓ **6. International AIDS Society (IAS)** ✓	**7. International Vaccine Institute (IVI)** ✓ **8. MSI Reproductive Choices** ✓ **9. Partnership for Maternal, Newborn and Child Health (The Partnership, PMNCH)** ✓ ***PMNCH is hosted by the WHO, and therefore this is a WHO policy.*** **10. Swedish International Development Cooperation Agency (Sida)** ✓ In addition, seven organisations shared non-public information and asked not to be named, including one organisation with a policy in development.

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TABLE 4. FERTILITY TREATMENT: FINDINGS BY POLICY AND ORGANISATION, 2026

NO. OF ORGS	POLICY/PRACTICE	DETAILS
36	**Financial and/or medical coverage** *Employer financial assistance and/or medical coverage for treatment.*	**1. AbbVie** ▪ **2. Abt Global** ▪ ✓ **3. Deloitte** ▪ **4. Eli Lilly and Company** ▪ **5. ExxonMobil** ▪ **6. Gilead** ▪ **7. Intel** ▪ **8. Johnson & Johnson** ▪ **9. McKinsey & Company** ▪ **10. Medtronic** ▪ **11. Nestlé** ▪ **12. Novartis** ▪ **13. Pfizer** ▪ **14. Bloomberg Philanthropies** **15. EngenderHealth** ✓ **16. Food and Agriculture Organization of the United Nations (FAO)** ✓ **17. Ford Foundation** **18. Fos Feminista (formerly IPPFWHR)** ✓ **19. Gates Foundation (formerly Bill & Melinda Gates Foundation)** **20. Global Financing Facility (GFF)** **21. i+solutions** ✓ **22. IFPRI** ✓ **23. International Rescue Committee (IRC)** ✓ **24. Jhpiego** ✓ **25. Partnership for Maternal, Newborn and Child Health (The Partnership, PMNCH)** ✓ *PMNCH is hosted by the WHO, and therefore this is a WHO policy.* **26. Pathfinder International** ✓ **27. Swedish International Development Cooperation Agency (Sida)** ✓ **28. UNICEF** ✓ **29. United Nations Development Programme (UNDP)** ✓ **30. World Bank Group** In addition, six organisations shared non-public information and asked not to be named.
8	**Fertility or personal leave** *Leave other than sick leave, such as dedicated assisted-conception leave.*	**1. PwC** ▪ **2. Sumitomo Chemical** ▪ **3. Fos Feminista (formerly IPPFWHR)** ✓ **4. International Planned Parenthood Federation (IPPF)** ✓ **5. International Vaccine Institute (IVI)** ✓ **6. MSI Reproductive Choices** ✓ **7. Wellcome Trust** ✓ In addition, one organisation shared non-public information and asked not to be named.

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ANNEX

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NO. OF ORGS	POLICY/PRACTICE	DETAILS	
9 (+1 policy in development)	**Sick leave** *General sick leave usable for fertility treatment.*	**1. EngenderHealth** ✓ **2. International AIDS Society (IAS)** ✓ **3. International Center for Research on Women Asia (Part of ICRW Global Network)** ✓ **4. Partnership for Maternal, Newborn and Child Health (The Partnership, PMNCH)** ✓ ***PMNCH is hosted by the WHO, and therefore this is a WHO policy.***	**5. Swedish International Development Cooperation Agency (Sida)** ✓ **6. United Nations Development Programme (UNDP)** ✓ In addition, four organisations shared non-public information and asked not to be named, including one organisation with a policy in development.
9	**Additional support** *Counselling, flexible working, or educational and emotional support from fertility experts.*	**1. AbbVie** ▪ **2. Coca-Cola** ▪ **3. Gilead** ▪ **4. Medtronic** ▪ **5. Unilever** ▪ **6. Drugs for Neglected Diseases Initiative (DNDi)** ✓ **7. Health Action International** ✓	**8. Open Society Foundations** In addition, one organisation shared non-public information and asked not to be named.

