San Francisco
Sugary Drink Distributors Tax Advisory Committee
March 2018 Report

The San Francisco Department of Public Health conducted the data analysis for this report.

The voters of San Francisco voted in favor of Proposition V in November of 2016. This law mandates the establishment of the Sugary Drink Distributor Tax Advisory Committee (SDDTAC) which is comprised of 16 people, representing experts and stakeholders. The SDDTAC is tasked with making recommendations for how San Francisco invests the revenue from the Sugary Drinks Distributor Tax (SDDT) to reduce consumption of sugary drinks and to mitigate the impacts of their consumption.

Because low income, ethnic minorities[1], and youth consume more sugary drinks than the general population and disproportionately suffer from chronic health conditions, equity was a foundational pillar for the SDDTAC's work and recommendations.

In addition, to capture the spirit of the SDDT, the Advisory Committee recommended that funds be used for new services or programming or expanding programming rather than replacing existing revenue. The SDDTAC recommends that funds be directed to support primary and secondary prevention efforts and not for medical treatment of disease. This includes work to support: decreasing consumption of sugary drinks, increasing water consumption, oral health, healthy food access, and physical activity.

Numerous proposals were shared with the SDDTAC. These proposals totaled much more than the committee could allocate. Unfortunately, the committee was faced with having to allocate less than each constituency had requested.

The final recommendations reflect a broad set of approaches to reduce the consumption of sugary drinks and mitigate the impacts of sugary drinks with a focus on the populations most burdened by the illnesses associated with the consumption of these products. Ultimately, the committee voted on and approved the strategies and allocations in this report with a vote of 11 in favor, one "no", 1 abstention, and three absences.

As co-chairs—and as native San Franciscans—we are honored and privileged to serve San Francisco in this capacity. We want to thank San Francisco voters and those who appointed us, for entrusting our committee with this responsibility.

Joi Jackson-Morgan, MPH
Executive Director
3rd Street Youth Center and Clinic

Roberto Ariel Vargas, MPH
Navigator
Community Engagement and Health Policy Program
& Center for Community Engagement
University of California, San Francisco

[1] African Americans, Asian, Latino, Native American, and Pacific Islander

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BACKGROUND

Sugary Drinks Distributor Tax Legislation

In November of 2016, the voters of San Francisco approved the passage of Proposition V. Proposition V established a 1 cent per ounce fee on the initial distribution of a bottled sugar-sweetened beverage, syrup, or powder, within the City and County of San Francisco. The Sugary Drink Distributor Tax (SDDT) is a general excise tax on the privilege of conducting business within the City and County of San Francisco. It is not a sales tax or use tax or other excise tax on the sale, consumption, or use of sugar-sweetened beverages. The funds collected from this tax are to be deposited in the General Fund.

The passage of Proposition V established the Sugary Drink Distributor Tax Advisory Committee (SDDTAC). The ordinance stated that the Advisory Committee shall consist of 16 voting members, who are appointed by either the Board of Supervisors or certain City departments. The powers and duties of the Advisory Committee are to make recommendations to the Mayor and the Board of Supervisors on the effectiveness of the Sugary Drinks Distributor Tax, evaluate the impact of the Sugary Drinks Distributor Tax on beverage prices, consumer purchasing behavior, and public health. The Advisory Committee is to also provide recommendations regarding the potential establishment and/or funding of programs to reduce the consumption of Sugar-Sweetened Beverages in San Francisco.

Unless the Board of Supervisors by ordinance extends the term of the Advisory Committee, it shall expire by operation of law, and the Advisory Committee shall terminate, on December 31, 2028.

Report requirements

Starting in 2018, by March 1, of each year, the SDDTAC shall submit to the Board of Supervisors and the Mayor a report that evaluates the impact of the Sugary Drinks Distributor Tax on beverage prices, consumer purchasing behavior, and public health. The Advisory Committee in their report shall make recommendations regarding the potential establishment and/or funding of programs to reduce the consumption of sugar sweetened beverages in San Francisco.

Within 10 days after the submission of the report, the City Administrator shall submit to the Board of Supervisors a proposed resolution for the Board to receive the report.

The legislation defines a sugary drink as:

> A sugar-sweetened beverage (SSB) means any non-alcoholic beverage intended for human consumption that contains caloric sweetener and contains 25 or more calories per 12 fluid ounces of beverage, including but not limited to all drinks and beverages commonly referred to "soda," "pop," "cola,'' soft drinks" "sports drinks," "energy drinks'' "sweetened ice teas" or any other similar names.

Advisory Committee

The Advisory Committee shall consist of the following 16 voting members:

> **Seats 1, 2, and 3** shall be held by representatives of nonprofit organizations that advocate for health equity in communities that are disproportionately impacted by diseases related to the consumption of Sugar-Sweetened

Beverages, as defined in Business and Tax Regulations Code Section 552, appointed by the Board of Supervisors.

Seats 4 and 5 shall be held by individuals who are employed at medical institutions in San Francisco and who have experience in the diagnosis or treatment of, or in research or education about, chronic and other diseases linked to the consumption of Sugar-Sweetened Beverages, appointed by the Board of Supervisors.

Seat 6 shall be held by a person who is under 19 years old at the time of appointment and who may be a member of the Youth Commission, nominated by the Youth Commission and appointed by the Board of Supervisors. If the person is under legal voting age and unable to be an elector for that reason, the person may hold this seat, but upon reaching legal voting age, the person shall relinquish the seat unless he or she becomes an elector, in which case the person shall retain the seat.

Seat 7 shall be held by a person appointed by the Director of the Office of Economic and Workforce Development or any successor office.

Seats 8 and 9 shall be held by persons appointed by the Board of Education of the San Francisco Unified School District. If at any time the Board of Education declines to appoint a member to Seat 8 or 9 and leaves the seat vacant for 60 days or longer, the Board of Supervisors may appoint a member of the public to fill the seat until such time as the Board of Education appoints a member.

Seat 10 shall be held by an employee of the Department of Public Health who has experience or expertise in the field of chronic disease prevention or treatment, appointed by the Director of Health.

Seat 11 shall be held by a person with experience or expertise in the field of oral health, appointed by the Director of Health.

Seat 12 shall be held by a person with experience or expertise in the field of food security or access, appointed by the Director of Health.

Seat 13 shall be held by an employee of the Department of Children, Youth & Their Families, appointed by the Director of that Department.

Seat 14 shall be held by an employee of the Recreation and Park Department, appointed by the General Manager of that Department.

Seat 15 shall be held by a parent or guardian of a student enrolled in the San Francisco Unified School District at the time of appointment, nominated by the San Francisco Unified School District's Parent Advisory Council, and appointed by the Board of Supervisors. If at any time the Parent Advisory Council declines to nominate a member to a vacant seat for 60 days or longer, the Board of Supervisors may appoint a member of the public to fill the seat until the seat becomes vacant again.

Seat 16 shall be held by a person with experience or expertise in services and programs for children ages five and under, appointed by the Board of Supervisors.

Sugary Drinks Distributor Tax Advisory Committee, 2018

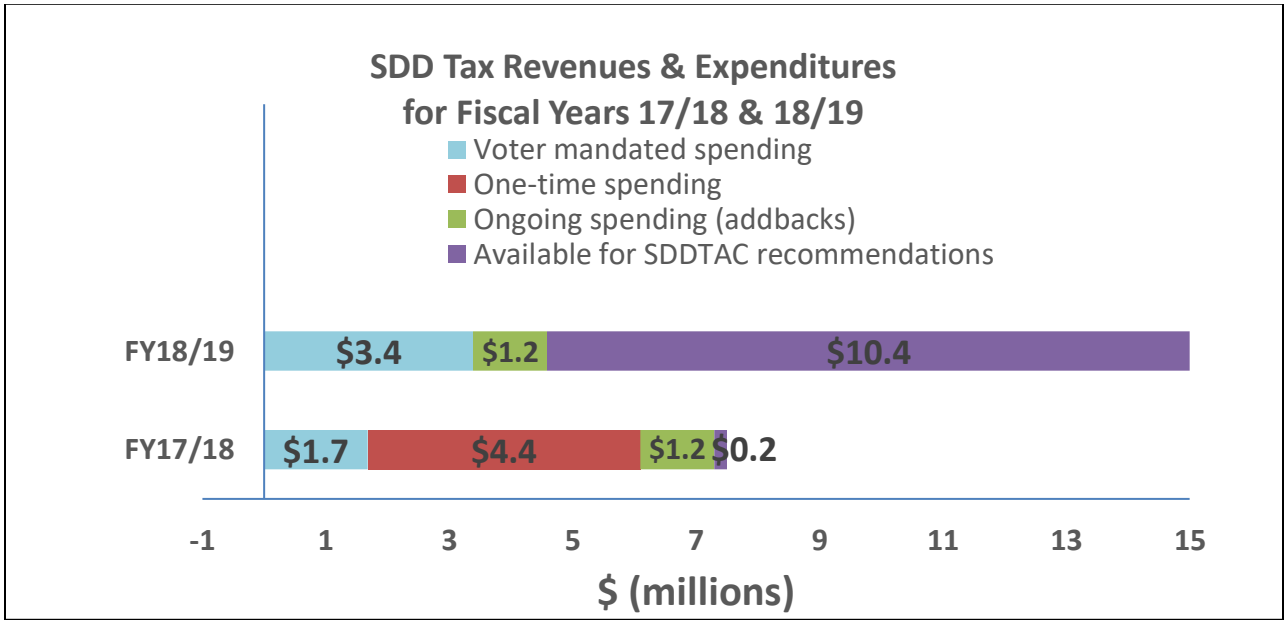
Seat 1	BOS Appointment - Health Equity- Latino/Chicano/Indigena	Vanessa Bohm
Seat 2	BOS Appointment - Health Equity – Asian/Pacific Islander	Kent Woo
Seat 3	BOS Appointment - Health Equity – Black/African American	Joi Jackson-Morgan
Seat 4	BOS Appointment - Research/Medical Institutions	Roberto Ariel Vargas
Seat 5	BOS Appointment - Research/Medical Institutions	Jonathan Butler
Seat 6	BOS Appointment - Youth Commission Seat	Areeya Chananudech
Seat 7	Office of Economic and Workforce Development Appointment	Jorge Rivas
Seat 8	Board of Education Appointment - San Francisco Unified School District	Saeeda Hafiz
Seat 9	Board of Education Appointment - San Francisco Unified School District	Libby Albert
Seat 10	Department of Public Health Appointment - SF Department of Health – Chronic Disease	Rita Nguyen
Seat 11	Department of Public Health Appointment - Oral Health	Irene Hilton
Seat 12	Department of Public Health Appointment - Food Access/Security	Ryan Thayer
Seat 13	Department of Children Youth and Their Families Appointment	Michelle Kim
Seat 14	Recreation and Parks Department - Appointment	Bob Palacio
Seat 15	BOS Appointment - SFUSD Parent Advisory Council	Janna N. Cordeiro
Seat 16	BOS Appointment - Children 0-5 Years Old	Lyra Ng

Revenue Projections

The City's fiscal year runs from July 1st to June 30th. Each year the Mayor and Board of Supervisors pass a rolling, two-year budget, with the second year becoming the first year of the next budget cycle. The Controller's Office estimates the sugary drinks tax will generate $7.5M in revenue for fiscal year 17/18, and $15M for fiscal years 18/19 and 19/20.

