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Agenda setting and framing of gender-based violence in Nepal: how it became a health issue

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Abstract (300)

Gender-based violence (GBV) has been addressed as a policy issue in Nepal since the mid 1990's, yet it was only in 2010 that Nepal developed a legal and policy framework to combat GBV. This paper draws on the concepts of agenda setting and framing to analyse the historical processes by which GBV became legitimised as a health policy issue in Nepal and explored factors that facilitated and constrained the opening and closing of windows of opportunity. The results presented are based on a document analysis of the policy and regulatory framework around GBV in Nepal. A content analysis was undertaken. Agenda setting for GBV policies in Nepal evolved over many years and was characterised by the interplay of political context factors, actors and multiple frames. The way the issue was depicted at different times and by different actors played a key role in the delay in bringing health onto the policy agenda. Women's groups and less powerful Ministries developed gender equity and development frames, but it was only when the more powerful human rights frame was promoted by the country's new Constitution and the Office of the Prime Minister that legislation on GBV was achieved and a Domestic Violence Bill was adopted, followed by a National Plan of Action. This eventually enabled the health frame to converge around the development of implementation policies that incorporated health service-responses. Our explicit incorporation of framing within the Kindgon model has illustrated how important it is for understanding the emergence of policy issues, and the subsequent debates about their resolution. The framing of a policy problem by certain policy actors, affects the development of each of the three policy streams, and may facilitate or constrain their convergence. The concept of framing therefore lends an additional depth of understanding to the Kindgon agenda setting model.

Introduction

Gender-based violence (GBV) is a serious human rights abuse and a global public health concern. Intimate partner violence (often referred to as domestic violence) is among the most common forms of GBV (World Health Organisation et al., 2013). Despite substantial evidence on the health consequences of GBV globally, the health sector has been slow to recognise GBV as a legitimate public health problem and identify its role in addressing the issue (García-Moreno et al., 2014, World Health Organization, 2013). Several challenges exist: GBV is excluded from many national health policies or budgets; many national GBV plans do not engage with health care issues (García-Moreno et al., 2014). In some countries, GBV is seen as a low priority issue given limited health budgets (Colombini et al., 2012, Jayasundere, August 2009). Although global guidelines on GBV (World Health Organization, 2013) state the importance of the health sector within a multi-sectoral approach to GBV, little guidance is given on policy, leadership and governance issues for integration of GBV into the health sector.

Similarly, much research on GBV has focused on the effectiveness of health interventions and their implementation within health care settings (García-Moreno et al., 2014), with little attention given to understanding health policy formulation, agenda-setting, or how GBV issues are identified and legitimised in policy (Colombini et al., 2011). Yet, both the nature and extent of service delivery is significantly affected by the legal and policy framework for GBV in which they occur. For example, in Malaysia, a high-level policy to create hospital-based *One Stop Crisis Centres* (promoted by influential women's groups and senior medical staff) legitimized ongoing pilot initiatives and facilitated their scale-up nationwide (Colombini et al., 2011, Colombini et al., 2012). This study is a contribution to filling the gap in understanding how GBV became legitimised as a health policy issue and provides a case-study of the policy responses in Nepal. More broadly, given the paucity of published resources around GBV health policy responses, this case study can become an example for other LMICs countries that are (or intend to) embarking on prioritising GBV as a public health issue, and could offer lessons learned around the process.

We also explore elements that facilitated and constrained the opening and closing of windows of opportunities in Nepal, and what eventually led to a policy window allowing the ascendance of GBV to become a national priority for health policy development. Our article makes not just an empirical contribution to the case in question, but a theoretical contribution to the study of policy-making and agenda setting in low and middle income settings. In particular, the study shows the additional insights which can be derived by incorporating the concept of policy framing within the Kindgon agenda setting model. The approach we develop enhances our understanding of emerging policy issues, and their solutions, and mare be more widely applied to policy analysis in LMICs and beyond.

The theoretical framework

Agenda setting is the process (or processes) by which an issue is brought to the attention of policy-makers (Rogers et al., 1993), and it is the first stage of the policy development process (Sabatier, 2007, Buse et al., 2005). Several theoretical approaches of agenda setting exist (Hall, 1975, Shiffman, 2007, Kingdon, 1984). This article draws on Kingdon's model of agenda setting and the concepts of "framing" derived from the field of interpretive policy studies. Kingdon's approach (Kingdon, 1984) is the most appropriate for our analysis because it helps understand what factors affect the opening of opportunities for political prioritisation of a health concern. The framework describes policy development as the result of three distinct and continuous 'streams' of activities or processes. The *problem stream* refers to the characteristics of problems and their perception as public matters necessitating government action. Officials and policy-makers learn about these issues through statistical indicators, policy reports, feedback from current programmes and pressure from advocacy groups and stakeholders. The *policy stream* comprises a set of possible analyses of problems and associated policy solutions proposed, for example, by researchers, politicians, experts, NGOs, along with debates about these problems and potential responses. The *politics stream* consists of political events such as changes in government, elections, and public campaigns by NGOs.