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TABLE 5. ANTENATAL CARE: FINDINGS BY POLICY AND ORGANISATION, 2026

NO. OF ORGS	POLICY/PRACTICE	DETAILS		
36 (+1 unpaid)	**Paid leave for antenatal appointments** *Access to paid leave, such as family or health-and-safety leave supplementary to sick leave, to attend antenatal care.*	1. Abt Global ▪ ✓ 2. Sumitomo Chemical ▪ 3. Cordaid ✓ 4. Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) 5. Drugs for Neglected Diseases Initiative (DNDi) ✓ 6. EngenderHealth ✓ 7. *Global Health Innovative Technology Fund (GHIT Fund)* ✓ *(leave is unpaid)* 8. Health Action International ✓ 9. Health Poverty Action 10. i+solutions ✓ 11. International AIDS Society (IAS) ✓ 12. International Federation of Red Cross and Red Crescent Societies (IFRC) ✓	13.International Planned Parenthood Federation (IPPF) ✓ 14. International Rescue Committee (IRC) ✓ 15. International Vaccine Institute (IVI) ✓ 16. Islamic Relief Worldwide ✓ 17. Memisa ✓ 18. MSI Reproductive Choices ✓ 19. National Institutes of Health (NIH) 20. Norwegian Agency for Development Cooperation (Norad) 21. Swedish International Development Cooperation Agency (Sida) ✓ 22. UN Women	23. UNHCR 24. United Nations Development Programme (UNDP) 25. United Nations Economic Commission for Africa (UNECA) 26. United Nations Population Fund (UNFPA) 27. Wellcome Trust ✓ In addition, ten organisations shared non-public information and asked not to be named.
8	**Additional support** *Support beyond leave, such as flexible working or employer-provided services.*	1. AbbVie ▪ 2. Nestlé ▪ 3. Philips ▪	4. PwC ▪ 5. Sumitomo Chemical ▪ 6. Bloomberg Philanthropies	7. Memisa ✓ In addition, one organisation shared non-public information and asked not to be named.

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- unmarked organisations are non-profit

NO. OF ORGS	POLICY/PRACTICE	DETAILS		
15 (+1 policy in development)	**Sick leave** *General sick leave usable to attend antenatal care.*	**1. Alliance for Health Policy and Systems Research (AHPSR)** **2. Centers for Disease Control and Prevention (US)** **3. Food and Agriculture Organization of the United Nations (FAO)** ✓ **4. Fos Feminista (formerly IPPFWHR)** ✓ **5. International Center for Research on Women Asia (Part of ICRW Global Network)** ✓	**6. Joint United Nations Programme on HIV and AIDS (UNAIDS)** **7. Medicines Patent Pool (MPP)** ✓ **8. Partnership for Maternal, Newborn and Child Health (The Partnership, PMNCH)** ✓ ***PMNCH is hosted by the WHO, and therefore this is a WHO policy.*** **9. Pathfinder International** ✓	**10. UNICEF** **11. Unitaid** **12. World Health Organization (WHO)** In addition, four organisations shared non-public information and asked not to be named including one organisation with a policy in development.
14	**Medical/insurance coverage** *Antenatal care covered by employer or state health insurance.*	**1. AbbVie** ▪ **2. African Population and Health Research Centre (APHRC)** ✓ **3. Bloomberg Philanthropies** **4. Food and Agriculture Organization of the United Nations (FAO)** ✓ **5. Fos Feminista (formerly IPPFWHR)** ✓	**6. icddr,b** ✓ **7. IFPRI** ✓ **8. Joint United Nations Programme on HIV and AIDS (UNAIDS)**	**9. Partnership for Maternal, Newborn and Child Health (The Partnership, PMNCH)** ✓ ***PMNCH is hosted by the WHO, and therefore this is a WHO policy.*** **10. Pathfinder International** ✓ In addition, four organisations shared non-public information and asked not to be named.

