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

Manuela Colombini1,*, Susannah H Mayhew1, Ben Hawkins1, Meera Bista2, Sunil Kumar Joshi2, Berit Schei3 and Charlotte Watts1 on Behalf of the ADVANCE Study Team

1Department of Global Health and Development, London School of Hygiene and Tropical Medicine, London, UK, 2Department of Community Medicine, Kathmandu Medical College and Teaching Hospital (KMC), Sinamangal, Kathmandu, Nepal, and 3Department of Public Health and General Practice, Faculty of Medicine, Norwegian University of Science and Technology, Trondheim, Norway

*Corresponding author. 15-17 Tavistock Place, London WC1H 9SH, UK. E-mail: manuela.colombini@lshtm.ac.uk

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Abstract

Gender-based violence (GBV) has been addressed as a policy issue in Nepal since the mid 1990s, yet it was only in 2010 that Nepal developed a legal and policy framework to combat GBV. This article draws on the concepts of agenda setting and framing to analyse the historical processes by which GBV became legitimized 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 characterized 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 Kindsgon 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 Kindsgon agenda setting model.

Key words: Agenda setting, framing, gender-based violence, Nepal, policy analysis
Key Messages

• In Nepal prominent ‘frames’ influenced by fluid political contexts have been used, sometimes in parallel, by different actors at different times to increase recognition of gender-based violence (GBV) as a national policy concern: gender equality and development, human rights, and public health.

• Windows of opportunity to prioritize GBV as a key health issue, opened when GBV was linked to prominent national concerns about human rights; high-level political support was announced; and a regulatory framework around GBV was established.

• The Ministry of Health and Population was unable to act as a policy entrepreneur and early windows of opportunity to address GBV as a health issue were missed; a current opportunity exists to address GBV through safe motherhood and ante-natal care—but has not yet been taken.

• The incorporation of framing theory within the Kingdon model has illustrated how important it is for understanding the emergence of policy issues, and the subsequent debates about their resolution.

Introduction

Gender-based violence (GBV) is a serious human rights abuse and a global public health concern. Intimate partner violence (IPV) (often referred to as domestic violence [DV]) is among the most common forms of GBV (World Health Organization et al. 2013). Despite substantial evidence on the health consequences of GBV globally, the health sector has been slow to recognize GBV as a legitimate public health problem and identify its role in addressing the issue (World Health Organization 2013; García-Moreno et al. 2014). 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 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 legitimized 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, 2012). This study is a contribution to filling the gap in understanding how GBV became legitimized 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 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 prioritization 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, e.g. 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, 2010) (Figure 1).

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 Schön (1994) set out a constructivist account of derived by incorporating the concept of policy framing within the Kingdon agenda setting model. The approach we develop enhances our understanding of emerging policy issues, and their solutions, and may be more widely applied to policy analysis in LMICs and beyond.
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 Schon 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 (Snow and Benford 1992; Rein and Schon 1994; Schon 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 (Edelman 1988; Rein and Schon 1994). 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 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 (Shiftman 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, e.g. the way in which particular frames may facilitate or constrain the opening of windows of opportunity for policy change.

The Nepalese context

Sociocultural, 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 (SAATHI and the Asia Foundation 1997; UNFPA et al. 2008; Family Health Division of the Department of Health Services and South Asian Institute for Policy Analysis and Leadership 2012; Ministry of Health and Population et al. 2012), with IPV—often also referred to as DV—among the most 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) 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] et al. 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.
analysis was also 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 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 organizations (Bhada 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 (Ministry of Women and Social Welfare 1997; National Planning Commission and His Majesty’s Government 1998, 2002) 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 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 and Social Welfare 1997).

Although the issue of GBV 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 organizations raising the mental health consequences of rape and sexual violence affecting women and girls during the political conflict (Justice 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 (Pathak et al. 1998; Deuba and Rana 2001), 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 Organization released its first ‘World Report on Violence and Health’ where it classified GBV as a global public health problem (Krug et al. 2002). Nationally, the Nepalese safe motherhood movement, supported by international donors (as a

