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A diagonal and social protection plus approach to meet the challenges of the COVID-19 syndemic: cash transfers and intimate partner violence interventions in Latin America

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Latin America has been particularly hard hit by the COVID-19 syndemic, including the associated economic fallout that has threatened the livelihoods of most families. Social protection platforms and policies should have a crucial role in safeguarding individual and family wellbeing; however, the response has been insufficient to address the scale of the crisis. In this Viewpoint, we focus on two policy challenges of the COVID-19 syndemic: rapidly and effectively providing financial support to the many families that lost livelihoods, and responding to and mitigating the increased risk of intimate partner violence (IPV). We argue that building programmatic linkages between social protection platforms, particularly cash transfers, and IPV prevention, mitigation, and response services, creates synergies that can promote freedom from both poverty and violence.

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Introduction

Intimate partner violence (IPV) is a core facet of the COVID-19 syndemic.[1–3] A pandemic even before COVID-19,[4] risk of IPV—including emotional, physical, or sexual violence from an intimate partner—increased with lockdowns and impoverishment. Government responses have focused on bolstering emergency helplines and other reporting mechanisms, shelters, and police or judicial responses.[5] However, continuity of services has been challenging, and reports from law enforcement and health providers indicate barriers to help seeking, suggesting that violence has often gone unreported and untreated.[6] A patchwork of policy responses emerged as some governments closed presential emergency services or offered inconsistent online assistance, whereas others classified at least some IPV programmes as essential.[7]

An effective syndemic response should simultaneously address deteriorating socioeconomic conditions and co-occurring risk factors, such as IPV, by identifying effective interventions and implementation platforms, and combining them in ways that target multiple goals and promote synergies. The diagonal approach to global health and health system strengthening[8,9] seeks to overcome barriers between vertical and horizontal programming by leveraging systemic health-care programmes and policies, and linking them with interventions specific to risk factors or disease. The social protection or cash transfer (CT)-plus model is a similar approach, in which complementary programmes are explicitly linked to or embedded in CTs (ie, direct monetary payments to eligible populations), often to alleviate non-financial barriers and to catalyse more sustainable impact.[10]

Although social protection encompasses various economic programmes and policies, CTs stand out for their effectiveness and scalability.[11] Decades of rigorous evaluation show that CTs, in both conditional and unconditional forms, are effective in improving maternal and child health, increasing educational attainment,[12] reducing household poverty, and building resilience to crises.[11,13] Additionally, CTs can provide operational platforms at scale for imbedding IPV reduction efforts, help to prevent IPV, and offer crucial economic support for survivors of IPV; however, these linkages are rarely operationalised.[14] In Latin America, CTs are well placed to reach women, given that they typically target mothers as caregivers of children, focusing on poor and vulnerable segments of the population. The COVID-19 syndemic has offered an essential juncture to re-examine these synergies and to reimagine future policy and programming.

In this Viewpoint, we focus on Latin America for several reasons. First, the region pioneered conditional CTs in the 1990s and, by 2017, programming of diverse designs reached 134 million people, about a fifth of the region's population.[13] The long history of established and rigorously evaluated social protection programming makes Latin America a promising environment for analysing synergies between IPV and CTs. Second, in the face of COVID-19, most countries in Latin America increased the sufficiency of existing CTs and implemented temporary, emergency income support. Furthermore, almost all of these countries created or adapted outreach through digital platforms for individuals at risk of or experiencing IPV. Third, Latin America has been an epicentre for COVID-19. Despite accounting for only 8% of the global population, as of September, 2021, this region has accounted for almost 30% of all COVID-19 deaths globally.[15] Long lockdowns and economic fallout produced the largest regional drop in gross domestic product during 2020, disproportionately affecting socially vulnerable populations. Fourth, women's access to income and IPV is linked in Latin America, where the gender gap in labour force participation is among the highest in the world.[16] Finally, a quarter of women reported experiencing IPV before the COVID-19 pandemic[17] and, following lockdowns, countries across the region have documented surges.[6]

We summarise data on CT expansions and IPV responses, and argue for a build-forward-better, diagonal, or plus approach that links pre-existing and emergency

CTs to vertical interventions focused on IPV prevention, mitigation, and response strategies. Additionally, we present the case of Peru, a country with one of the longest and strictest COVID-19 lockdowns and most serious disease paths worldwide, to show the unrealised potential for this approach.