TABLE 6. STILLBIRTH AND MISCARRIAGE: FINDINGS BY ORGANISATION, 2026

A1. DIFFERENT PROVISION AFTER MISCARRIAGE AND STILLBIRTH (13)

ORGANISATION	AFTER MISCARRIAGE	AFTER STILLBIRTH
Food and Agriculture Organization of the United Nations (FAO) ✓	Sick leave	Other paid leave
International Planned Parenthood Federation (IPPF) ✓	Sick leave; Other forms of support	Maternity or parental leave

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ORGANISATION	AFTER MISCARRIAGE	AFTER STILLBIRTH
MSI Reproductive Choices ✓	Sick leave	Maternity or parental leave
UN Women	Sick leave	Other paid leave
UNHCR	Sick leave	Other paid leave
UNICEF	Sick leave	Other paid leave
United Nations Economic Commission for Africa (UNECA)	Sick leave	Other paid leave
United Nations Population Fund (UNFPA)	Sick leave	Other paid leave
Wellcome Trust ✓	Sick leave; Other forms of support	Maternity or parental leave; Other forms of support
	Sick leave	Maternity or parental leave
	Other paid leave	Maternity or parental leave
	Bereavement or compassionate leave; sick leave	Maternity or parental leave
	Sick leave	Other paid leave

A2. SAME TYPE OF LEAVE AFTER MISCARRIAGE AND STILLBIRTH (28, +1 IN DEVELOPMENT)

ORGANISATION	LEAVE OR SUPPORT (BOTH)
Abt Global ▪ ✓	Other paid leave
Medtronic ▪	Other paid leave
Philips ▪	Bereavement or compassionate leave
Alliance for Health Policy and Systems Research (AHPSR)	Sick leave
Drugs for Neglected Diseases Initiative (DNDi) ✓	Sick leave
EngenderHealth ✓	Sick leave; Bereavement or compassionate leave

Continues on next page.

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ORGANISATION	LEAVE OR SUPPORT (BOTH)
Fos Feminista (formerly IPPFWHR) ✓	Bereavement or compassionate leave
Health Action International ✓	Bereavement or compassionate leave
i+solutions ✓	Sick leave
IFPRI ✓	Maternity or parental leave
International AIDS Society (IAS) ✓	Sick leave
International Center for Research on Women Asia (Part of ICRW Global Network) ✓	Maternity or parental leave
International Rescue Committee (IRC) ✓	Bereavement or compassionate leave; Sick leave
International Vaccine Institute (IVI) ✓	Other paid leave
Medicines Patent Pool (MPP) ✓	Sick leave
National Institutes of Health (NIH)	Unpaid leave
Partnership for Maternal, Newborn and Child Health (The Partnership, PMNCH) ***PMNCH is hosted by the WHO, and therefore this is a WHO policy.*** ✓	Maternity or parental leave; Other forms of support
Swedish International Development Cooperation Agency (Sida) ✓	Sick leave
Unitaid	Sick leave
	Bereavement or compassionate leave
	Other forms of support
	Policy in development
	Bereavement or compassionate leave; Sick leave
	Other paid leave
	Bereavement or compassionate leave
	Sick leave; Other forms of support
	Sick leave

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ORGANISATION	LEAVE OR SUPPORT (BOTH)
	Bereavement or compassionate leave
	Sick leave

A3. STILLBIRTH ONLY (18)

ORGANISATION	AFTER STILLBIRTH
African Population and Health Research Centre (APHRC)	Maternity or parental leave
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	Maternity or parental leave
Foreign, Commonwealth & Development Office (FCDO, UK)	Maternity or parental leave
Global Financing Facility (GFF)	Maternity or parental leave; Unpaid leave
icddr,b ✓	Maternity or parental leave
International Federation of Red Cross and Red Crescent Societies (IFRC) ✓	Maternity or parental leave
International Labour Organization (ILO)	Other paid leave
Islamic Relief Worldwide ✓	Maternity or parental leave
Ministry of Foreign Affairs and International Cooperation, Italy	Maternity or parental leave
Ministry of Foreign Affairs of the Netherlands	Maternity or parental leave
Pathfinder International ✓	Maternity or parental leave
SRHR Africa Trust ✓	Maternity or parental leave
United Nations Development Programme (UNDP)	Maternity or parental leave
World Bank Group	Maternity or parental leave; Unpaid leave
	Maternity or parental leave
	Maternity or parental leave

Continues on next page.