Because the sugary drinks tax is a general tax, a portion (~22%) of the revenues contributes to various voter-mandated spending requirements, known as set-asides and baselines. After accounting for the voter mandates, the revenue projection for fiscal year 17/18 is $5.8M and $11.6M for fiscal years 18/19 and 19/20.

During last year's (FY 17/18) budget process, the Mayor's Office and Board of Supervisors mostly allocated the $5.8M to support programs aimed at reducing health disparities (home delivered meals, Peace Parks, DPH's community prevention programs). Of the FY 18/19 spending, $1.2M is for ongoing programming added in by the Board of Supervisors in its phase of the budget, leaving $10.4M in unallocated soda tax money for FY 18/19. The Mayor and Board chose to hold off on full expenditure plans for FY 18/19, pending the recommendations of the SDDTAC, which was not yet seated.



Funded Projects (2017/18 funded projects)

For the Fiscal Year 2017/2018 the projected revenue is $5.8 million, after the removal of mandated baseline spending. The Mayor and Board of Supervisor have allocated certain expenditures from this revenue for the following:

	FY 17-18 Funding ($/millions)	FY 18-19 Funding ($/millions)	Description/Notes
Revenue (Sources)	**5.8**	**11.6**	**This is the amount of revenue after baselines and set asides. Total revenue projected by the Controller is $7.5M in FY 17-18 (half a year of revenue) and $15 million in FY 18-19 (a full fiscal year of revenue).**
Expenditures (Uses)			
DPH - Community Health Equity & Promotion Branch	2.3	-	Includes funding for the Black/African American Wellness and Peer Leadership (BAAWPL) program, healthy eating & active living programming, active transportation and pedestrian safety program, as well as the Sunday streets program.
Peace Parks & Peace Hoops	0.5	-	Pilot funding for Peace Parks initiative.
Home Delivered Meals	0.5	-	Increased funding for nutritional supports for low-income, disabled, and senior residents.
Healthy Addbacks	2.3	1.2	See addback list for details.
Total Expenditures	**5.6**	**1.2**	
Uncommitted Sources Available	**0.2**	**10.4**	

After the allocation of these funds by the Mayor and Board of Supervisors, $200,000 uncommitted revenue was available. The SDDTAC recommendations for expenditure of those funds is in the “Advisory Committee Recommendations” section.

For the Fiscal Year 2018/2019 the projected revenue is $11.6 million after the removal of mandated baseline spending. The Board of Supervisors have allocated $1.2 million of the projected revenue for Healthy Addbacks. After the removal of this allocated amount, there are $10.4 million of uncommitted revenue for the rest of that fiscal year.

Addback Funded with SDDT Fiscal Years 17/18 & 18/19

Program	Department	Description	FY 17-18	FY 18-19
Family Violence Services	WOM	Direct services, training and assistance to improve San Francisco child abuse prevention and intervention services building upon existing Family Resource Centers Initiative	500,000	
Food Security - Congregate Lunch Meals	HSA	Address current waitlist: Daily, hot, nutritious meals for seniors/adults with disabilities	220,000	220,000

Food Security - Healthy Food Purchasing Supplement	DPH	Maintain current service levels: Vouchers and education to increase consumption and access to nutritious foods by increasing the ability of low income residents to purchase fruits and vegetables at neighborhood vendors and farmers' markets in collaboration with DPH healthy Retail Program.	50,000	50,000
Food Security - Home-Delivered Meals (HDM)	HSA	Address current waitlist: Delivery of nutritious meals, a daily safety-check/friendly interaction to homebound seniors/adults with disabilities who cannot shop or prepare meals themselves. Many providers offer home assessments/ nutrition education/counseling.	477,000	477,000
Healthy Corner Store Retail	ECN	Promoting corner stores and markets to sell healthy Products as opposed to sugary beverages, etc.	60,000	60,000
Medical Assisting and Hospitality Training	ECN	Funding to support Medical Assisting and Hospitality Training	150,000	
Women's Health Rights in the Workplace Policy Coordinator	DPH	New women's health in the workplace outreach coordinator to conduct outreach to businesses and provide trainings on women's health issues	80,000	80,000
Upgrading services for a food pantry in Ingleside/Ocean Avenue	DAS	Renovation and upgrades for a food pantry that serves residents on Ocean Avenue and Ingleside neighborhood	25,000	
Day laborer mental health support in the Mission	DPH	Bilingual Spanish speaking Peer Health Navigator to conduct psycho-social training and individualized support sessions with Day Laborers in the Mission	65,000	
I Am Bayview Marketing Campaign	ECN	Marketing campaign for Bayview merchant corridor	20,000	
Mental health services	MOH	Mental health and trauma counseling services at Vis Valley elementary	50,000	
Resilient Bayview	ADM	Enhancement of existing programming, including free training for residents and non-profits	25,000	
Senior Fitness	HSA	Senior fitness programming at IT Bookman and George Davis	200,000	200,000
Third Street Economic Development	ECN	Development and marketing of Third Street corridor	75,000	
Congregate Meal Program	HSA	Congregate Meal Program A	75,000	75,000
Congregate Meal Program	HSA	Congregate Meal Program B	75,000	75,000
Small Business Support	ECN	1.5 FTE to serve Outer Mission and Broad Randolph business development	115,000	
			2,262,000	**1,237,000**

ANNUAL EVALUATION REPORT

The Sugary Drinks Distributor Tax (SDDT) legislation calls for an annual report evaluating the impact of the SDDT on beverage prices, consumer purchasing behavior, and public health. As the tax has only been in effect for three months at the time of the writing of this report, this inaugural report will focus on presenting a current state in terms of beverage prices, consumer purchasing behavior, and public health. Additionally, it is the intent of the SDDTAC to make recommendations for tax dollar expenditures to target populations consuming high amounts of sugary beverages and experiencing disproportionately high burden of diet-sensitive chronic disease. As such, this report seeks to further describe these populations to help inform recommendations.

In general, existing data sources are not robust reflections of the burden of disease in San Francisco especially for communities of color (particularly African American, Pacific Islander, and non-Chinese Asian populations given the small population and sample sizes). Thus, tracking the measures included in this report likely will not be able to reflect the impact of the SDDT over time with the exception of more robust data sources such as the youth soda consumption data collected by San Francisco Unified School District in partnership with UC Berkeley and the Nutrition Policy Institute. Given the need for more robust data and data infrastructure to better understand and track the impact of the SDDT on beverage prices, consumer purchasing behavior, and the health of communities most vulnerable to sugary beverages, the SDDTAC has recommended investment in data infrastructure and evaluation.

About the Data Sources

San Francisco has a range of data describing consumer purchasing behavior and health conditions associated with sugary drink consumption.

There are two sources of sugary drink consumption data for public school students: the Youth Risk Behavior Surveillance Survey (YRBSS) and a survey administered by San Francisco Unified School District (SFUSD). The Youth Risk Behavior Surveillance Survey (YRBSS) is a national biennial survey that asks high school students a range of health related questions. It asks if they drank a can, bottle, or glass of a sugar-sweetened beverage (SSB) in the prior seven days. This question was modified for SFUSD middle school students to ask about SSB beverage consumption in the prior day. Additionally, UC Berkeley and the Nutrition Policy Institute in partnership with San Francisco Unified School District (SFUSD) have conducted a survey of 7th to 10th grade students each spring since 2015 that provides insight into types of beverages consumed.

The California Health Interview Survey (CHIS) is an annual telephone survey that uses a random-digit-dial technique to landlines and cell-phones and asks respondents to answer health related questions. CHIS only asks about soda consumption and does not include other sugary drinks. In San Francisco, CHIS samples about 400 adults, which provides data for the county, but does not allow to stratify across different demographic categories.

Nielsen Scanner data provides information about sugary drink sales primarily from chain retail stores. Small, independent convenience stores and markets as well as Costco sales are not included in this data set. Nielsen represents about 40-50% of all retail sales from stores that sell SSBs in San Francisco. The per capita estimate was calculated using San Francisco's 2015 population estimate of 864,816 residents.

Measure of fitness and weight among San Francisco youth are captured by the FitnessGram® which the San Francisco Unified School District measures annually in grades 5, 7, and 9. FitnessGram® data for youth in San Francisco describe students as having body compositions either being within or outside the "healthy fitness zone" which is comprised of BMI and a measure of percent body fat.

The maps from CDC 500 Cities Project 2015 provide modeled estimates of chronic disease prevalence at the census tract and San Francisco city levels. CDC used multi-level regression and post-stratification to account for the associations between individual health outcomes, individual characteristics, and geographical factors at multiple levels (e.g. state, county). These maps can be used to establish a baseline estimate of the geographic distribution of disease burden and health behaviors, but it cannot be used to compare pre-prevention and post-prevention outcomes to evaluate the effectiveness of prevention programs.