CTs in Latin America before and during COVID-19

Most national CT programming in Latin America is conditional, meaning that participants must comply with co-responsibilities to qualify or remain eligible for benefits, primarily in the form of child health check-ups and school attendance. Although conditional CTs have been criticised for reinforcing gender inequity in child care and burdening women with conditionality compliance,[18] there is also evidence that they improve the wellbeing and economic autonomy of women.[16] Conditional CTs in Latin America channel cash to low-income mothers who would not otherwise have their own income, assuming they can and will invest in family wellbeing.[18] This support is essential, given that almost 60% of Latin American women with low educational attainment have at least one child by age 20 years and few income-generation opportunities.[16] Pioneered in Mexico and Brazil in the late 1990s, CTs became a policy export to other regions.[13]

At the beginning of 2020, most countries in Latin America operated national conditional CTs. A study of social protection programming in ten countries reported that the inclusion of families with members younger than 18 years ranged from 15% in Peru to over 50% in Uruguay and Bolivia. The largest programme in Latin America, Brazil's *Bolsa Familia*, reached just over 40% of the country's children.[19] Despite the programmes being national in scope, coverage was insufficient because 46% of children lived in poverty before the pandemic. In addition, few countries met sufficiency criteria (ie, cash value sufficient to meet basic needs). Only Uruguay's transfers were sufficient to lift the children in the household above the extreme poverty line, compared with Brazil's transfers, which met 40%, and Bolivia's transfers, which met only 4% of the extreme poverty line per child (all calculated on the basis of a family of two adults and two children).[19]

During the pandemic, most Latin American countries increased social protection spending and coverage.[20] Seven of the ten countries studied increased the sufficiency of their national conditional CTs to rapidly provide cash to mothers to meet basic needs, and simultaneously suspended conditionalities due to physical distancing mandates.[19] Sufficiency increased the most in Chile and Brazil, where CTs during the first 6 months of the pandemic brought a family of four above the extreme poverty line; however, this was met with reductions in the following 6 months, especially in Brazil.[21] Nine of the countries also established new temporary assistance programmes for vulnerable households within the informal sector that had not been included in existing social protection systems. In Argentina, Brazil, Chile, Bolivia, Peru, Costa Rica, and Uruguay, these programmes were broad with inclusive eligibility criteria, whereas coverage in Ecuador and Colombia was more restricted. Mexico is an exception because, in 2019, the government eliminated its conditional CT, *Prospera*,[22] and no national emergency CTs have since been established, nor has sufficiency been increased through the CTs that the new government created for families with children.[19]

To date, several limitations have reduced the potential effectiveness of emergency transfers, including delays in programme development and delivery. First, an analysis of 30 governmental emergency cash responses in Latin America and the Caribbean showed that, on average, first payments were made over 70 days after the first case of COVID-19 was reported in each country.[23] Second, many emergency programmes did not specifically target women. In Argentina, Chile, and Peru, where new emergency CTs targeted one person per household, 50–70% is reported to have been received by men.[19] By contrast, in Bolivia and Brazil, more than one recipient per household was allowed, which ensured that women had an increased chance of receiving cash. Additionally, in Brazil, single mothers received a CT of double value. Third, complementary programming for promoting family health and wellbeing was put on hold during the first lockdown (although challenges in access extended to subsequent lockdowns as well). Finally, emergency assistance has mostly been temporary, limiting long-term impacts.

Linkages and opportunities to integrate IPV and CTs

A large body of evidence from before the COVID-19 syndemic showed that CTs are promising tools to reduce IPV.[14,24,25] One such review of qualitative and quantitative research, including studies from Brazil, Colombia, Ecuador, Mexico, Peru, and Uruguay, showed that three-quarters of studies found that CTs reduced IPV, with stronger impacts on physical or sexual violence, or both, than for emotional or economic abuse.[14] The studies hypothesised that increased economic security and women's empowerment, as well as decreased conflict within the household and stressors over daily needs, were the mechanisms through which CTs promoted reductions in IPV.[14]

However, select studies also reported heterogeneous effects. These effects included subsample increases in IPV due to CTs, primarily for groups of vulnerable women, highlighting the need for attention to and integration of operational IPV safeguarding and mitigation measures, and ongoing research to better understand these dynamics.[24–26] Harnessing the primary health sector, complementary programming, and targeting survivors of

IPV are three additional methods in which CT implementation can align or create linkages with IPV programming.