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ORGANISATION	AFTER STILLBIRTH
	Maternity or parental leave
	Maternity or parental leave

A4. MISCARRIAGE ONLY (3)

ORGANISATION	AFTER MISCARRIAGE
PwC ▪	Other paid leave
Global Alliance for Improved Nutrition (GAIN) ✓	Other forms of support
	Sick leave

The length of leave can differ between miscarriage and stillbirth within the same type of leave, for example where it is graded by week of pregnancy. Provision may restate or add to statutory entitlements in the organisation's headquarters country, which can include maternity leave after a stillbirth.

TABLE 7. MENOPAUSE: FINDINGS BY POLICY AND ORGANISATION, 2026

NO. OF ORGS	POLICY/PRACTICE	DETAILS		
5	**Dedicated menopause policy** *A named, comprehensive policy of its own.*	**1. GSMA** ▪ **2. International Planned Parenthood Federation (IPPF)** ✓	**3. Islamic Relief Worldwide** ✓ **4. Medicines Patent Pool (MPP)**	**5. MSI Reproductive Choices** ✓
5	**Personal or paid leave** *General personal leave usable for menopause; where an organisation provides paid leave that names menopause, that is noted beside the entry.*	**1. Abt Global (personal leave)** ▪ ✓ **2. EngenderHealth (paid leave)** ✓		**3. International Center for Research on Women Asia (Part of ICRW Global Network) (paid leave)** ✓ In addition, two organisations shared non-public information and asked not to be named.

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ANNEX

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- **organisations in this colour are new in 2026**
- ▪ marks a for-profit organisation (private sector or consultancy)
- unmarked organisations are non-profit

NO. OF ORGS	POLICY/PRACTICE	DETAILS
13 (+1 policy in development)	**Sick leave** *Symptoms accommodated*	**1. Drugs for Neglected Diseases Initiative (DNDi)** ✓ **2. Fos Feminista (formerly IPPFWHR)** ✓ **3. i+solutions** ✓ **4. International AIDS Society (IAS)** ✓ **5. International Center for Research on Women Asia (Part of ICRW Global Network)** ✓ **6. International Vaccine Institute (IVI)** ✓ **7. Partnership for Maternal, Newborn and Child Health (The Partnership, PMNCH)** ✓ ***PMNCH is hosted by the WHO, and therefore this is a WHO policy.*** **8. UNICEF** ✓ In addition, six organisations shared non-public information and asked not to be named including one organisation with a policy in development.
6 (+1 working towards)	**External accreditation (recorded separately, not counted as provision)** *A third-party standard (Menopause Friendly, Henpicked) rather than provision the employer sets for itself.*	**1. Accenture** ▪ **2. Bristol Myers Squibb** ▪ **3. Medtronic** ▪ **4. Mott MacDonald** ▪ **5. Novo Nordisk** ▪ **6. Unilever** ▪ **7. Save the Children — working towards accreditation**
19	**Adjustments, flexible working or workplace discussions** *Workplace adjustments, flexible working, or awareness sessions and discussions about menopause.*	**1. AbbVie** ▪ **2. Gilead** ▪ **3. Nestlé** ▪ **4. Philips** ▪ **5. PwC** ▪ **6. Unilever** ▪ **7. EngenderHealth** ✓ **8. Food and Agriculture Organization of the United Nations (FAO)** ✓ **9. Fos Feminista (formerly IPPFWHR)** ✓ **10. Global Alliance for Improved Nutrition (GAIN)** ✓ **11. International Rescue Committee (IRC)** ✓ **12. Swedish International Development Cooperation Agency (Sida)** ✓ **13. UNICEF** ✓ **14. Wellcome Trust** ✓ In addition, five organisations shared non-public information and asked not to be named.

ANNEX: METHODS AND METHODOLOGY

SAMPLE, DATA COLLECTION AND VALIDATION WITH ORGANISATIONS

Organisational sample and criteria for inclusion.