Only when these three largely independent (but simultaneous) streams combine or intersect forming *policy windows,* can new issues enter the agenda and policy change occur. Actors who promote

specific policy solutions – *policy entrepreneurs*– may be located inside or outside Government. They may be visible, publicly advocating for a problem, or acting behind the scenes (e.g. experts in their field developing potential solutions to policy problems); they impact greatly on the likelihood that a problem would ascend to national prominence (Kingdon, 1984, Kingdon, 2010).

Framing theory has been applied to a number of fields in the social sciences as diverse as psychology (Druckman, 2001), behavioral economics (Tversky and Kahneman, 1987), media and communications studies (Semetko and Valkenburg, 2000) and public opinion research (Sniderman and Theriault, 2004). In the field of policy studies, Rein and Schoen (1994) set out a constructivist account of policy framing and its significance for the resolution of protracted policy controversies. Frames, they contend, are 'underlying structures of belief, perception and appreciation' on which distinct policy positions depend (Rein and Schön, 1994). Policy frames construct a particular view of social reality, defining both the political issues (and problems) at stake and the policy responses which follow from this framing of the problem. Each policy frame is underpinned by a set of institutional and meta-cultural frames. Meta-cultural frames can be thought of as a shared set of values, which a particular society holds. They are context specific and are thus shaped by the prevailing hierarchies and power relations in a given policy setting. Political actors can attempt to frame issues in ways amenable to their interests and policy objectives, promoting a particular understanding of the issue at hand (Rein and Schön, 1994, Snow and Benford, 1992, Schön and Rein, 1996). Crucially the framing of an issue and its solution by a given actor may shift over time.

Political controversies emerge where mutually incompatible policy frames compete to define a given issue and to dictate the policy responses to which it gives rise. In other words, political contestation becomes a contest between different systems of meaning (Rein and Schön, 1994, Edelman, 1988). From this perspective, policy analysis requires an appreciation of the key terms in which policy debates are couched and the assumptions on which they are based. The specific framing of an issue is a key factor in determining whether it enters the policy agenda, and under what circumstances it does so. We thus understand attempts by actors to frame policy debates as political acts designed to shape

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the terrain on which these debates are conducted and the terms in which they are couched an integral

part of the political process.

The concept of framing adds additional insights to the Kingdon model of policy analysis. Although

the framing of ideas around a specific problem is not explicitly discussed by Kingdon, ideas and the

presentation of issues are considered important elements by other agenda setting models applied to

global health (Shiffman, 2007, Geneau et al., 2010). We incorporate the concept of framing theory

into our analysis to understand the way the key actors (e.g. Government Ministries and NGOs in field

of health policy) understand, describe and present (i.e. how they "frame") the problem of GBV and

the potential solutions to this (Jerit, 2008), in other words into Kingdon's *problem and policy streams*.

In addition, we argue that framing is of key importance in understanding the dynamics of Kingdon's

politics stream, which he sees as functioning quite separately from the other two streams.

Incorporating concepts of framing within this model allows a more nuanced approach to

understanding the dynamics of the policy process. Framing theory helps to identify how issue framing

can shape event in the politics stream, for example the way in which particular frames may facilitate

or constrain the opening of windows of opportunity for policy change.

The Nepalese Context

Socio-cultural, economic and religious factors allied to traditionally defined roles and responsibilities

between Nepali men and women have led to an institutional system that treats women inequitably

(UNFPA, 2008). These factors together with gender norms have driven the context of GBV in the

country. Moreover, the years of political conflict increased the risk of violence in the country,

particularly through rape, trafficking, sexual slavery, and displacement (Dhakal, 2008). GBV is highly

prevalent in Nepal (Family Health Division of the Department of Health Services and South Asian

Institute for Policy Analysis and Leadership, 2012, SAATHI and the Asia Foundation, 1997 ,

Ministry of Health and Population (MOHP) [Nepal] et al., March 2012, UNFPA et al., 2008), with

intimate partner violence (IPV) – often also referred to as domestic violence (DV) – among the most

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common form of GBV. In Nepal, DV is defined by law "as any form of physical, mental, sexual, or economic harm perpetrated by one person on another with whom he or she has a family relationship, including acts of reprimand or emotional harm" (Ministry of Law and Justice (MOLJ) [Nepal], 2009). The Nepalese DHS found that 22% of women of reproductive age have experienced physical violence at least once since age 15, and 12% of women reported having experienced sexual violence at least once in their lifetime (Ministry of Health and Population (MOHP) [Nepal] et al., March 2012). A more recent study on Women's Empowerment and Spousal Violence in Relation to Health Outcomes in Nepal estimated that 28% of ever-married women have experienced physical and/or sexual violence from their husband (Tuladhar et al., 2013). Other studies also indicate the high prevalence of partner violence within the Nepali society (Informal Sector Service Center (INSEC), 2012, SAATHI and UNFPA, 2008, Lamichhane et al., 2011, UNFPA et al., 2008). Moreover, the Maternal Mortality and Morbidity Studies of 1998 (Pathak et al., 1998) and 2008/09 (Suvedi et al., 2009) have reported that Nepali women of reproductive age have high suicide rates, many of which are attributed to domestic violence by spouse or family-members (Joshi, 2009, Pradhan et al., July 2011). The Nepalese DHS data shows domestic violence during pregnancy is also widespread, ranging from 2% (among women with higher levels of education) to 10% (women who are divorced, separated or widowed) (Ministry of Health and Population (MOHP) [Nepal] et al., March 2012). Other small-scale studies also indicate the prevalence of domestic violence during pregnancy among Nepali women (Chaudhary et al., 2010, Deuba and Rana, 2005).