Conditional CTs in Latin America typically harness primary health care, with the objectives of increasing maternal and child health service utilisation. These touch points provide opportunities to imbed information on women's rights and violence prevention, identify populations who could be at risk of or have experienced IPV, and refer these individuals to additional health and legal services. There is also some evidence that the link to health care among participants receiving CTs can improve IPV mitigation. For example, one Peruvian study found that reductions in IPV from the national conditional CT programme were larger among women who had health check-ups than among those who did not.[27]

Cash-plus programmes provide additional design opportunities to address IPV by integrating or linking CTs to complementary programmes focused on IPV prevention and associated risk factors (eg, mental health or alcohol misuse). For example, *Chile Solidario* and *Chile Seguridades y Oportunidades* integrated intensive psychosocial support via social workers in their *Puente* programme, which provided preferential access to services for families at risk of IPV.[10] Cash-plus programming focused on equitable gender norms explicitly, through couples counselling or community mobilisation, might also be useful for addressing IPV in the event of repercussions resulting from the norm changes when women become financially empowered.[14] Furthermore, cash alone should never be expected to address IPV fully, and must be implemented within a setting of supportive IPV-specific laws, policies, and services.

Another way to explicitly address IPV within CT programming is by directly targeting survivors of IPV. Since 2009, the Uruguayan Government has targeted survivors of IPV with CTs and housing to enable them to leave abusive partners, as well as offering a broad-based CT for vulnerable families with children. In Argentina, a new nationwide programme, implemented in 2021, provides survivors of IPV with CTs for 6 months.[28] Furthermore, in March, 2021, the municipal government of São Paulo, Brazil, passed a law establishing CTs for survivors of IPV who live in situations of extreme social vulnerability.[29] Careful targeting and implementation of these programmes are essential to protect the anonymity and safety of survivors of IPV in collaboration with response services.

The Peruvian Government has faced challenges in targeting and delivering CTs to vulnerable families and in ensuring access to IPV services during and following COVID-19 lockdowns. This situation can be characterised as a set of missed opportunities, which might still be harnessed to support social protection through a plus approach that embeds violence programming to build forward better.

CTs and IPV in Peru

According to Peru's Instituto Nacional de Estadística e Informática,[30] nearly 60% of Peruvian women report experiencing IPV over their lifetime. In response, Peru has established a relatively strong IPV service infrastructure based on a national network of women's justice centres (WJCs)—ie, *Centros de Emergencía Mujer*. By 2020, these centres numbered almost 400 and covered most urban areas of the country. These specialised institutions are mostly staffed by women who provide police and legal services related to gender-based violence in so-called one-stop shops.[31] A comprehensive study identified an enforcement effect and showed that the opening of a WJC reduced gender-based violence by 10% in the covered neighbourhoods.[32]

The conditional CT programme in Peru, *JUNTOS*, has been in operation since 2005. In 2020, *JUNTOS* covered 15% of Peruvian children, largely in rural areas, and almost all transfers went to mothers.[19] One impact evaluation found that the prevalence of physical IPV decreased by 25–30% after programme phase-in,[33] and another found reductions of 46%.[27] Although effective, coverage was inadequate because over 50% of children lived in poverty before the COVID-19 pandemic.[34]

When the pandemic hit, the Peruvian Government imposed one of the strictest lockdowns in the region, starting from mid-March to July, 2020, followed by a series of nightly curfews alongside progressive reopening. Financial hardship combined with mandated shelter-in-place (ie, orders to stay at home) probably aggravated the risk of IPV during this lockdown, and calls to domestic violence helplines doubled.[35]

Most IPV services were shut down during this time. An analysis of hotline data found that calls ended with the recommendation of going to a WJC,[36] even though all WJCs had closed operations for the duration of the first lockdown and only eight medical emergency centres remained open nationwide.[37] The government began to set up mobile teams, a novel initiative to replace the WJCs; however, these teams reached a much smaller number of women. In July, 2020, the mobile units treated 5608 cases, a third of the caseload treated in February of that year.[36] The Ministry for Women also launched IPV awareness campaigns during this period. In January, 2021, another less strict lockdown was imposed and all WJCs remained open.

During the first lockdown, the government rapidly increased the sufficiency of CTs, including for *JUNTOS* recipients. However, this assistance reached only a small proportion of vulnerable households.[19] 5 weeks into the lockdown, the government announced an emergency CT to all households without a stable income (which was renewed twice, once in late 2020 and again in early 2021). Delivery was slow and by the end of June, 2020, only 65% of targeted households had received transfers. Cash reached all remaining households during August, over 1 month after the lockdown had been lifted.[19] Financial

assistance was not targeted to women. The government allowed only one recipient per household and, according to available data, 50% of emergency transfers were directed to men.[38]

Before and during the pandemic, *JUNTOS* and WJCs operated independently, with little geographical overlap. Nevertheless, it is probable that, in coordination, these two programmes could have multiplicative effects for individuals at risk of IPV. Fostering coordination between these programmes and with social protection interventions more broadly would ensure that CT recipients have access toWJCs, and that survivors of IPV who use WJCs can be targeted to receive CTs.