Other health related data are derived from hospital discharge data and mortality data. Office of Statewide Health Planning and Development (OSHPD) collects and publicly discloses facility level data from more than 6,000 CDPH-licensed healthcare facilities—hospitals, long-term care facilities, clinics, home health agencies, and hospices. California Department of Public Health compiles the information reported on birth, death, and fetal death certificates, including detailed demographic information related to the infant, mother, and father (for births and fetal deaths) or decedent (for deaths), as well as medical data related to the vital event.

As this is the inaugural report for the SDDT which has only been in effect for three months, this report seeks to describe the current state of health in San Francisco as it relates to diet-sensitive chronic diseases that may be affected by sugary drink consumption. This report draws heavily from the 2016 Community Health Needs Assessment (CHNA) which was a comprehensive report on the status of health in San Francisco. The CHNA was created as a collaborative process involving community residents, community-based organizations, health care partners, academic partners, and the Department of Public Health. The Community Health Needs Assessment and Impact Unit of the San Francisco Department of Public Health conducted the data analysis for the report.

Relationship Between Sugary Drink Consumption, Health, and Health Equity

A large body of evidence exists indicating that sugary drink consumption increases risk for cavities, overweight/obesity, type 2 diabetes, hypertension and heart disease.[i,ii,iii,iv,v] Although sugary beverages can contain hundreds of calories in a serving, they do not signal "fullness" to the brain and thus facilitate overconsumption.[vi] Sugary beverages are the leading source of sugar in the American diet, contributing 36% of the added sugar Americans consume.[vii]

Numerous organizations and agencies, including the American Heart Association, American Diabetes Association, American Academy of Pediatrics, Institute of Medicine of the National Academies, American Medical Association, and the Centers for Disease Control, recommend limiting intake of added sugar and sugar sweetened beverages (SSBs) to improve health. Studies show that sugary beverages flood the liver with high amounts of sugar in a short amount of time and that this "sugar rush" over time leads to fat deposits and metabolic disturbances that are associated with the development of diabetes, cardiovascular disease, and other serious health problems.[iiviii] Of note, every additional sugary beverage consumed daily can increase a child's risk for obesity by 60%[ix] and the risk of developing Type II diabetes by 26%.[x]

Diseases connected to sugary beverages are also found to disproportionately impact ethnic minority and low-income communities – the very communities that are found to consume higher amounts of sugary beverages. Diabetes hospitalizations are approximately three times as high in low-income communities as compared with higher income communities. African American death rates from diabetes are two times higher than San Francisco's overall rate. In San Francisco, approximately 42% of adults are estimated to be obese or overweight, including 66% of Latinos and 73% of African Americans. With respect to oral health, the data indicate that Asian and Pacific Islander children suffer from cavities at a higher rate than other populations; but Latino and African American children also have a higher prevalence than the average for cavities

The Sugary Drinks Distributor Tax is intended to discourage the distribution and consumption of sugar-sweetened beverages in San Francisco by taxing their distribution. Mexico, where an average of 163 liters of sugar-sweetened beverages are consumed per person each year, enacted an excise tax on sugary drinks in 2014, with the result that the purchase of taxed sugar sweetened beverages declined by 12% generally and by 17% among low-income Mexicans. The Mexico data indicate that, when people cut back on sugary beverages, to a significant extent they choose lower-caloric or non-caloric alternatives. Studies have projected that a 10% reduction in SSB consumption in Mexico would result in about 189,300 fewer incident type 2 diabetes cases, 20,400 fewer incident strokes and myocardial infarctions, and 18,900 fewer deaths occurring from 2013 to 2022. This modeling predicts the SSB tax could save Mexico $983 million international dollars.[xi] This body of research demonstrates that taxation can provide a powerful incentive for individuals to reduce their consumption of SSBs, which in turn can reduce the burden of chronic disease.

Beverage Prices

There are no current data systems in place that track beverage prices in San Francisco. Researchers at UC Berkeley are beginning to collect data on beverage prices. The San Francisco Department of Public Health will work with researchers to better understand what impact the SDDT may have on beverage prices in San Francisco.

Consumer Purchasing Behavior

Sugary Drink Consumption

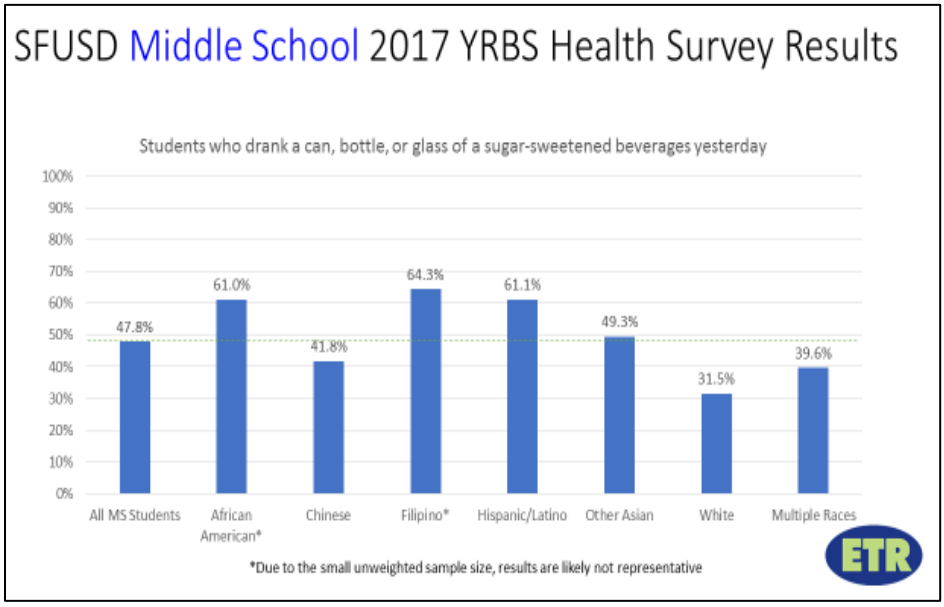
The U.S. Department of Health and Human Services, the U.S. Department of Agriculture, and the World Health Organization, have recommended that Americans consume no more than 10% of their daily calories in the form of added sugar. Yet standard single serving sizes of sugary drinks provide all (in a 20-ounce serving of many sugary drinks) or nearly all (in a 12-ounce serving) of the recommended maximum daily added sugar amount for most adults, and generally exceed the recommended maximum daily added sugar amount for children.[xii]

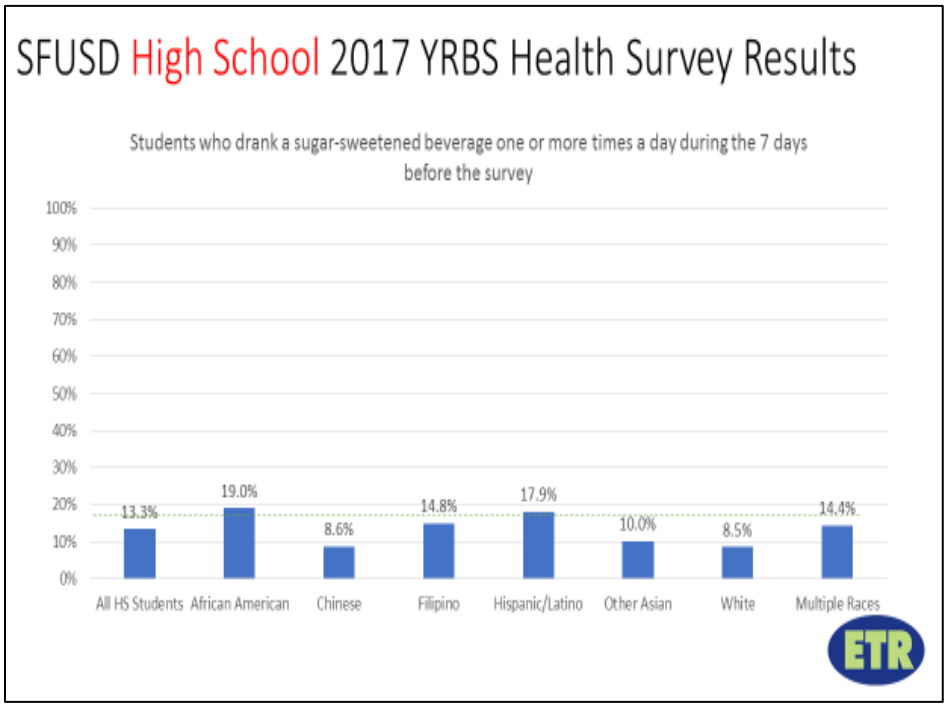
San Francisco data suggest that sugary drink consumption is highest among youth (middle school more than high school), young adults (age 18-29), and ethnic minorities, particularly Black and Latino populations. There is also likely greater consumption among Filipino and non-Chinese Asians. Males also consume more soda than females.[xiii, xiv]