GBV has been addressed as a policy issue in Nepal since the mid 1990's, yet it was only in 2010 that Nepal developed an overarching legal and policy framework to combat GBV and discrimination towards women, and adopted a National Plan of Action against GBV that incorporated a health sector response (Government of Nepal, 2009). This article will explore what events influenced these delayed actions and, in particular, how GBV has been 'framed' over time.

Methods

The results presented in this article are based on a document analysis of the policy and regulatory framework around GBV in Nepal. The document review was conducted of documents published and/or adopted between 1998 to present. National and regional public health documents containing any relevant information on GBV were reviewed, specifically: domestic violence laws, national and regional policies, national health plans, health protocols, health reports, NGO and donors reports, national guidelines, and training manuals.

Electronic searches were conducted in Popline, Google and specific websites of Nepalese government agencies, NGOs and other international donors. When not electronically available, identified policies and documents were collected and translated (when needed) by the local partners. No interviews were conducted with key informants, though local partners asked key informants from women' NGOs and from Department of Health (Family Health Division) for key policy documents on GBV.

Once all relevant documents were collected, a qualitative content analysis (Graneheim and Lundman, 2004) was undertaken. Over 40 documents were analysed, including legal ones (8), national policies and plans (19), training manuals and protocols (5), policy statements (3), national and donor reports (9). Moreover, over 40 published articles were used to help understand the context of GBV. Textual data was systematically coded by the first author and key themes identified in order to understand meanings of specific concepts and patterns. The informational content of the data was categorised deductively, using pre-conceived themes elaborated at the beginning of the analysis. These included, among others, the: conceptualisation of GBV as a health issue; enabling policy and regulatory environment around GBV and health; rationale for integration of GBV into health sector; and the rationale for adoption of key health policies around GBV. Direct explanations of some contextual factors and political events were not always possible with the available documentation data. However, to reduce such limitation and enhance our understanding, contextual insights and tacit knowledge of the two local researchers working with us on the document analysis was also was called upon to help clarify some of the historical events and the context of the GBV.

Results: Development of GBV policies in Nepal 1995-2013

Table 1 illustrates the various stages of the historical context.

Growing awareness of GBV as a women's rights and security issue in a rapidly changing political context (1997-2002)

In the 1990s a range of *politics stream* events contributed to the recognition of gender-based violence (GBV) as critical issue for Nepal's Government to address; in particular the country was moving away from absolute monarchy towards multi-party democracy bringing with it widening awareness of international commitments towards gender equality and facilitating the rise of influential national women's advocacy organisations (Bhadra, January 2001, Thapa, 2004).

Following the Fourth World Conference on Women in Beijing in 1995, the initial rationale for the Government to consider GBV was that it was seen as an obstacle to economic and social development, and was subsequently framed as a major development issue to be addressed in order to attain gender equality. Key high-level policy documents (National Planning Commission and His Majesty's Government, 1998, National Planning Commission and His Majesty's Government, March 2002, Ministry of Women & Social Welfare, 1997) mentioned – though briefly – the integration of women into the mainstream development of Nepal through "gradually eliminating violence, exploitation, injustice and atrocities being committed against women" (National Planning Commission and His Majesty's Government, 1998). At this early stage only one policy document mentioned any role for the health sector (through counselling services) (National Planning Commission and His Majesty's Government, March 2002).

Women's NGOs contributed significantly to help place GBV onto the national policy agenda by using advocacy campaigns and lobbying the Ministry of Women and Social Welfare for legal changes. They produced evidence based studies to influence the Government's position on GBV. For example, a study on GBV and girls in Nepal by SAATHI –- the first Nepali NGO which worked on GBV since

1992 – highlighted widespread prevalence of GBV and showed how it impeded the progress of women and the development of society (SAATHI and the Asia Foundation, 1997). This was strategically published soon after the Nepali Government's National Plan on Gender in 1997 confirmed its commitment to women's empowerment (Ministry of Women & Social Welfare, 1997).

Although the issue of gender-based violence had been in the *problem stream* for some time by the late 1990s, no political action had been taken to develop a law or a specific policy. Contextual and political *politics stream* factors – in particular the fact that Nepal was undergoing a decade of armed conflict (1996-2006) – deeply affected the conceptions of GBV during this time. Initially, Government's focus was on women's security, safety and rehabilitation and its efforts to prevent GBV (including rape, sexual slavery and trafficking) concentrated on the development of women's police cells and referral to NGOs for rehabilitation support (Ministry of Women Children and Social Welfare 1999); there was little recognition of the negative health impact of violence on women's lives or the role of the health sector in preventing GBV, despite the publication of a study by SAATHI on its psychosocial impacts on women and girls (Deuba and Rana, 2001) and the claims from rights-based organisations raising the mental health consequences of rape and sexual violence affecting women and girls during the political conflict (Justice, December 2010).