<table>
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<th>Stage in time (year)</th>
<th>Key actors</th>
<th>Changes over time around GBV ‘frames’</th>
<th>Health sector context</th>
<th>Broader contextual factors</th>
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| 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 | • Democratization 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  
• 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 |
| 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, midwives) around GBV | • Adoption of new Constitution (legitimizing right to be free from GBV)  
• Legal revisions to promote gender equality  
• UNFPA study on Nepal Gender Equality recognizing GBV as important element of SRH and calling for the integration of IPV in safe motherhood and other RH programmes |
| 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 | |
| 2009-2014           | • Prime Minister Office  
• MoHP | • Recognition of GBV as a national priority needing concerted effort  
• Legitimization 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 GBV  
• More studies published on GBV |
major Millennium Development Goal target), was a catalyst for securing recognition by 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 (NNSMLTP) (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 2002), the NSMLTP called for the MoHP to develop protocols and specific mechanisms in district hospitals to deal with ‘battered women’, and to sensitize 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 DV Bill would be adopted by the end of 2003 to provide a legal framework and mandate for service provision; this was not achieved (Bhada 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 and Social Welfare (MWCSW). In 2001, the MWCSW forwarded two bills for combating GBV: the Bill on DV and the Bill on Human Trafficking Control. They were both stopped when the Parliament was dissolved in May 2002 (Bhada 2004). Moreover, the MWCSW was not a strong Ministry and the energies of women’s reform groups were concentrated more on liberalizing 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 legitimization of violence as a maternal health issue thereby linking GBV to a current national priority. In 2005, a study on ‘Linkages between DV and Pregnancy’ revealed that IPV was reported to result in high maternal death, preterm birth and high perinatal 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 Antenatal care 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 2005a,b) 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 de-criminalizing 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 (Ministry of Health and Population [MoHP] 2010; Bhandari et al. 2011; Witter et al. 2011). 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.

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 GBV, 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 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 and 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 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 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 (National Planning Commission 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 DV was criminalized, 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 3-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 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] 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 Organization/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 conduct studies to document the pervasiveness of GBV and its health consequences (UNFPA et al. 2008; Adhikari and Tamang 2010; Puri et al. 2010; The Asia Foundation and SAATHI 2010; Lamichhane et al. 2011; Family Health Division of the Department of Health Services and South Asian Institute for Policy Analysis and Leadership 2012; Government of Nepal 2012; Government of Nepal et al. 2012; Tuladhar et al. 2013; 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 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 Organization based in Kathmandu’].

Discussion

This article draws on the concepts of agenda setting and framing to analyse the historical processes by which GBV became legitimized as a national priority issue with health as an integral dimension.
a health policy issue in Nepal and explored factors that facilitated
and constrained the opening and closing of windows of opportunity
(see figure 1). 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 differ-
tent 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 recognized
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 so-
lution. 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 strat-
tegies. 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 liberalizing abortion laws and
reducing maternal mortality. A lack of political will, together with
the end of Parliamentary cycle, thwarted early attempts at legisla-
tion on GBV. After a new Constitution was agreed, following a pro-
longed 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 re-
sulted in legislative efforts to address it, but not as a health issue.

Nevertheless, this powerful non-health framing (promoted by in-
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 criminalize)
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 DV
Bill, consolidating the national legal framework for GBV and, critic-
ally, 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 imple-
menter, 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 interna-
tional levels contributed to the increasing political prioritization of
GBV. First, key political events had an impact on the rise of GBV as
a national concern. The democratization process exposed Nepal to
intergovernmental negotiations and treaties on rights and develop-
ment, including the need for gender-equality and reduction of discrim-
ination—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 fa-
vour 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 adop-
tion 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 incorpo-
rated health. Thus these big political events affected the ‘framing’ of
the issue of GBV and at different times created, and closed off, win-
dows 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 be-
fore the alignment passes and policy entrepreneurs are crucial to
seize the moment and act to achieve policy change (Kingdon 1984,
2003).

Initially in Nepal the MoHP was not an entrepreneur. The com-
plex multi-sectoral nature of GBV (which is both a health and social
problem and can be addressed as a human 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 recog-
nized 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 profes-
sionals, 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) (Government of Nepal 2005; Suvedi et al. 2009; Bhandari et al. 2011; Witter et al. 2011), and ANC, recognized globally as an entry point for preventing and addressing the health consequences of GBV (Miller et al. 2010; García-Moreno et al. 2014). 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 ANCSRH response.

Conclusions
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 recognized as an important component of agenda setting. Our explicit incorporation of it within the Kindgund 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 Kindgund 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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Conflict of interest statement
None declared.

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