Youth Sugary Drink Consumption

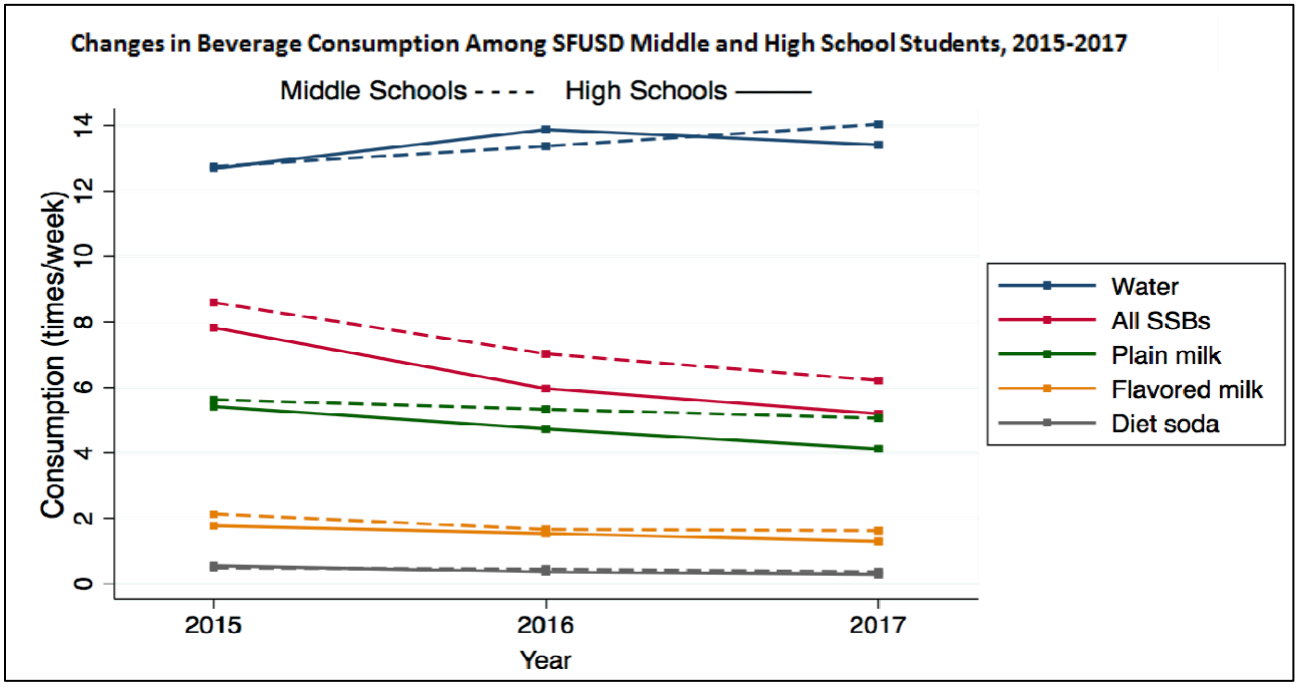
Both the YRBS and SFUSD data suggest middle school students consume more sugary drinks than high school students. Consistent with national trends, students of ethnic minority backgrounds are more likely to have consumed sugary drinks in the prior week than white students. Nationally, among youth, SSB intake is higher among boys, adolescents, Black/African Americans, or youth living in low-income families.[xv]

In San Francisco, Hispanic/Latino middle school students (64%) consume more than the overall average middle school student (48%) and the data suggest this is also true for African American, Filipino, and non-Chinese Asian middle school students though the data for these latter groups is not statistically stable due to small sample sizes.[xvi]

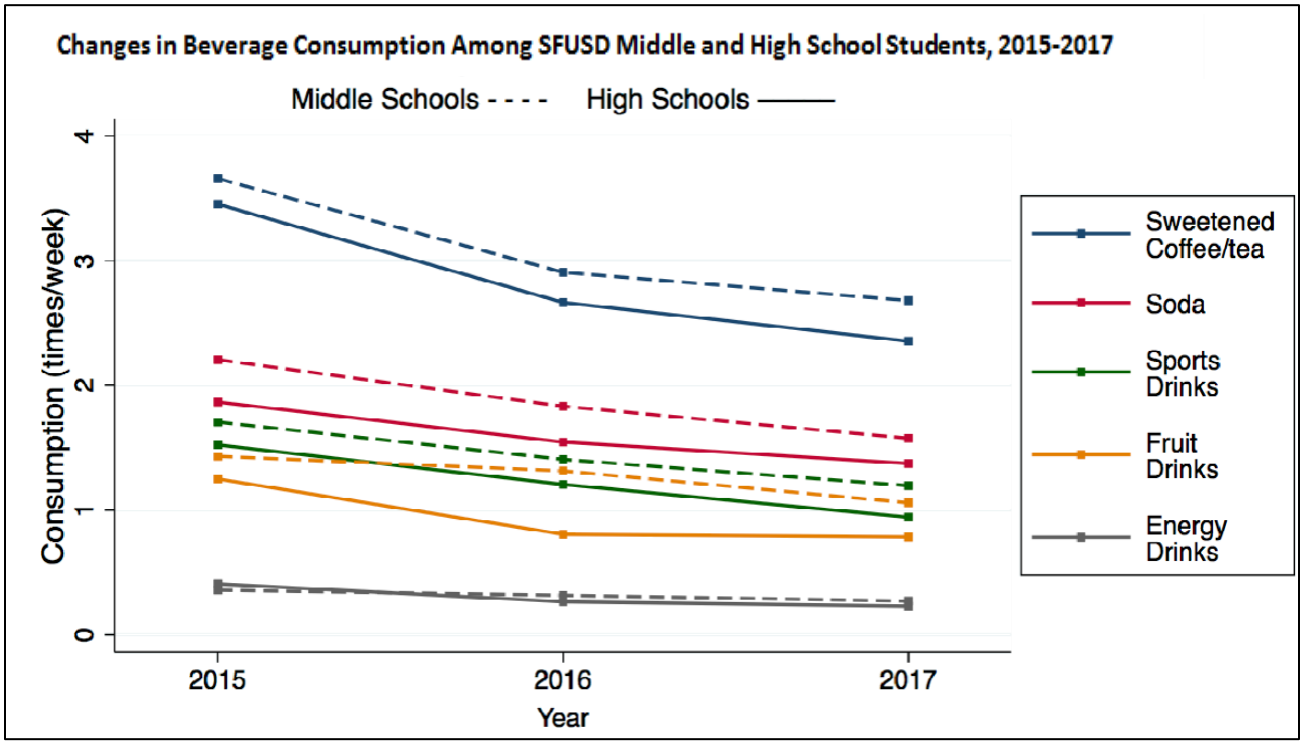




Based on surveys conducted with SFUSD middle and high school students by UC Berkeley and the Nutrition Policy Institute, preliminary results appear to indicate a decline in the frequency of consumption of all sugary drinks between 2015 and 2017 with the exception of energy drinks which is the least frequently consumed sugary beverage at baseline. In contrast, there appears to be an increase in the frequency of water consumption between 2015 and 2017.



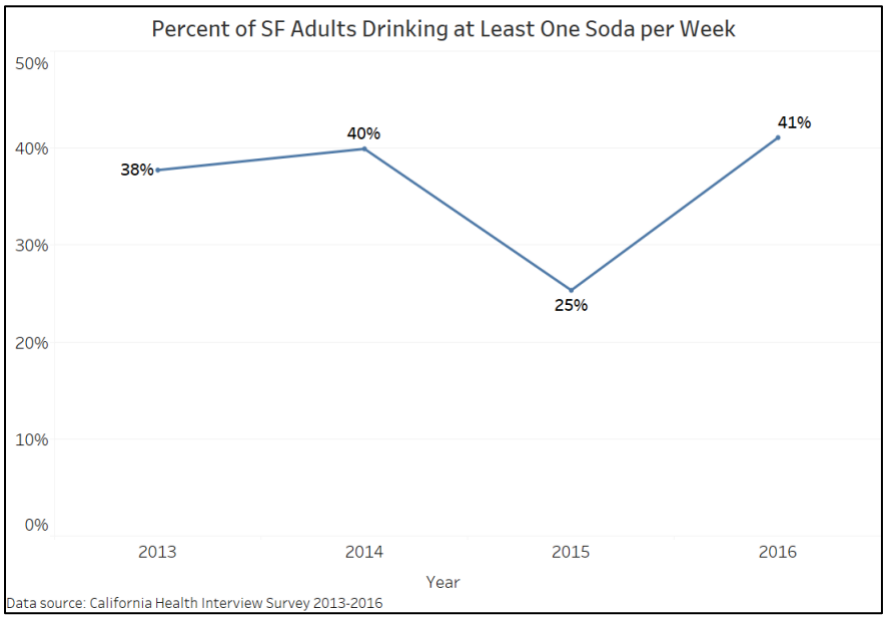
Data Source: San Francisco Unified School District and UC Berkeley, 2018.