Recognition of GBV as a health issue: entrepreneurship and missed opportunities by the Ministry of Health (2002-2006)

A parallel process of defining GBV as a health problem started in the early 2000s, initially through studies focusing on suicides and psycho-social impacts of GBV on women and girls (Deuba and Rana, 2001, Pathak et al., 1998), especially following the conflict, and later on through advocacy on maternal health. Although difficult to determine exactly what triggered this process, both international events and domestic ones influenced it. At international level, the World Health Organisation released its first *World Report on Violence and Health* where it classified gender-based violence as a global public health problem (Krug et al., 2002). Nationally, the Nepalese safe motherhood movement, supported by international donors (as a major MDG target), was a catalyst for securing recognition by

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the Government that GBV was a public health concern that needed to be addressed (Engel et al., 2013). It was argued that women's empowerment and the elimination of GBV were important issues for improving women's health status (especially in relation to psychological issues) and reducing maternal mortality. In particular, the National Safe Motherhood Long Term Plan (NSMLTP) (2002-2017), adopted in 2002 focusing on increasing access to maternal health services, gave 'policy visibility' to GBV as a health concern. Echoing the latent national interest in GBV (National Planning Commission and His Majesty's Government, March 2002), the NSMLTP called for the MoHP to develop protocols and specific mechanisms in district hospitals to deal with *battered women*, and to sensitise professionals from multiple sectors and levels, on GBV (Government of Nepal and Family Health Division of the Department of Health Services, 2002). The *problem solution* proposed by the Plan (and the MoHP) was the establishment of service delivery systems in hospitals and health facilities to provide support to abused women. A critical assumption for the implementation of these activities was that a Domestic Violence (DV) Bill would be adopted by the end of 2003 to provide a legal framework and mandate for service-provision; this was not achieved (Bhadra, May 2004) and a health policy change around GBV was prevented.

In fact there had been several attempts to pass a DV Bill by this time, primarily led by SAATHI, together with the Ministry of Women, Children & Social Welfare (MWCSW). In 2001 the MWCSW forwarded two bills for combating gender-based violence: the Bill on Domestic Violence and the Bill on Human Trafficking Control. They were both stopped when the Parliament was dissolved in May 2002 (Bhadra, May 2004). Moreover, the MWCSW was not a strong Ministry and the energies of women's reform groups were concentrated more on liberalising abortion, which was within their grasp at that time, with its tangible impact on maternal mortality and morbidity (Thapa, 2004). Thus although the *problem stream* defining GBV as health concern and the *policy solution* (certain women's groups and Ministry of Women pushing for a DV law and establishment of services) coincided in the late 1990s/early 2000s they did not meet with the *political will* at the time, which was more focused on maternal mortality reduction and safe abortion.

Having secured recognition of GBV as a serious issue for women's (and therefore national) development by the late 1990s, but not achieving the necessary political will for policy change, the next few years were crucial for creating the evidence base to link GBV to sexual and reproductive health (particularly with safe motherhood which had emerged as a national concern) thus consolidating the framing of GBV as a *health* policy problem. Research was conducted by women's NGOs and academics to establish the evidence base for the legitimisation of violence as a maternal health issue thereby linking GBV to a current national priority. In 2005, a study on *Linkages between Domestic Violence and Pregnancy* revealed that IPV was reported to result in high maternal death, preterm birth and high prenatal mortality, abortion, miscarriage and impacted on long-term health of women. Moreover, the survey showed that one third of women interviewed experienced physical abuse during pregnancy (Deuba and Rana, 2005). A smaller study conducted in 2007 in a Kathmandu Maternity hospital showed that 33% of pregnant women attending the ANC services were facing regular violence and that very few sought help unless they were physically injured (Chaudhary et al., 2010).

Following these public studies, the Ministry of Health seized the opportunity to develop two guidelines for service providers to address GBV (Family Health Division of the Ministry of Health, 2005b, Family Health Division of the Ministry of Health, 2005a) but missed the opportunity to include GBV into the policy and awareness campaigns around safe motherhood which could have reinvigorated progress on a national GBV health policy. It is likely that other more urgent health concerns around reaching the MDG goal 5 to improve maternal health (and the role of decriminalising abortion in this) were seen more important by the MoHP and other policy makers. For example, several incentives schemes were introduced nationally to support women delivering in public hospitals to reduce maternal mortality (Bhandari et al., 2011, Witter et al., 2011, Ministry of Health and Population, 2010). No mention was made to GBV in these policies – a missed opportunity, but there may have been a fear that it would dilute the focus or commitment to reducing maternal mortality.