The new Peruvian president, inaugurated in July, 2021, began an additional one-time transfer to existing CT recipients and others in poverty in October, 2021. However, coverage in the *JUNTOS* programme is still insufficient. For the ongoing pandemic and the concept of building forward better, the Peruvian Government should generously expand *JUNTOS*, targeting mothers as recipients, to cover all children in households living in poverty or facing severe income loss or economic insecurity in the informal sector. Furthermore, although maintaining public information campaigns and mobile units for IPV is a promising step, it is crucial to ensure that emergency services (eg, WJCs) continue to stay open during future lockdowns.

Recommendations and call to action

Latin America is ill prepared to tackle the COVID-19 syndemic, which includes the associated economic crisis and increased incidence of IPV. What makes this region uniquely placed to innovate in responding to both of these challenges is the long history of CT and social protection programming, paired with the recent upsurge of feminist movements, manyof which were sparked by violence against women and girls. Latin America can combine social protection platforms with components that promote freedom from violence to build forward better, mitigate both poverty and IPV, and improve preparedness for public health emergencies.

Most governments across Latin America implemented emergency CTs to address employment crises triggered by the pandemic. Although the transfers provided immediate, essential income support, their potential efficacy was limited by delays in delivering funds, which increased financial insecurity and stress; the absence of a gender lens, which aggravated inequities; and the missed opportunities to implement programmes for promoting health and wellbeing.

Now is a unique time to innovate how social protection can be linked to violence-specific services. Existing conditional CTs offer an opportunity to integrate IPV interventions through multisectoral linkages to help break cycles of violence. If conditional CTs were more extensively available, they could be a broad-based method of expanding horizontal anti-poverty programming with a gender lens and imbedding stronger vertical supports to mitigate IPV. Although existing conditional CTs should be expanded, a focus on integrating plus components into programming and improving access to combined programming should be prioritised, rather than a focus on enforcing conditionalities, many of which were put on hold during social isolation measures. Decisions around design and operational models should be made in partnership with civil society and women's organisations, which understand local gender dynamics and have long histories of working with survivors of IPV.

Efforts to prevent and respond to IPV require various health, legal, and social services. Linking these services to social protection platforms is an opportunity not to be missed, both during and after COVID-19. Overlapping and multiplicative benefits are promising avenues to improve cost–benefit ratios by taking advantage of positive externalities: reducing IPV can help to reduce poverty, while reducing poverty empowers women and mitigates IPV. These mechanisms are also salient pathways for prevention of violence against children and help to break the intergenerational cycle of violence.[39] Therefore, governments should invest in and establish permanent, comprehensive, and geographical coverage for centres that provide IPV, health, legal, and social services, and streamline access to survivors of IPV.

Despite the potential of integrated approaches and the rigorous evaluations of social protection and CTs, to date, we are not aware of any completed impact evaluations of CTs with violence-specific plus components.[40] Research should accompany innovative implementation to link evidence to action and improve understanding of how to most effectively and efficiently tackle future syndemics and the ongoing goals of eliminating poverty and violence.

Policies that directly address violence against women have undergone considerable advances since the landmark Inter-American Belém do Pará Convention in 1994. Over the past 25 years, the 18 member states of this convention have revised their legislation for violence against women and established national action plans. Despite these advances, the 2020 report by the monitoring arm of the Organization of American States lamented deficits in implementation and evaluation of policies, as well as the fact that the eradication of violence against women was still not prioritised in all public policies.[41]

Elimination of all forms of violence is targeted in Sustainable Development Goal 5, which is focused on gender equality and empowerment of women and girls. Governments should leverage the political will and attention to poverty and violence resulting from the COVID-19 syndemic to increase investment in quality and accessible IPV services, and to frame access to social protection and freedom from violence as a human right.[42]

Contributors

FMK, MB, and FB contributed to the conceptualisation of this Viewpoint. MB and FMK drafted the manuscript. RC-A, AP, JMF, MO'D, and FB

contributed to the analysis and bibliography, and reviewed and provided detailed comments and text inputs on various drafts of the manuscript. RC-A and MB wrote the section on Peru with input from FMK.

Declaration of interests

All authors declare no competing interests.

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