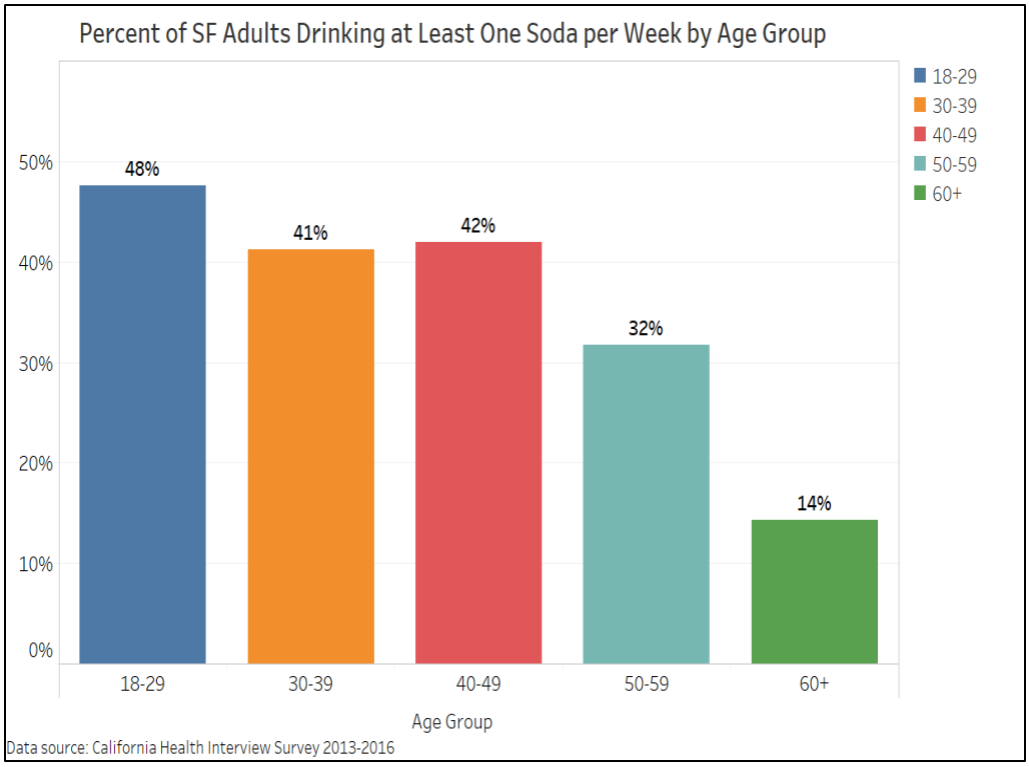


Data Source: San Francisco Unified School District and UC Berkeley, 2018

Adult Sugary Drink Consumption

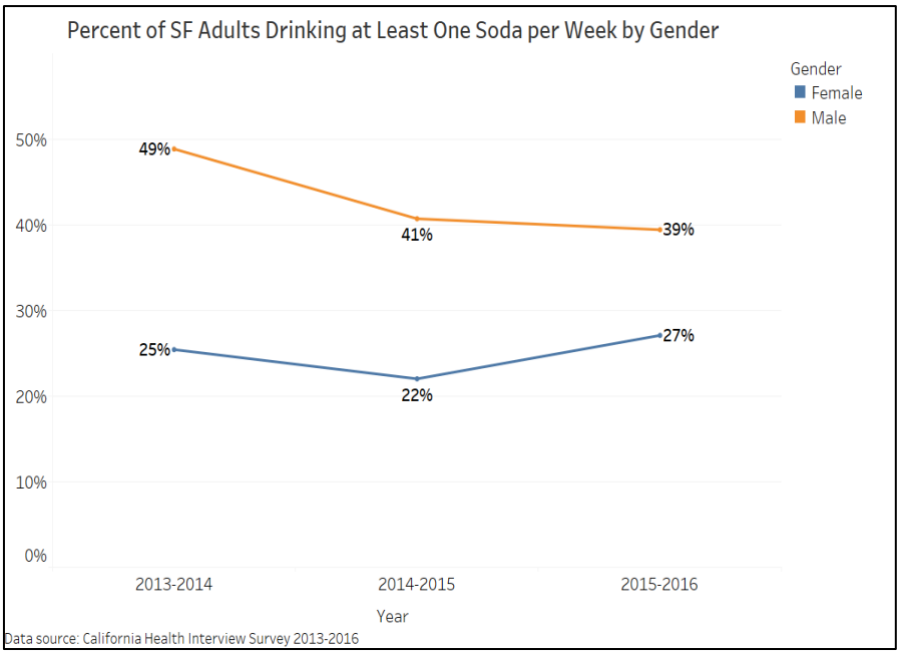
The percent of San Francisco adults reporting drinking soda at least once per week has remained relatively stable since 2013.[xvii] Although the chart shows marked change between 2014 and 2016, this is due to the small sample size and thus a few changes in responses can reflect large changes in the percentages. In California, approximately 40% of adults drank at least one soda per week, which is essentially the same as San Francisco adults.[xviii]

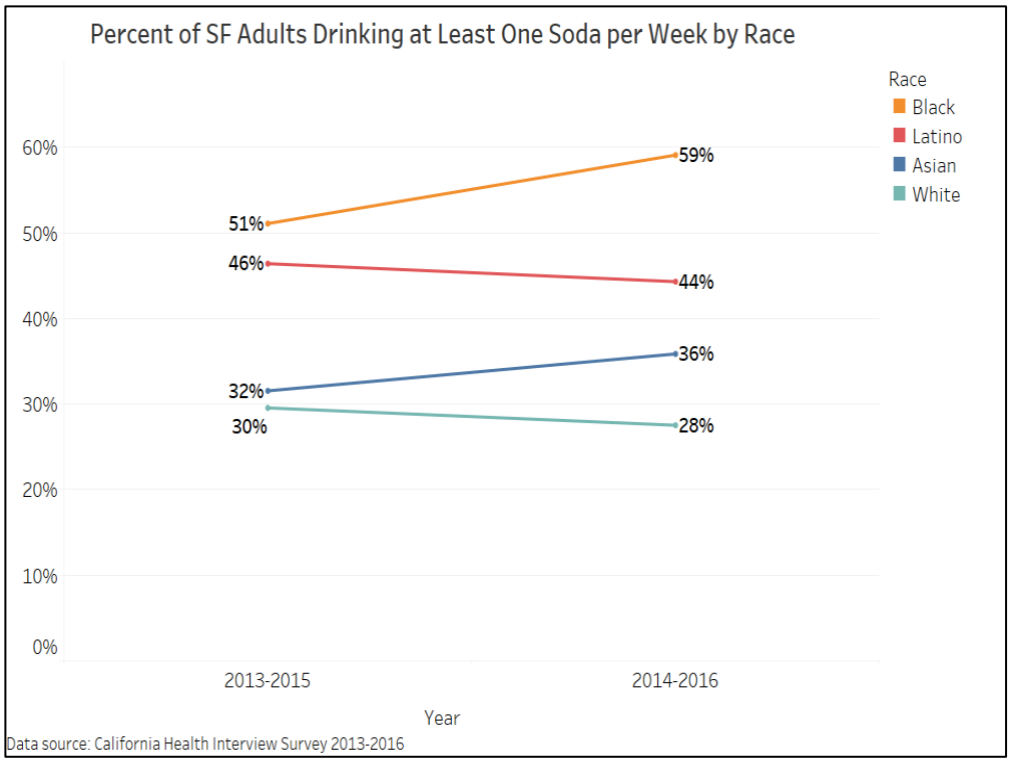




The California Health Interview Survey, found that soda consumption is highest among younger San Francisco adults; nearly 50% of adults between 18 and 29 years report consuming soda at least once per week.

Male adults tend to be more likely to consume soda than female adults. Although there appears to be a trend toward decreasing consumption among men, the small sample size is too small to determine true trends at this time.

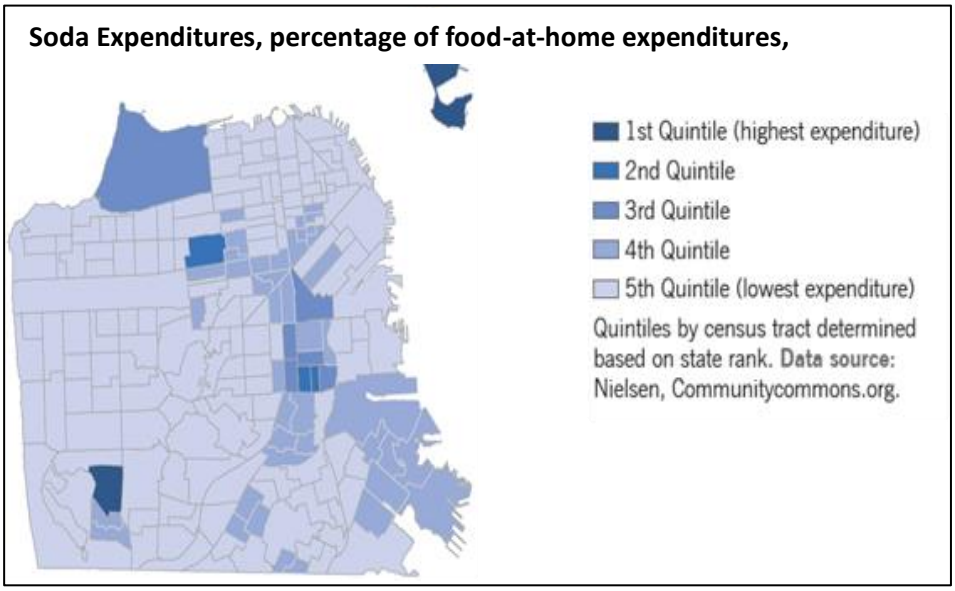




Similar to trends seen in the youth data, San Francisco Black and Latino adults consume more soda than their Asian and White counterparts.

Sugary Drink Sales and Expenditures

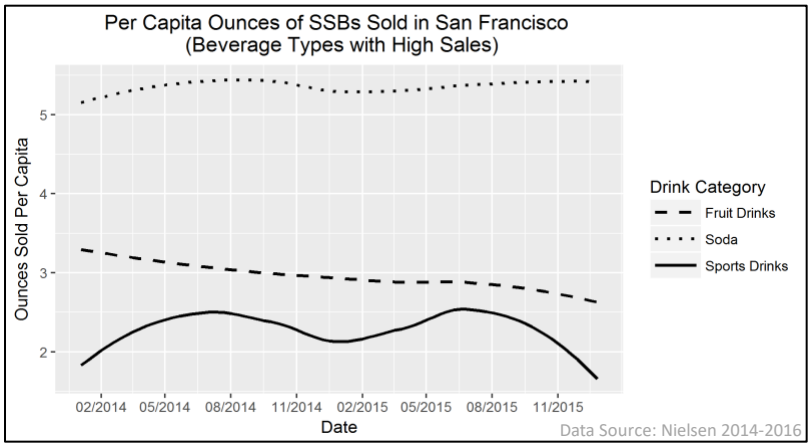
The proportion of income spent on soda varies by neighborhood. Residents in Bayview Hunters Point, Mission, Tenderloin, SOMA, Treasure Island, West Addition as well as students in Lakeshore spend a greater proportion of their household income on soda. This map coincides with the soda consumption data showing the neighborhoods where many Black/African American and Latino populations live and consume more sugary drinks than the overall average.

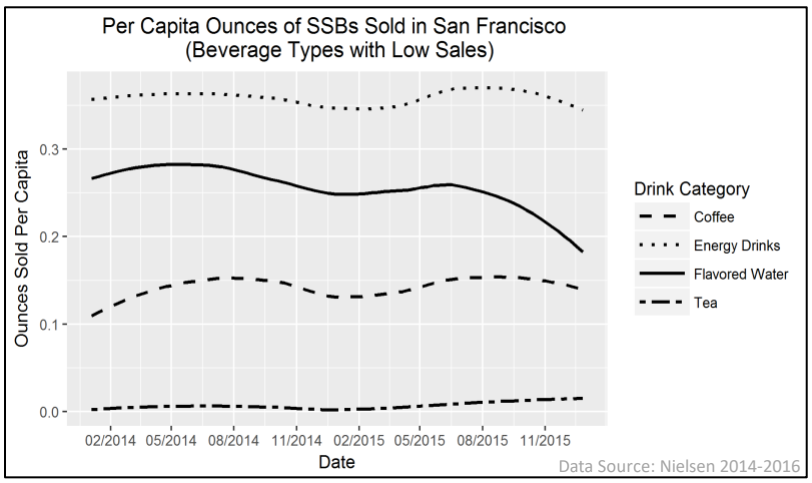


With respect to sugary drink sales, Nielsen data indicate that sodas account for the largest proportion of weekly sugary drink sales at about 5 oz./capita.