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The intention of the Government to connect GBV and health is less clear in its revised *National Safe Motherhood and Neonatal Health-Long Term Plan* (2006-2017) (Ministry of Health and Population and the Department of Health Services, 2006), in which GBV is barely mentioned. Significantly, the revised Plan stated that rights-based approaches would be used to reduce gender-based violence, but without explanation of these. This represents a shift in the way the Government 'framed' GBV as a human rights issue and is probably attributable to the desire to align high-level policy documents more explicitly to the human rights focus of the newly adopted Constitution (Government of Nepal, 21 November 2006) – violence as a human rights, rather than a health, issue was seen to have more traction: it was this reframing that eventually led to a window of opportunity.

Emerging Windows of Opportunity: regeneration of political priority & recognition of health dimensions of GBV (2006-2008)

Windows of opportunity often emerge quickly with a clear triggering event, however in Nepal they appear to have emerged incrementally after a gradual change in the political environment and the establishing of a groundwork legal framework within which it became possible to act on GBV through a health entry point. Changes in the *political stream* occurred relatively fast in Nepal with the creation of a new constitutional democracy (Government of Nepal, 21 November 2006) and the end of the ancient monarchic system in the early 1990s. As Nepal became party to intergovernmental negotiations and treaties on gender and rights, there were opportunities for GBV to become a high national issue as the government sought to respond to gender discrimination and the promotion of human rights. In particular, these political changes influenced a paradigm shift in policymaking from a welfare to a rights-based approach (in the socio-economic sector) greatly influencing the promotion of women's empowerment (Government of Nepal and United Nations Country Team of Nepal, 2013), and leading to revision of legal acts to promote gender equality (Government of Nepal and Nepal Law Commission, 2006). The new Constitution, explicitly prohibiting physical, mental or any other forms of GBV, provided an important framework within which other actions could legitimately be taken (Government of Nepal, 21 November 2006). The Government's 3-year Interim Plan, a high-level policy document, went further calling for the creation of a legal framework to address GBV

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(Commission, December 2007). Under the section on Health (under the Safe Motherhood and New-Born Child Health Programme), it called for a study to document the numerous injuries caused to women by violent acts.

Despite the pushes to promote gender equality, and the new Constitution prohibiting GBV, the MWCSW's second attempt to pass a Bill on GBV failed again in 2006. The reasons for this are unclear, but one explanation could be that the country's energies were more occupied with its reconstruction and rehabilitation after the decade of conflict. Moreover, the influential women's groups were focused on advocating for a Human Trafficking Act, which was subsequently adopted in 2007 (Government of Nepal and Nepal Law Commission, 2007). Another explanation could be that until domestic violence was criminalised, the Ministry of Health would not consider its role around an issue that was not traditionally understood as a health one.

Recognition of GBV as a national priority (2009-2014)

In 2009, a number of factors converged to accelerate action on the elimination of GBV in Nepal and contributed to the convergence of the three streams, providing a genuine window of opportunity to consider health as an entry point for tackling GBV. First, in its Three Year Plan (2010-13), the Nepal Planning Commission reiterated the Government's commitment to reduce GBV, calling for campaigns to prevent and control it (National Planning Commission (NPC), 2011). A second element was the strong advocacy coalition of women's NGOs who once again turned their attention back to GBV and, together with the MWCSW, led a Pressure Group to push for Domestic Violence (DV) Legislation which was subsequently adopted (SAATHI). The DV Bill was a critical step in consolidating the necessary legal framework for acting on GBV, detailing specific measures to control violence, making such violence punishable, and providing protection to the victims (Ministry of Law and Justice (MOLJ) [Nepal], 2009). Critically, it also underlined the need for development and implementation of plans and services offering a major opportunity to incorporate health sector implementation.

This opportunity was not lost on the health stakeholders who began more concerted action. Possibly influenced by a global call to end GBV (women, 2008) and to generate evidence for action (World Helath Organisation/London School of Hygiene and Tropical Medicine, 2010), international donors and UN agencies, including Dfid and UNFPA, commissioned the MoHP, local NGOs, research and consultancy groups to conducted studies to document the pervasiveness of GBV and its health consequences (University College London (UCL) and Centre for Research on Environment, 2013, Government of Nepal, November 2012, Tuladhar et al., 2013, Government of Nepal (GoN) et al., 2012, Family Health Division of the Department of Health Services and South Asian Institute for Policy Analysis and Leadership, 2012, Lamichhane et al., 2011, The Asia Foundation and SAATHI, 2010, Puri et al., 2010, Adhikari and Tamang, 2010, UNFPA et al., 2008). These documents contributed to building the evidence base to legitimise GBV as a public health *problem* to be taken seriously by the Government of Nepal under its new framework. Supported by this emerging evidence of the health consequences of GBV in Nepal, the MoHP was able to take advantage of the shift in focus of Government activities that occurred after the DV Bill was adopted, to move beyond advocacy for legal change to focus on strategies and plans for service implementation as a viable *solution* to address the health dimensions of GBV. Thus the role of MoHP in addressing GBV became more dominant, especially in relation to service provision and training of health staff. The Ministry of Health openly stated that GBV affected women's health (Ministry of Health and Population, December 2009) and should be an integral component of healthcare provision that included violence-related mental health services (Ministry of Health and Population (MOHP), 2010b).

