CALIFORNIA HIV/AIDS POLICY RESEARCH CENTERS

November 2026

Making the Case for Conditional Cash Transfers

POLICY

California is an ideal testing site for Conditional Cash Transfers (CCTs), as there are existing infrastructure and widespread acceptance for cash transfer programs.

California's Ending the Epidemics Integrated Statewide Strategic Plan (2022-2026) reports stark racial ethnic disparities; Black Californians account for 17% of new HIV infections despite being only 6% of the state's population, and Latinx Californians account for 50% of new infections against 39% of the population, with young Black and Latino gay and bisexual men experiencing especially high rates. Economic Justice is one of the six core focus areas the plan uses to address these disparities, alongside racial equity and health access. Despite these findings, federal funding supporting CCTs is currently less stable. Federal Ending the HIV Epidemic funding was nearly eliminated in the FY2026 federal budget before being preserved by U.S. Congress. Broader CDC HIV prevention and surveillance funding was cut substantially in the same cycle.

California has embraced guaranteed income programs with no strings attached as a policy tool over the past several years, with pilot programs backed by mayors, county board of supervisors, and philanthropic funders across the state. Across multiple California pilot programs, results are consistently positive with participants reporting reductions in income volatility and greater financial stability, alongside measurable improvements in mental well-being.

Statewide pilot programs vary in scale and demonstrate consistent, replicated stakeholder buy-in and administrative capacity across multiple California cities and counties. Examples include:

- SEED (Stockton, CA): 125 residents, $500/month for 24 months (2019-2021)
- Breathe (Los Angeles, CA): 1,000 residents, $1,000/month for 3 years (2022-present), later expanded to foster youth cohorts
- Big: LEAP (Los Angeles, CA): 3,200 households, $1,000/month; the largest guaranteed income pilot in the nation
- Compton Pledge: 800 families, $300-$600/month for 2 years (2021-2023)
- Long Beach Pledge: 250 single-earner families, $500/month for 12 months (2022), later expanded by 200 households (2024)
- El Monte Guaranteed Income Pilot: 125 single mothers, $500/month, administered by RAND Corporation

Additionally, California operates larger scale programs that utilize principles of CCTs such as California Work Opportunity and Responsibility to Kids (CalWORKs), California's version of the

federal TANF Program, which has provided conditional cash aid to low-income families for decades, requiring recipients to meet work participation requirements to maintain eligibility. This also demonstrates that the state already has infrastructure such as eligibility verification, compliance monitoring, and tiered benefit delivery, all elements that a CCT program would require.

While none of the pilot programs mentioned above target HIV prevention specifically, Los Angeles County has existing HIV prevention cash transfer programs. Los Angeles County's FLEX Card Program (Division of HIV/STI Prevention, Los Angeles County Department of Public Health) ran from September 2024 through February 2025, providing $400 monthly gift cards to people with HIV for basic needs like groceries and transportation, tied to care engagement rather than prevention. The program is not currently accepting applications, and no published evaluation of its outcomes currently exists in the literature.

Additionally, Medi-Cal's no-cost PrEP coverage (since 2021) provides the structural foundation a CCT could complement. For example, it addresses medication cost; however, other costs shape PrEP uptake including transportation, time, and competing-cost barriers. CCTs could potentially offset some of these opportunity costs.

RESEARCH EVIDENCE

An Effective HIV Prevention Strategy: Conditional cash transfers (CCTs), are programs that pay people incentives or rewards directly for completing a specific health behavior. They show promise at increasing HIV testing, although evidence for their impact on HIV PrEP uptake and adherence is mixed.

CCTs provide direct payments to individuals or households, contingent on completing a specific behavior like attending a health appointment, staying in school, or getting a preventative screening. This differs from unconditional cash transfers (UCTs), which pay an incentive with no strings attached.