Sport and fruit drinks account for about one to three ounces per capita. Because these data represent only 40-50% of retail sales from stores that sell SSBs in San Francisco, the per capita ounces shown in the following graphs is an underestimate.

Other sugary drinks, such as coffees/teas, energy drinks, and flavored waters, show lower sales volumes in Nielsen data averaging between, 0 – 0.3 ounces per capita.





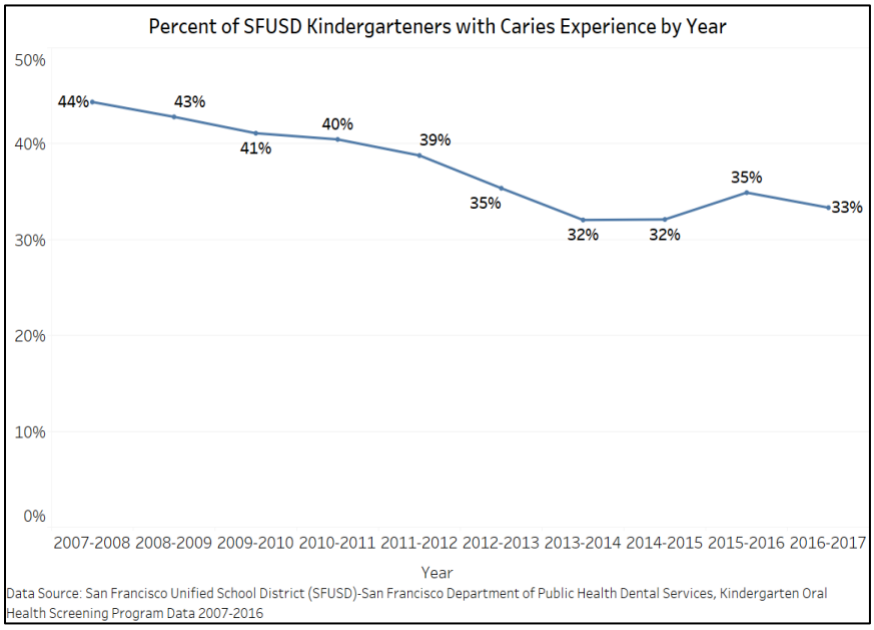
Current State of Diet-Sensitive Health in San Francisco

Children's oral health

Oral health is essential to general health and quality of life. It is a state of being free from mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual's capacity in biting, chewing, smiling, speaking, and psychosocial well-being.[xix]

Tooth decay is the most common chronic disease and leading cause for missed school days. Poor oral health can cause pain, dysfunction, school or work absences, difficulty concentrating, and poor appearance—problems that greatly affect quality of life and ability to interact with others. Children who experience dental decay miss more school, have lower academic achievement, and have an increased risk for a lifetime of dental problems.[xx,xxi] California students are estimated to miss 874,000 days of school each due to dental problems, costing schools over $29 million in funding based on reductions in the average daily attendance rate.[xxii] Poor oral health can reflect systemic inflammation, which over time may limit growth and development, as well as increase risk of adverse health outcomes, including hypertension, cardiovascular disease, and cancer.[xxiii]

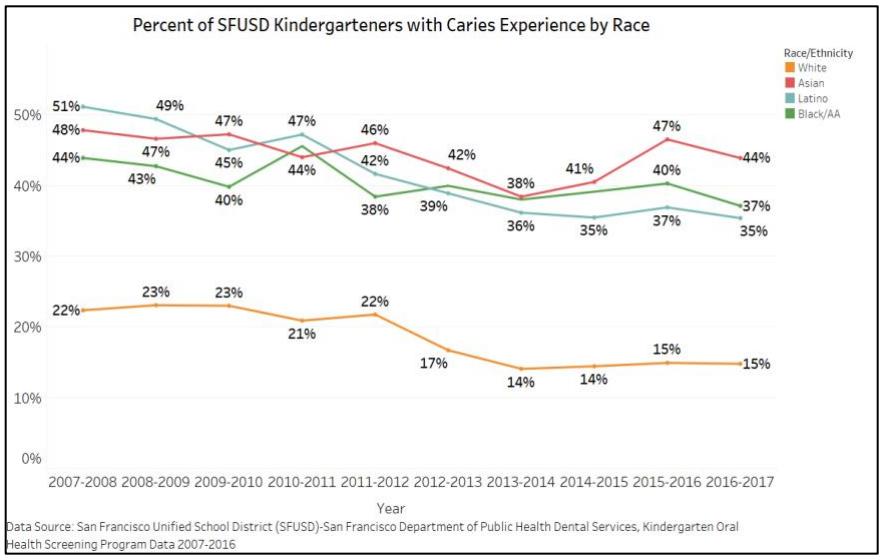
Routine preventive dental care including daily oral hygiene, fluoride treatments and dental sealants, and reduction of sugars in the diet can prevent tooth decay. Fluoride varnish applications reduce decayed/missing/filled tooth surfaces by 43% in permanent teeth and by 37% in primary teeth.[xxiv]
Dental sealants can prevent up to 80% of tooth decay in children and adolescents.[xxv]

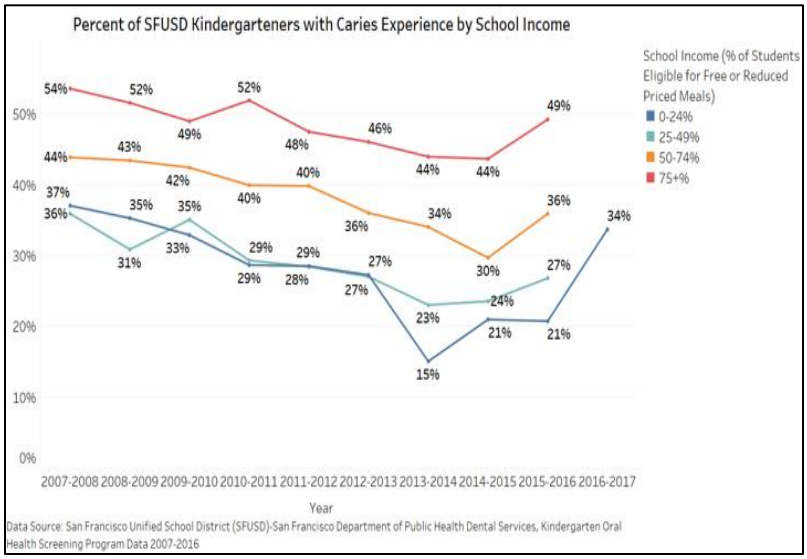


Despite steady decreases in caries (i.e. tooth decay or cavities) prevalence in San Francisco over the past 10 years, tooth decay remains a prevalent local health problem. In 2016–17, 33% of San Francisco Unified School District (SFUSD) kindergarteners had experienced caries. Nationally, in 2013-2014, 29.7% of children ages 3 to 5 years experienced at least one cavity in their primary teeth. In 2013–14, 51.7% of children ages 6–9 years had dental caries in at least one primary or permanent tooth.[xxvi] In California, 54% of kindergartners and 71% of third graders had experienced dental caries, and that 28% and 29%, respectively, had untreated caries.[xxvii]

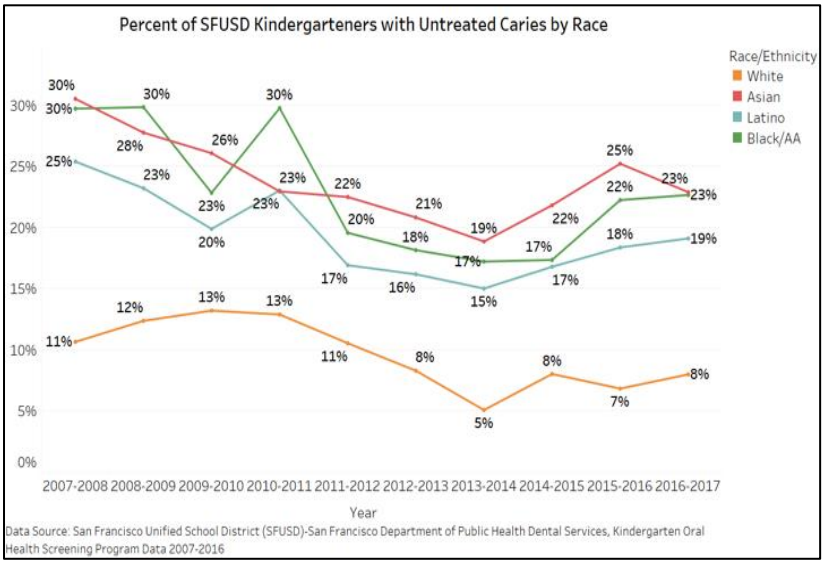
Even if decay is properly treated before kindergarten, children who do not receive fluoride treatments, dental sealants, or reduce sugars in the diet are at higher risk for the development of further caries. Cavity fillings also need ongoing care, management, and possible replacement. Therefore, the initial development of caries signals the beginning of a lifetime of otherwise preventable dental procedures.

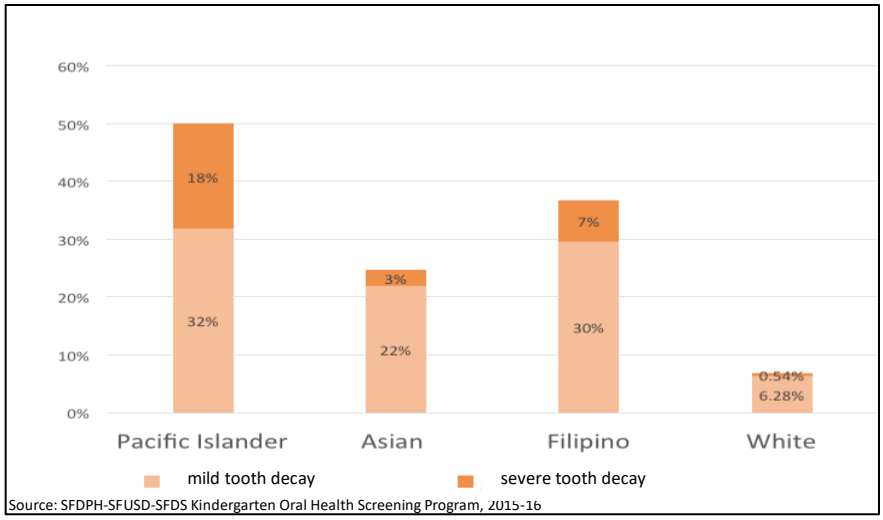
Consistent with nationwide patterns and trends, disparities in oral health persist in San Francisco. Low-income and minority children have higher tooth decay rates. In San Francisco, low-income, Black/African American, Latino, and Asian children continue to be more than two to three times as likely to experience dental decay as higher-income and White children. Pacific Islander kindergarteners are seven times more likely than White kindergarteners to have caries.