The final critical event that consolidated a window of opportunity occurred on November 2009, when the former Prime Minister directed the Office of the Prime Minister and Council of Ministers to take concrete steps to develop an action plan to end GBV and declared the year 2010 as the "Year against gender-based violence (GBV)". A national public awareness campaign was launched and GBV declared as a cross-party priority (Thapa Shrestha, December 2013). Subsequently, a Prime Ministerial Unit (Gender Empowerment and Coordination Unit) to address GBV, was established (University College London (UCL) and Centre for Research on Environment, 2013), and an Inter-

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Ministerial Committee (including the Ministry of Health) on GBV was created (in consultation with NGOs, donors, private sectors and the media) charged with drafting the Government Plan of Action for the '*Year against GBV*'. The adopted *National Plan of Action against GBV* (2010) (Government of Nepal, 2009) focused on protection, prosecution and prevention, but also explicitly recognized the need for a multi-sector response (including health) to address GBV. This Plan finally legitimised the GBV as a national priority issue with health as an integral dimension.

A consolidated role for MoHP in GBV-response

The National Plan recognised the role of MoHP to address GBV giving it the official responsibility for establishing services. MoHP became the main executive body responsible for implementing Clause 3 of the 'National Action Plan 2010 against Gender-Based Violence', which called for the provision of integrated services to survivors of gender-based violence by establishing hospital-based one-stop crisis management centres (OCMCs). The MoHP developed a Manual providing guidance on how OCMCs should function, detailing the role and responsibilities of each stakeholder (Ministry of Health and Population (MOHP), 2010a), and establishing OCMCs in a phased manner (Health and Education Advice and Research Team (HEART), 15 February 2013). Since 2011, 15 OCMCs were established (Ministry of Health and Population et al., October 2013).

A year later the detailed first year Plan was followed by a 5-year Plan – *National Strategy and Action Plan on Gender Empowerment and End of Gender-based Violence* (Government of Nepal and Office of Prime Minister and Council of Ministers, July/August, 2012)- establishing provisions to address institutional capacity to respond to GBV within health services (University College London (UCL) and Centre for Research on Environment, 2013). The Ministry of Health plays a crucial part in the implementation of this Plan, being a key member of the Advisory Committee and Inter-Ministerial Committees created to monitor the implementation of the GBV Plan. Ongoing government commitment to tackling GBV is manifest in its latest MDG Progress Report, which calls for a policy of zero tolerance towards GBV and the development of a GBV indicator to monitor progress (Government of Nepal and United Nations Country Team of Nepal, 2013). The MoHP has also

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reiterated its commitment to reduce GBV in a draft report on major health policy issues, which states that spousal violence can lead to serious health implications for women and their children and calls for a multi-sectoral approach to reduce GBV (Ministry of Health and Population, 2014). However, despite a long section on ANC and RH the report failed to mention GBV and its threat to pregnancy outcomes. Nevertheless, recent discussions around the new Reproductive Health Policy seem to indicate that GBV will be among its components (the ninth) [*from personal discussion with key informant from SRH Organisation based in Kathmandu*].

Discussion

This paper draws on the concepts of agenda setting and framing to analyse the historical processes by which GBV became legitimised as a health policy issue in Nepal and explored factors that facilitated and constrained the opening and closing of windows of opportunity. This marrying of two theoretical bodies of work has revealed many insights that further our understanding of factors influencing agenda setting and help to refine existing theories. First, our analysis of the different frames used by different actors at different times reveals that there may be parallel sets of streams based on different frames that may eventually converge. Second, we find that the politics stream should not be viewed as a disconnected factor at macro level - but as an ever-changing political context operating at macro, meso and micro levels. Furthermore, it can profoundly affect issue framing – and therefore the perceptions of policy problems and solutions. Third, the ability of entrepreneurs to act is constrained or facilitated by their reading of the political context, their alignment with powerful actors and their strategic use of framing.

Multiple frames, parallel policy streams and convergence

Previous studies from high income countries have shown that the way and form in which particular problems are conceived and framed affects how they will be tackled by policy-makers (Cobb and Elder, 1983, Entman, 1993, Jerit, 2008). Our analysis shows that the existence of multiple frames around the conception of GBV may lead to parallel policy streams. Over the years, GBV was

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recognised as a problem in Nepal, but how it was framed varied according to the actors' interests, their understanding of the political context, and their consequent perceptions of both the type of problem and its solution. The Government of Nepal initially adopted a gender equality and development frame, in line with the international women's movement and the international push for poverty reduction strategies. The Ministry of Women and Social Welfare joined forces with influential women's NGOs framed the issue of GBV in terms of a gender equality and empowerment approach. This was in keeping with the national position on the importance of gender equality for advancing the development of the country. Moreover, GBV was not successfully connected to the health policy agenda (or a health frame) which was focused instead on liberalising abortion laws and reducing maternal mortality. A lack of political will, together with the end of Parliamentary cycle, thwarted early attempts at legislation on GBV. After a new Constitution was agreed, following a prolonged period of armed conflict, the Government adopted a human rights lens to addressing GBV in alignment with the core principles of the Constitution. This gave GBV a higher political profile and resulted in legislative efforts to address it, but not as a health issue.

