A COMPARATIVE STUDY OF GIRLS' MENSTRUAL HEALTH FACILITIES IN INDIA AND SOUTH KOREA

Access, Policy, and Sociocultural Barriers

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Abstract

Menstrual health remains an unevenly addressed dimension of adolescent and women's healthcare across the world, shaped as much by infrastructure and policy as by culture and silence. This paper compares the state of menstrual health facilities, government policy, and social attitudes in India and South Korea, two countries at very different points on the development spectrum but joined by a common thread: menstruation is still spoken about in hushed tones in both. Drawing on the National Family Health Survey (NFHS-5), Dasra's 'Spot On!' report, Seoul Metropolitan Government data, and recent 2026 policy announcements from South Korea's Ministry of Gender Equality and Family, the paper finds that India's central challenge is one of infrastructural and regional inequity, while South Korea's is one of affordability despite near-universal product availability. A working medical student's perspective is used throughout to connect population-level data with what is actually seen in clinics and community placements. The paper closes with policy recommendations relevant to both contexts and argues that neither economic development nor product availability alone is sufficient to guarantee menstrual dignity; sustained destigmatisation work is required in parallel.

Keywords: menstrual hygiene management, period poverty, adolescent health, India, South Korea, WASH, public health policy

Index

1. Introduction

Roughly half the world's population menstruates for a significant portion of their lives, yet menstrual health is routinely pushed to the margins of public health planning. During my clinical postings in a district hospital, I have repeatedly seen young patients hesitate to name their own symptoms, using vague phrases instead of the word 'period,' and this hesitation is rarely just personal shyness. It reflects a broader silence that shapes how facilities are funded, how schools are built, and how comfortable a girl feels raising her hand to ask for a washroom break.

This paper sets out to compare two countries that rarely appear side by side in menstrual health literature: India, a lower-middle-income country of 1.4 billion people with wide internal disparities, and South Korea, a high-income, highly urbanised country with near-universal literacy and healthcare access. The comparison is instructive precisely because it separates two variables that are often conflated: economic development and menstrual equity. If development alone solved period poverty, South Korea's 2016 'insole girls' scandal — in which low-income schoolgirls were found using shoe insoles in place of pads — would not have happened. Examining both countries side by side helps identify which barriers are structural (infrastructure, income) and which are cultural (stigma, silence), and where the two intersect.

2. Methodology

This is a narrative comparative review rather than a primary research study. Data was drawn from publicly available government reports and peer-reviewed literature, including the National Family Health Survey (NFHS-5, 2019-21), the Dasra 'Spot On!' report (2014), systematic reviews of school menstrual hygiene preparedness in India, Seoul Metropolitan Government publications, and recent (2026) Korean government policy announcements on free sanitary product provision. Wherever government survey data was unavailable for a specific comparison point, this is stated explicitly rather than estimated. Observations from clinical postings are included as illustrative, not statistical, evidence, and are clearly flagged as personal reflection.