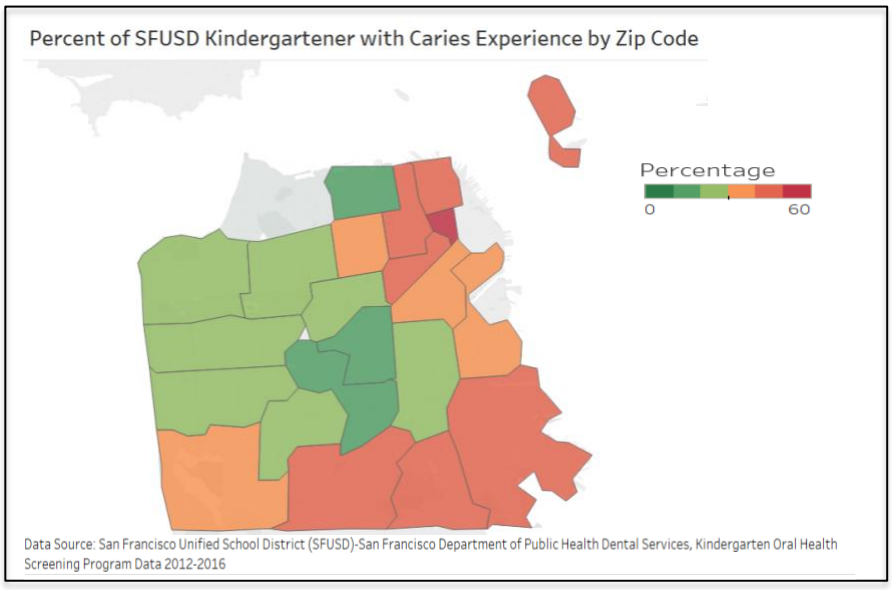
Disparities are similar for untreated caries with Black/African American, Latino, and Asian children experiencing more than two to three times the prevalence of untreated caries as compared to White children.





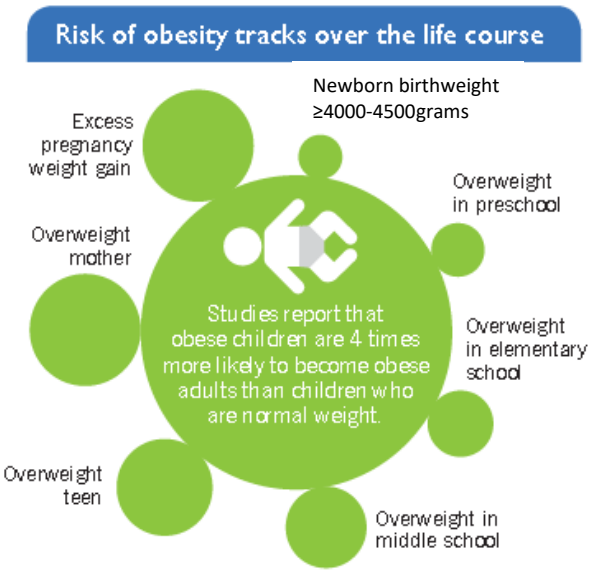
Source: SFDPH-SFUSD-SFDS Kindergarten Oral Health Screening Program, 2015-16

Caries experience clusters by neighborhood. Children in some San Francisco neighborhoods like Chinatown, North Beach, Nob Hill/Russian Hill/Polk, Tenderloin, SOMA, Bayview/Hunter's Points, Visitation Valley, Excelsior, and Portola experience two to three times more caries. These are also the neighborhoods with high proportions of Latino, African American, Asian, and low income residents.



Overweight and Obesity

Overweight and obesity reflect excess body weight relative to height. For adults, overweight is defined as a body mass index (BMI) of 25.0 to 29.9 kg/m2 and obesity as a BMI of ≥ 30 kg/m2.[xxviii] For infants and toddlers up to two years of age, excess weight is identified as a weight-for-length greater than or equal to the 98th percentile.[xxix] For children and adolescents, the CDC defines overweight as a body mass index (BMI) percentile over the 85th percentile for age and sex.[xxx] FitnessGram® data for youth in San Francisco describe students as having body compositions either being within or outside the "healthy fitness zone" which is comprised of BMI and a measure of percent body fat. For pregnant women, excess weight gain is defined as a gain of more than 40 pounds if the mother is underweight before pregnancy, more than 35 pounds if she is normal weight before pregnancy, more than 25 pounds if she is overweight before pregnancy, and more than 20 pounds if she is obese before pregnancy.[xxxi]



Data source: CDPH Birth Statistical Master File

Risk of overweight and obesity begins early in life, during pregnancy, and tracks throughout the life course. Excess maternal weight gain during pregnancy programs the unborn fetus for a lifetime of exaggerated response to insulin and stress hormones, and increased susceptibility to weight gain.[xxxii, xxxiii, xxxiv, xxxv, xxxvi, xxxvii, xxxviii] Excess weight gain during pregnancy is associated with excess infant weight at birth, excess weight gain before age five, and childhood and adult obesity.

FitnessGram Healthy Fitness Zone Measure of Body Composition

Age	Percent Body Fat (Skinfold Measurements/ Bioelectric Impedance Analyzer) Healthy Fitness Zone		Body Mass Index Healthy Fitness Zone	
	Females	Males	Females	Males
5	20.8 – 9.8	18.8 – 8.9	16.8 – 13.6	16.8 – 13.9
6	20.8 – 9.9	18.8 – 8.5	17.2 – 13.5	17.1 – 13.8
7	20.8 – 10.1	18.8 – 8.3	17.9 – 13.6	17.6 – 13.8
8	20.8 – 10.5	18.4 – 8.4	18.6 – 13.7	18.2 – 14.0
9	22.6 – 11.0	20.6 – 8.7	19.4 – 14.0	18.9 – 14.2
10	24.3 – 11.6	22.4 – 8.9	20.3 – 14.3	19.7 – 14.5
11	25.7 – 12.2	23.6 – 8.8	21.2 – 14.7	20.5 – 14.9
12	26.7 – 12.7	23.6 – 8.4	22.1 – 15.2	21.3 – 15.3
13	27.7 – 13.4	22.8 – 7.8	22.9 – 15.7	22.2 – 15.8
14	28.5 – 14.0	21.3 – 7.1	23.6 – 16.2	23.0 – 16.4
15	29.1 – 14.6	20.1 – 6.6	24.3 – 16.7	23.7 – 16.9
16	29.7 – 15.3	20.1 – 6.5	24.8 – 17.1	24.5 – 17.5

Overweight children are more likely to become overweight adolescents who in turn have a 70% chance of becoming an overweight or obese adult.[xxxix,xl] Prevention and early intervention are very important, because obesity is difficult to treat once established.[xli]

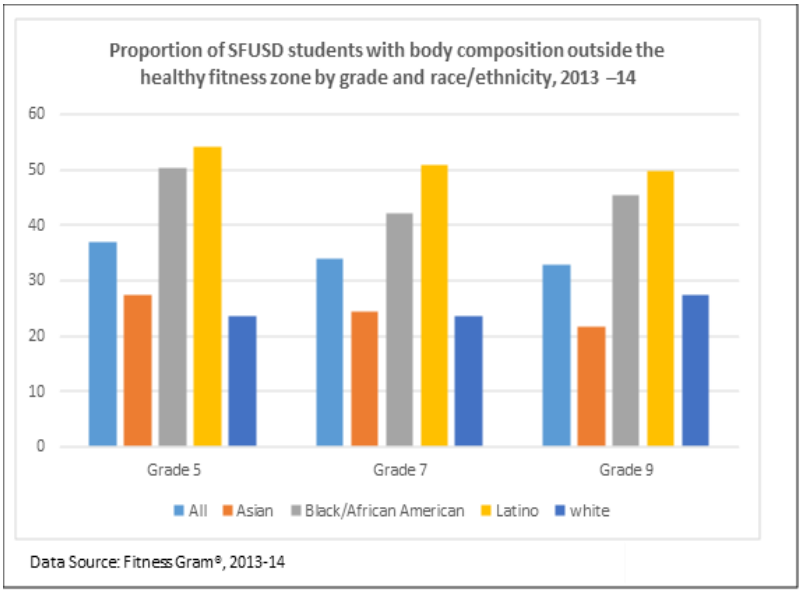
Obesity is associated with greater risk of chronic disease, pain, disability, anxiety, depression, mental illness, and lower quality of life.[xlii] Obesity increases risk of chronic conditions, including high blood pressure, high cholesterol, heart disease, type 2 diabetes, osteoarthritis, breast and colon cancers, sleep apnea, and gynecological problems.[xliii]

Obesity is associated with all-cause mortality, and is a leading cause of preventable death.[xxxviii] [xliv]Obese adults age 20 to 39 have an estimated six years of life lost.[xlv] Interventions to prevent overweight and obesity are recommended to address health disparities.[xlvi]

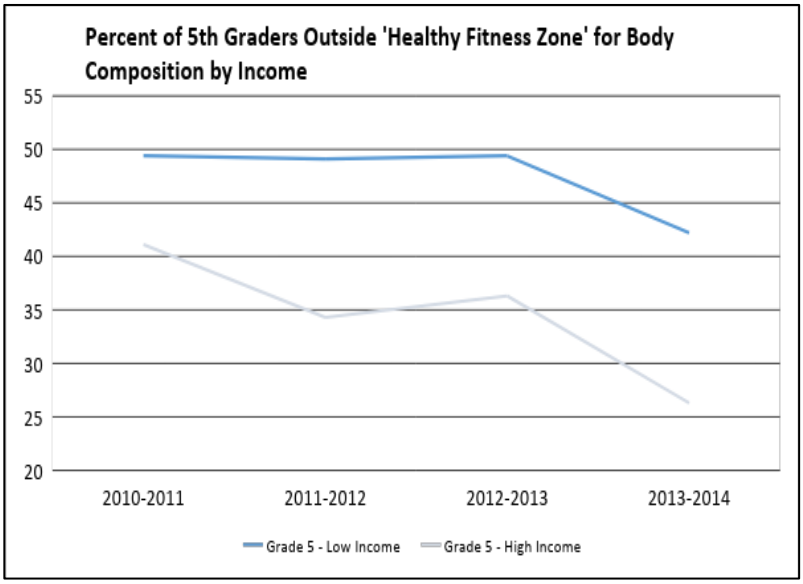
YOUTH – Overweight and Obesity

Nationally, childhood obesity has more than doubled in children and tripled in adolescents in the past 30 years; in 2010, more than one-third of children and adolescents were overweight or obese.[xlvii]

The SF Unified School District assesses students for body mass index (BMI) and other fitness measures annually in grades 5, 7, and 9 (the Fitness Gram®). From 2011 to 2014, the proportion of 5th-, 7th-, and 9th-graders with a body composition outside of the healthy fitness zone decreased from 47%, 39%, and 39%, respectively, to 37%, 34%, and 33%, respectively.