Nevertheless, this powerful non-health framing (promoted by influential women's groups and accepted by the Prime Minister's Office) facilitated the convergence of the three streams – problem (GBV as a human rights issue), solution (legislation to criminalise) and politics (New Constitution upholding rights of all citizens) – which created a window for policy change that secured the linkage of health and GBV. Once again the influential women's groups turned their attention back to GBV legislation and secured the Domestic Violence Bill, consolidating the national legal framework for GBV and, critically, paving the way for multi-sector implementation plans. The international donors funded evidence-gathering to support the MoHP, which finally attempted to align its arguments about the problem of GBV and its potential solution to the Safe Motherhood Movement. This showed that GBV had significant maternal (and other) health consequences and thus any solution to the problem must include health services. This aligned with the requirement to develop plans for service-implementation in the Joint Plan and the MoHP was belatedly able to secure its position as a key

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implementer, though it continues to miss opportunities to align health-sector GBV-responses to an ANC entry point.

Politics stream and fluid political contexts

In Nepal numerous *politics stream* factors at national and international levels contributed to the increasing political prioritisation of GBV. First, key political events had an impact on the rise of GBV as a national concern. The democratisation process exposed Nepal to intergovernmental negotiations and treaties on rights and development, including the need for gender-equity and reduction of discrimination – including violence – against women. This lead to the emergence of a gender and development frame for ending GBV. The ongoing civil war and its final resolution resulted in a necessary focus on security and reconstruction promoting a security-focussed response to GBV. The influential MDG-aligned *Safe Motherhood Campaign* was an early focus of women's groups active on GBV issues in Nepal, but they quickly abandoned their health focus in favour of the more potent legal, rights-based frame that aligned with the programme of constitutional legal change. It was only after this constitutional legal change was consolidated (resulting in the adoption of the DV Bill), and the international donors came in to support the MoHP by providing the evidence to link GBV to health, that the opportunity was seized to align the health frame with the calls for a service-implementation response to GBV. The Declaration of the Year to end GBV and the high-level actions by the Prime Minister were critical components in ensuring the *Joint Plan* finally incorporated health. Thus these big political events affected the 'framing' of the issue of GBV and at different times created, and closed off, windows of opportunity for policy change.

Political Entrepreneurship

The convergence of the three policy streams alone does not secure political will. Policy windows remain open for only a short time before the alignment passes and policy entrepreneurs are crucial to seize the moment and act to achieve policy change (Kingdon, 2003, Kingdon, 1984).

Initially in Nepal the Ministry of Health and Population was not an entrepreneur. The complex multi-sectoral nature of GBV (which is both a health and social problem and can be addressed as a human

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rights and criminal justice issue) makes it difficult for a single Ministry to tackle alone. Yet whilst the

MoHP began to engage with GBV from the early 2000s, it failed to coordinate or collaborate with key

policy actors in other sectors or to strategically align itself with the powerful human-rights frame

promoted by women's groups and taken up by the Government which provided a window of

opportunity for health policy change. One explanation is that the MoHP never had a policy

'champion' who could push forward its health-frame and show that integrating GBV services within

health care settings should be part of the national response. Having such a champion within the most

important tertiary hospital in the country was a key ingredient for Malaysia's successful adoption of

national policy guidance on the integration of GBV services within hospitals (Colombini et al., 2011).

In Nepal, the presence of such a 'champion' could have led to a much earlier window of opportunity

for MoHP.

Nevertheless, once the Joint Plan was agreed, the MoHP recognised their opportunity and partnered

with international donors and agencies (especially UNFPA and DFID) to create an evidence base for

integrating GBV services into the health sector, developing guidelines for health service responses

and training for health professionals, with a focus on OCMCs. Although an important step, the MoHP

missed an opportunity to integrate GBV within other health services, particularly safe motherhood (a

government priority since the late 1990s) (Bhandari et al., 2011, Suvedi et al., 2009, Witter et al.,

2011, Government of Nepal, 2005), and ANC, recognized globally as an entry point for preventing

and addressing the health consequences of GBV (García-Moreno et al., 2014, Miller et al., 2010). The

MoHP could have promoted these as additional entry points alongside the further development of the

OCMCs, as happened in Bangladesh (UNFPA Asia Pacific Office, 2010). Another window may be

emerging since the current revision of the New RH Strategy contains references to GBV - the

opportunity should not be missed a second time to develop an ANC/SRH response.

Conclusions

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Nepal represents a very good example of a country that was able to move from a narrow view of GBV as a criminal justice issue, towards a public health approach, framing GBV as a health issue. In contrast, less progressive countries continue to ignore the health consequences of GBV. Understanding how this change occurred in Nepal could provide important lessons for other countries in the region that want to broaden the conceptualization of GBV policies to encompass the health consequences.