3. The Indian Context

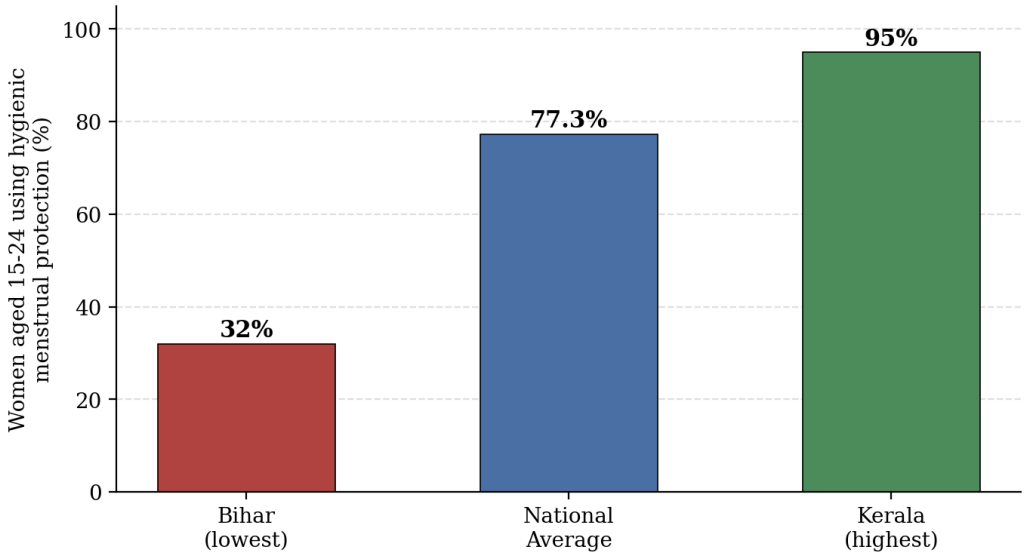
3.1 Policy Architecture

India's principal national intervention is the Menstrual Hygiene Scheme (MHS), launched in 2011 under the Ministry of Health and Family Welfare, which subsidises sanitary pads for adolescent girls aged 10-19 through the Adolescent Reproductive and Sexual Health (ARSH) programme and community health workers known as ASHAs. A parallel initiative, 'Suvidha,' introduced 100 percent oxo-biodegradable sanitary napkins priced at INR 1 through Jan Aushadhi generic drug stores, an attempt to combine affordability with environmental safety. Several states run their own supplementary schemes, and some, like Odisha's 'Khusi' programme, focus specifically on rural adolescent girls.

3.2 Access and Infrastructure

Despite these schemes, access remains highly uneven. According to NFHS-5, 77.3 percent of women aged 15-24 nationally reported using hygienic methods of menstrual protection, but this average conceals extreme regional variation: from 95 percent in Kerala to just 32 percent in Bihar (see Figure 1). Even where products are available, school infrastructure often falls short — a 'menstrual hygiene friendly school' requires clean and separate girls' toilets, water, soap, changing space, and safe disposal, and many government schools, particularly in rural districts, still lack one or more of these basics.

Figure 1: State-wise Disparity in Hygienic Menstrual Product Use, India



Source: National Family Health Survey (NFHS-5), 2019-21

Figure 1. State-wise disparity in hygienic menstrual product use among women aged 15-24. Source: NFHS-5, 2019-21.

3.3 Social and Economic Barriers

The Dasra 'Spot On!' report estimated that nearly 23 million girls drop out of school annually around the onset of menstruation, driven by a combination of inadequate sanitation, product unavailability, and stigma. A study in urban slums of Madhya Pradesh found that even where 82 percent of adolescent girls used sanitary pads, 37.5 percent still missed school during their periods — a reminder that product access and social inclusion are not the same thing. Fear of leakage, embarrassment, lack of privacy, and limited availability of pain relief at school are recurring themes in the qualitative literature on absenteeism.

Cultural stigma compounds these material barriers. Menstruation is still widely regarded in many Indian households as something unclean, and menstruating women and girls are in some communities restricted from entering kitchens or temples, or from touching pickled foods. This silence discourages girls from asking teachers or even parents for help, and it discourages boys and men from understanding the issue at all — a gap that recent Indian policy has begun, tentatively, to address through gender-neutral menstrual education in some states.

4. The South Korean Context

4.1 From Statutory Leave to the 'Insole Girls'

South Korea's engagement with menstrual policy has a longer formal history than is often assumed: menstrual leave for female employees has been enshrined in the Labour Standards Act since 2001, a full fifteen years before period poverty became a mainstream public issue. That shift arrived in 2016, when media reports revealed that low-income adolescent girls, unable to afford pads after a major manufacturer raised prices by 20 percent, were using shoe insoles as a substitute. The ensuing public outcry — girls became known in the press as 'insole girls' — did more to galvanise Korean menstrual policy than a decade of advocacy had achieved.

4.2 Policy Response and the 2026 Pilot

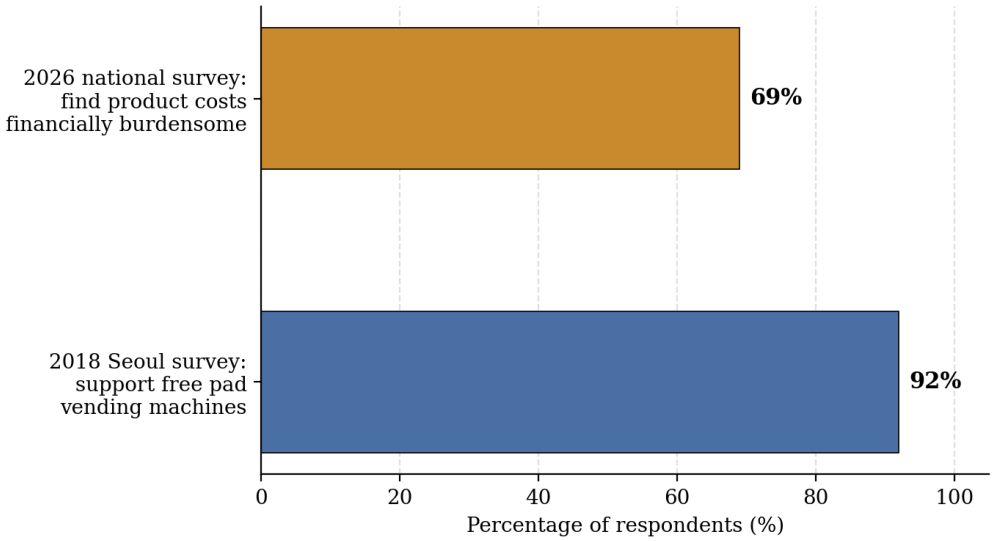
Seoul's municipal government responded first, piloting free sanitary pad vending machines in ten public facilities in 2018, an initiative that a public forum survey found was supported by 92 percent of nearly 1,500 citizen respondents. The Youth Welfare Act was revised in 2021 to provide a legal basis for free product access for low-income youth aged 9 to 24, delivered through monthly vouchers worth 14,000 KRW. However, uptake has lagged: only around 173,000 of 243,000 eligible young people had applied for these vouchers as of recent reporting, pointing to a gap between entitlement on paper and access in practice.