This report reviews 198 organisations active in global health. Global 50/50 defines global organisations as those with a presence in at least three countries. The sample includes organisations actively involved in global health and those organisations that aim to influence global health policy even if this is not their core function. Inclusion of an organisation does not signify G5050's endorsement of its activities, nor that G5050 considers the organisation to be contributing to advancing population-level health in a positive direction. Rather, organisations under review have been identified as having demonstrated an interest in influencing global health and/or global health policy.

For an overview of the sample and sector breakdown please **see Figure 3**.

Approach and methods for data collection.

Global 50/50 has developed a rigorous methodology that is consistent with established systematic review research methods. At least two reviewers extract each publicly available data item independently and a third verifies it. The reviewers discuss any discrepancies in data extraction until they reach consensus. Data are coded according to content against a scheme set in advance and refined iteratively.

Aside from human resources policies (see below), we do not ask for confidential information, information of a commercially sensitive nature or information that would identify individuals in organisations.

This year's report covers human resources policies – some of which remain internal to the organisation itself and have not been published online. At the start of our data collection we requested organisations to share relevant policies with us. The policies have been coded and we have indicated, where appropriate, when these were internal rather than public policies. As per ethical approval (see below), these internal policies were stored by us on secure servers and will be destroyed from our servers after an agreed length of time.

Some organisations follow the workplace policies of host organisations or parent companies. In these cases, we used the same code as for the host/parent. For example, several organisations employ the workplace policies of the World Health Organization (WHO), e.g. Partnership for Maternal, Newborn and Child Health and the Alliance for Health Policy and Systems Research. Other non-workplace policy variables (e.g. gender parity in leadership, stated commitment to gender equality, etc.) are coded for each organisation individually.

The Unaccommodated Body Report, 2026

To identify and extract information on the variables selected for inclusion in this report — menstruation, abortion, fertility treatment, antenatal care, pregnancy loss and menopause — we retained the 2023 coding scheme throughout, with some adjustments.

We reviewed available human resource policies – those found on the internet and those shared directly with us upon request.

Organisations' websites and shared internal policies were searched using the following search terms:

POLICY ISSUE	SEARCH TERMS
Menstruation	Menstrual, menstruation, period
Menopause	Menopause, menopausal
Abortion	Abortion, termination
Antenatal care	Antenatal, prenatal
Miscarriage, stillbirth	Pregnancy loss, miscarriage, stillborn, demise
Fertility	Fertility, conception assistance

Engaging and validating results with organisations

We contact each organisation at least twice during the course of data verification. Initially we inform the CEO and head of human resources, or their equivalent, about the project and the start date of data collection, using email addresses found online. In that correspondence, we request the nomination and contact details of a focal point in the organisation who can review and validate the data once collected. Following completion of data collection, we send each organisation their preliminary results and ask them to review and provide any additional information, documentation or policies to review. Throughout the process of data collection, G5050 encourages organisations to contact us to discuss queries about the process and the variables.

For 2026, 71 organisations validated or partially validated their data.

Comparability with 2023, and its limits

The 2023 report reviewed 197 organisations; this report reviews 198, of which 193 were assessed in both rounds. In 2023, 73 organisations validated their data and 30 of those shared 183 internal policy documents. In 2026, 71 validated and 47 shared 426 documents, with a further 24 providing non-public information during validation. Not everything shared is relevant to the six issues covered here: 54 organisations shared non-public information we drew on for this report.

Ethics

Approved by the UCL research ethics committee (which housed the project until 2021); since becoming an independent charity, methods reviewed by the Social Research Association.

ENDNOTES

1 Acker, J. (1990). Hierarchies, jobs, bodies: A theory of gendered organizations. Gender & Society, 4(2), 139–158. https://doi.org/10.1177/089124390004002002

2 Gibore, N. S., Bali, T. A., & Kibusi, S. M. (2019). Factors influencing men's involvement in antenatal care services: A cross-sectional study in a low resource setting, Central Tanzania. Reproductive Health, 16(1), 52.

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