Studies consistently link CCTs to higher rates of HIV testing and suggest they may also boost improvement across broader sexual health outcomes. A meta-analysis of 22 studies and over 38,000 participants found significant improvements in HIV testing attributable to financial incentives, a finding reinforced by a more recent systematic review and meta-analysis confirming that CCTs improve testing and care continuum outcomes more broadly. For instance, a 2012 study in Tanzania found that tying $20 payments on the condition of receiving negative STI results reduced combined STI prevalence by 27% relative to control groups after 12 months, with the strongest effects among lower-risk participants.

However, some studies suggest that behavioral benefits of CCTs fade once financial incentives end. A 2012 Malawi study found CCTs increased HIV testing, but broader behavioral effects were mixed and did not last after the incentive stopped being disbursed. What this finding suggests is that CCTs may reliably get people through the door for HIV testing and broader HIV prevention services and care but may not lead to lasting behavioral change.

Similarly, more recent studies have shown that CCTs can improve PrEP adherence, though evidence on whether these benefits last over time remains mixed. A 2025 study in Mexico among male sex workers found CCTs ($0-$25 based on adherence level) produced a 28.7% increase in objectively measured PrEP adherence over 6 months (p=0.05), using hair drug-concentration testing rather than self-report. A 2020 South African study found that women who received adherence-conditioned incentives showed meaningfully higher adherence at 3 months than controls (56% versus 41%) though this difference was not statistically significant.

Limited Research in the United States: Few HIV prevention CCTs studies have been implemented in the United States (U.S.), and none have studied their acceptability and effectiveness among Black and Latino men who have sex with men (MSM).

The effectiveness of CCTs on PrEP maintenance past 6 months also remains uncertain. In the South African trial, adherence benefits faded entirely by Month 12, among both incentive and control groups. PrEP-specific CCT studies have yet to follow participants long enough to know whether PrEP maintenance lasts beyond that window.

Global reviews confirm CCT-HIV research is concentrated almost entirely in low- and middle-income countries; a 2024 review found U.S.-based CCT HIV research is essentially absent. A broader review of structural HIV interventions for U.S. MSM identified only a handful of domestic CCT or financial-incentive studies at all. The few domestic studies that exist fall short for Black and Latino MSM and have real limitations. A 2020 study modeled cost-effectiveness of financial incentives for HIV testing in emergency departments, finding $5 and $10 incentives increased HIV test acceptance by 10.5 and 15 percentage points respectively. In Louisiana, researchers found CCTs (up to $140) significantly improved engagement in care (70% to 93%) and retention in care (32% to 64%) among 781 people with HIV, but viral suppression rates significantly declined over the same period (59% to 34%). Neither study targeted PrEP uptake or Black and Latino cisgender MSM specifically.

PROGRAM AND POLICY RECOMMENDATIONS



Fund a pilot CCT. State data show Black and Latinx communities acquire HIV at a disproportionate rate, a disparity the state's own EHE plans is already structured to address. EHE high-burden jurisdiction funding and statewide funding should be

directed toward a PrEP-based CCT pilot serving this population. Given the instability of federal EHE funding, state-only or blended funding should be explored.



Invest in more infrastructure to establish CCTs in HIV prevention. The infrastructure for CCTs as a social policy already exists in California. CalWORKs demonstrates decades of experience administering CCTs at scale; SEED and Breathe demonstrate large-scale unconditional distribution; and FLEX Card demonstrates that Los Angeles County can design and launch HIV-specific cash assistance programs. An existing gap may be capacity to verify PrEP-related behaviors before payment, which could draw on CalWORKs-style eligibility or other lessons learned from the scientific literature assessing biomarker objective measurements of adherence. Community-based delivery is likely necessary for trust and cultural relevance, but community-based organizations face documented funding instability and administrative capacity limits.[15] A stronger infrastructure that is not siloed within a single agency or administration must be created and budgeted for as core costs. Enabling policy will be required to facilitate this expansion.