The most significant recent development is the national government's 'Public Sanitary Pad Dream Project,' announced in early 2026, which moves beyond income-based eligibility altogether. Beginning in July 2026, free vending machines and dispensers are being installed in community service centres, public health centres, family centres, and — pending Ministry of Education cooperation — schools, funded by an initial budget of roughly 3 billion KRW. President Lee Jae-myung explicitly tied the initiative to concerns about 'price gouging' after government analysis found Korean sanitary pads cost roughly 40 percent more than comparable products in the United States, Japan, and most of Europe, attributed partly to a market trend toward premium 'organic' branding that crowded out basic low-cost options.

4.3 Cost as the Central Barrier

Unlike India, South Korea's challenge is rarely one of physical unavailability — pads are sold nearly everywhere — but of price. A 2026 Ministry of Gender Equality and Family survey of 1,000 women found that 69 percent considered menstrual product costs financially burdensome, indicating that the strain extends well beyond the low-income households originally targeted by welfare vouchers (Figure 2).

Figure 2: Public Sentiment on Menstrual Product Costs, South Korea



Source: Seoul Metropolitan Government (2018); Ministry of Gender Equality and Family survey (2026)

Figure 2. Public sentiment on menstrual product access and cost in South Korea. Sources: Seoul Metropolitan Government (2018) citizen forum; Ministry of Gender Equality and Family survey (2026).

4.4 Residual Stigma

Even in a high-income, highly literate society, menstruation carries social discomfort. Internal products such as tampons and menstrual cups remain considerably less popular in Korea than in many Western countries, a pattern researchers link to cultural beliefs about virginity and to a general reluctance to discuss menstruation openly, even within families. This suggests that stigma is not simply a function of income or education level, but a distinct variable that must be tackled on its own terms.

5. Comparative Analysis

Placing the two country timelines side by side clarifies how differently — and on what different schedules — each country has moved (Figure 3). India's engagement began earlier, in 2011, and has unfolded as a series of incremental, product-and-subsidy-focused schemes layered over an uneven infrastructural base. South Korea's engagement was jump-started by a single scandal in 2016 and has moved through fast, centrally coordinated policy escalation, culminating in a near-universal free-access pilot within a decade.

Figure 3: Comparative Policy Timeline — Menstrual Health Milestones

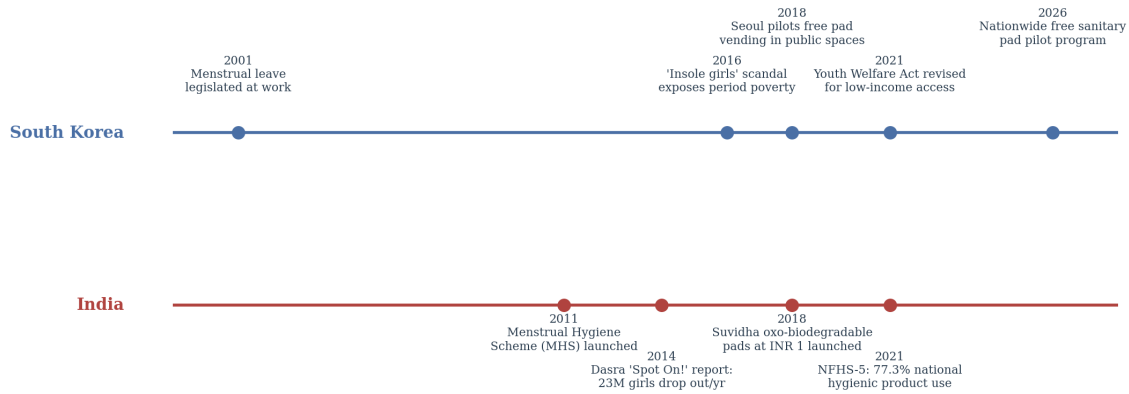


Figure 3. Comparative policy timeline of menstrual health milestones, India and South Korea, 2001-2026.