Framing is recognised as an important component of agenda setting. Our explicit incorporation of it within the Kindgon model of policy streams and entrepreneurs has illustrated how important it is for understanding the emergence of policy issues, and the subsequent debates about their resolution. The framing of a policy problem by certain policy actors affects the development of each of the three policy streams, and may facilitate or constrain their convergence. This may lead to windows of opportunity being opened or closed, and whether these windows result in effective policy change or not. The concept of framing therefore lends an additional depth of understanding to the Kindgon model agenda setting model.

In particular, the study contribute to increase the limited literature on GBV agenda setting in order to comprehend the factors influencing prioritization of GBV and the consequent development of the legal and policy environment which can inform other countries wishing to act on GBV as a health issue. Furthermore, these insights can be helpful for other countries who are embarking on a similar process to understand what shapes the formation of political will and the involvement of key stakeholders in the implementation of GBV services, since the actions of these actors have a direct impact on service-delivery, including why it has not so far been taken up within health settings.

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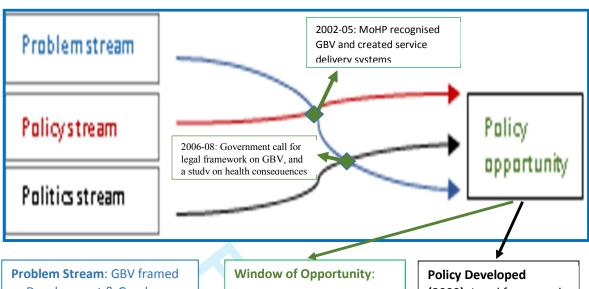UNFPA, INTERNATIONAL RESCUE COMMITTEE, SAATHI & WOMEN FOR HUMAN RIGHTS 2008. Situational analysis of gender-based violence in Surkhet and Dang districts, Nepal Kathmandu.

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Table 1: Changes over time in GBV Nepal context

Stage in time (year)	Key actors	Changes over time around GBV 'frames'	Health sector context	Broader contextual factors
1997-2002	• Government of Nepal • SAATHI (local NGO) and other women's groups • Ministry of Women and Social Welfare	• First recognition of GBV as major impediment to development and women's equality • First prevalence study on GBV	• No recognition of GBV as a health issue. Focus was on women's police cell (safety and security of women) and rehabilitation (through NGOs) • Only one study on GBV prevalence, but none on its health consequences	• Democratisation process leading to proliferation of women's NGOs • Nepal's adoption of principles of 1995 Beijing Conference • Government's commitment to women's empowerment and gender equality
2002-2005	• Ministry of Health and Population • Samanita (private consultancy group)	• Recognition of GBV as a public health concern, particularly for safe motherhood and women's health	• MoHP, through Safe Motherhood Plan, plans for creation of GBV service delivery systems in hospitals • MoHP developed a training Manual and a protocol for health staff on GBV service provision • First survey on linkages between IPV and pregnancy published, showing lack of training and knowledge among health providers (OBGYN, midwifes) around GBV	• Adoption of Abortion Law • Published research on linkages between GBV and maternal mortality and morbidity • National concern for maternal mortality and strong focus on reducing it

2006-2008	• Government of Nepal • MoHP • UNFPA	• Recognition of the right of women to be free from GBV acts, which are seen as punishable by law • Government call for legal framework around GBV, and a study on health consequences of GBV	• With the revised Safe Motherhood Plans (2006), MoHP shifted GBV focus from service implementation to primary prevention (community awareness) and rights-based approaches • Creation of Gender Equality and Social Inclusion Unit within MoHP	• Adoption of new Constitution (legitimising right to be free from GBV) • Legal revisions to promote gender equality • UNFPA study on Nepal Gender Equality recognising GBV as important element of SRH and calling for the integration of IPV in safe motherhood and other RH programmes
2009-2014	• Prime Minister Office • MoHP	• Recognition of GBV as a national priority needing concerted effort • Legitimisation of MoHP role in integrating GBV services into health sector	• Recognition of GBV as integral part of health service provision • MoHP as leading actor in health sector response to GBV with creation of 15 OCMCs in 2011	• Adoption of DV Law • Government declared Year against GBV • First National Plan of Action Against GBV • National Strategy and Action Plan on Gender Empowerment and to End Gender-based Violence • More studies published on GBV

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Figure 1 – Kingdon's Policy Streams Approach: applied to development of GBV Policy in Nepal

Problem Stream: GBV framed as Development & Gender Equity Issue; also as Public Health issue

Policy Stream: 1) Some studies on GBV and health; 2) MoHP develops protocols and training for GBV response.

Politics Stream: 1) Women's groups and less powerful Ministries promote development, and equity frames; 2) MoHP and international donors support health frame.

Window of Opportunity:

Change of Government (2006) led to new constitution enshrining a Human Rights approach for women and for GBV.

This facilitated the alignment of health frames and actors with implementation policies for GBV.

Policy Developed (2009): Legal framework established; Domestic Violence Bill & National Plan of Action incorporating health response.