5.1 Facilities and Policy: Side by Side

Indicator	India	South Korea
Primary policy vehicle	Menstrual Hygiene Scheme (MHS, 2011); state-level schemes (e.g., Suvidha, INR 1 pads)	Youth Welfare Act (2021 revision); 2026 nationwide free-pad pilot
Target population	Adolescent girls aged 10-19, mainly through the ASHA/school network	Vulnerable youth aged 9-24 (vouchers); expanding to all women (2026 pilot)
Delivery mechanism	Subsidised pads distributed via schools and rural health workers	Vending machines and dispensers in public facilities, community centres, schools
Documented gap	Rural-urban and inter-state disparity (32% in Bihar vs 95% in Kerala)	High retail price (~40% above US/Japan/EU); patchy uptake of welfare vouchers
School-level infrastructure	Uneven: many rural schools lack private toilets, water, and disposal units	Generally strong WASH infrastructure; gap is product cost, not sanitation
Cultural stigma	Strong; menstruation widely treated as unclean, restricting attendance at school, temples, kitchens	Present but less restrictive; topic still considered awkward to discuss openly
Leave policy	No national menstrual leave law; a few states/companies offer informal leave	Statutory monthly menstrual leave for employees since 2001 (Labour Standards Act)

5.2 Strengths and Limitations

	Strengths	Limitations
India	Large-scale national scheme reaching tens of millions of adolescents; low-cost INR 1 biodegradable pads; growing NGO and	Severe rural-urban and state-wise inequity; weak WASH infrastructure in many government schools; deep-rooted cultural taboo restricts open discussion

	ASHA-worker network; strong political attention since 2011	and product choice; disposal and environmental safety remain unresolved
South Korea	High baseline literacy and product availability; statutory menstrual leave since 2001; rapid, well-funded policy response once the issue reached public attention (2016-2026); centralised, technology-enabled distribution (vending machines)	Among the most expensive sanitary products in the OECD; welfare vouchers under-claimed (roughly 70% uptake among eligible youth); lingering stigma limits use of tampons/menstrual cups; free-pad programme is still a pilot, not yet nationwide law

6. Discussion

The comparison suggests that India and South Korea sit on opposite ends of a single access equation. India has real product-availability and infrastructure gaps layered on top of stigma; South Korea has largely solved availability but still struggles with affordability and a lighter, but persistent, layer of stigma. Neither country has yet solved for all three variables — availability, affordability, and acceptability — at once, and this is a useful lens for any country designing menstrual health policy: a scheme that fixes only one variable will plateau.

From a clinical standpoint, the Indian data on school absenteeism and dropout is the more urgent finding, because it compounds into long-term effects on girls' education, age at marriage, and economic independence — outcomes that a purely product-subsidy scheme cannot fix on its own. The Korean case is a useful counter-example precisely because it shows that even a country with strong WASH infrastructure and no absenteeism crisis can still have a period-poverty problem driven entirely by cost and market structure. Policymakers in India could draw on Korea's rapid, centrally funded distribution model (vending machines in public facilities) once infrastructural basics are secured, while Korea's government might look at India's ASHA community-health-worker network as a model for last-mile education, not just distribution.

A limitation of this paper is that much of the Korean data reflects a policy that is, as of writing, still at the pilot stage; its national rollout and long-term impact cannot yet be evaluated. Similarly, India's state-wise figures are drawn from a single national survey round and may understate more recent local improvements or setbacks.

7. Conclusion

Comparing India and South Korea shows that menstrual health is not a problem that resolves itself with rising national income. India's challenge remains fundamentally one of physical and infrastructural access, worsened by deep cultural stigma, while South Korea's is a market and affordability problem operating alongside a subtler, but real, cultural silence. Both countries have made genuine policy progress in the last fifteen years, but both also illustrate that progress tends to arrive in response to a crisis — a scandal, a survey, an activist report — rather than as steady, anticipatory planning. As a future clinician, my own takeaway is that menstrual health has to be treated as core public health infrastructure, not an afterthought bolted onto adolescent health programmes, and that closing the 'last mile' — the actual toilet, the actual

vending machine, the actual comfort to ask for help — matters just as much as the national policy announcement.

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