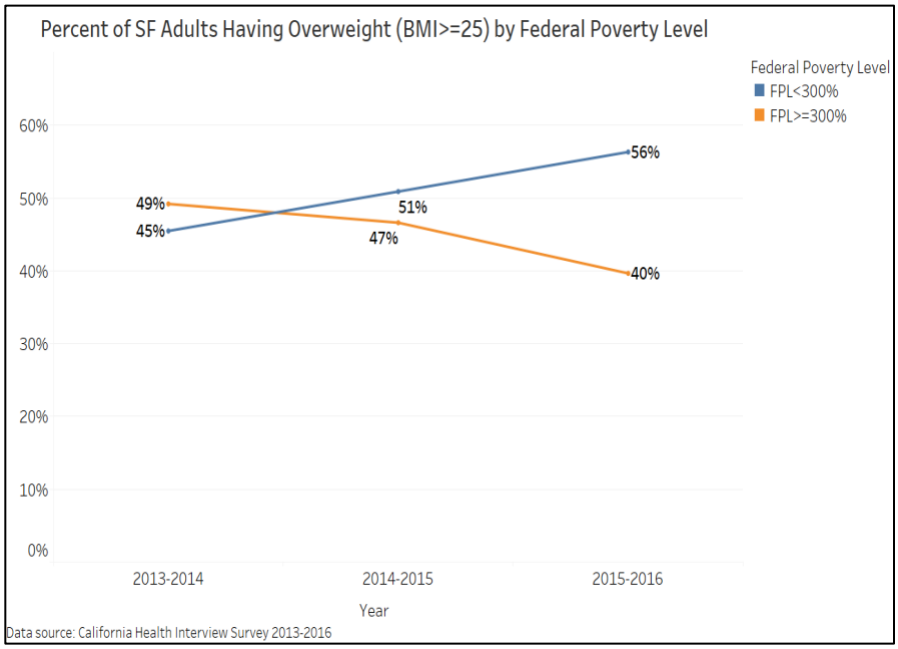
Compared to the broader population of SFUSD students, a higher proportion of Black/African American and Latino students in all grade levels have a body composition outside of the healthy fitness zone with approximately 40-50% of Black/African American and 50% of Latino students compared to about 25% of White students. White and Asian students have lower prevalence of body composition outside of the healthy fitness zone than the general population by grade. These trends are mirrored in the adult population.



Higher income students have a greater decrease in body composition outside the healthy fitness zone than lower income students. Among higher income 5th-graders attending SFUSFD, the prevalence of body composition outside the healthy fitness zone decreased by 15 percentage points between 2014 and 2011 whereas for low income 5th-graders the prevalence decreased by seven percentage points. Between 2011 and 2014, the disparity widened from an eight-percentage-point difference between income groups (49% vs. 41%) to a 16-percentage-point difference: 42% of low income 5th-graders have a body composition outside the healthy fitness zone compared to 26% of higher income 5th-graders.

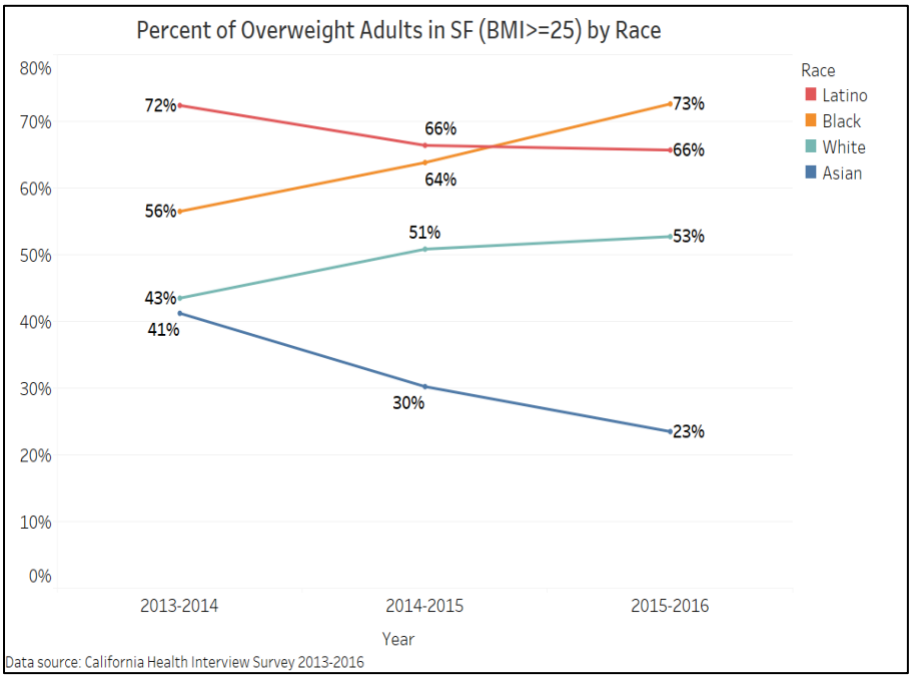
ADULTS – Overweight and Obesity

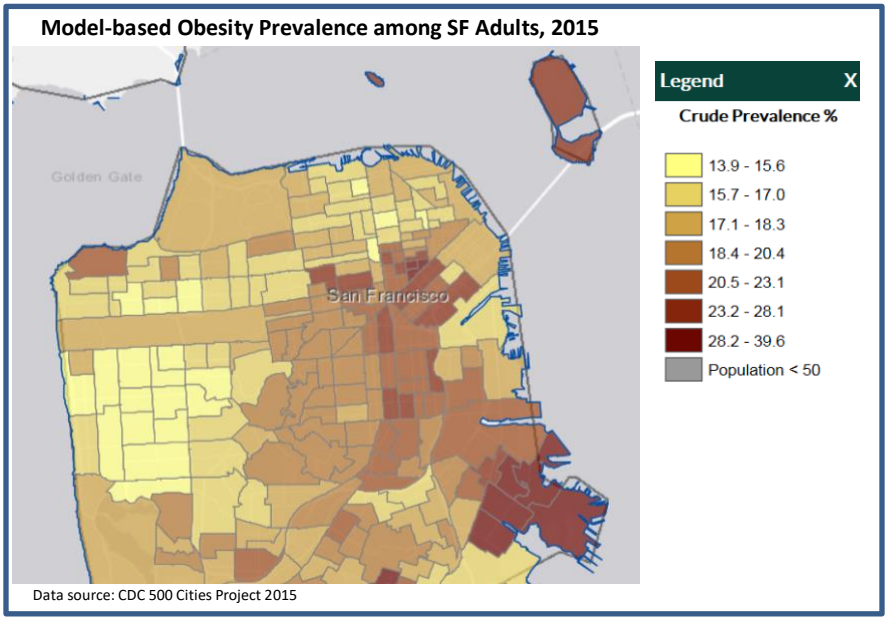
Overweight (which includes obesity BMI>30) among adults has remained relatively stable since 2013. In 2016, 42% of San Francisco adults reported a height and weight consistent with the overweight/obesity category compared to 62.7% of adults in California.[xlviii]



Consistent with national obesity disparities, the risk of overweight and obesity locally varies by income, race/ethnicity, and zip code.

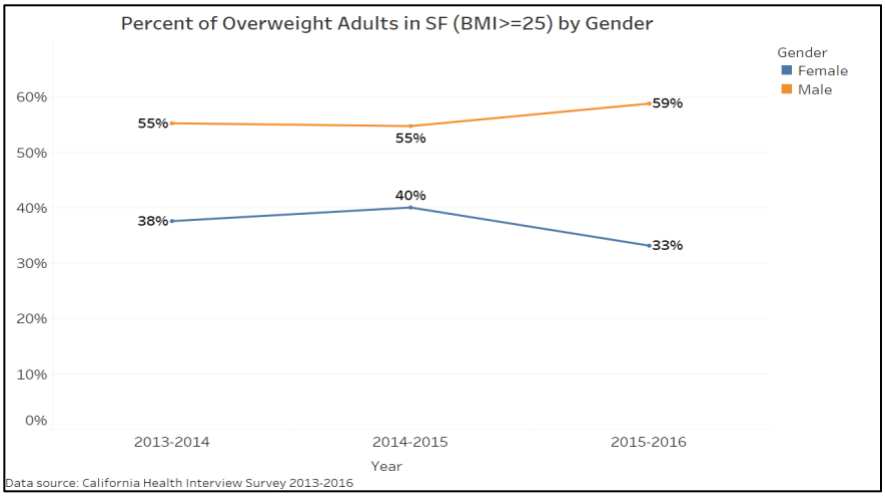
Pooled data from the California Health Interview Survey indicates that Black/African Americans (73%), Latinos (66%), and Whites (53%) have higher prevalence of overweight/obesity than the general San Francisco adult population (42%) and are statistically significantly higher as compared with Asian populations (23%).[xlix]

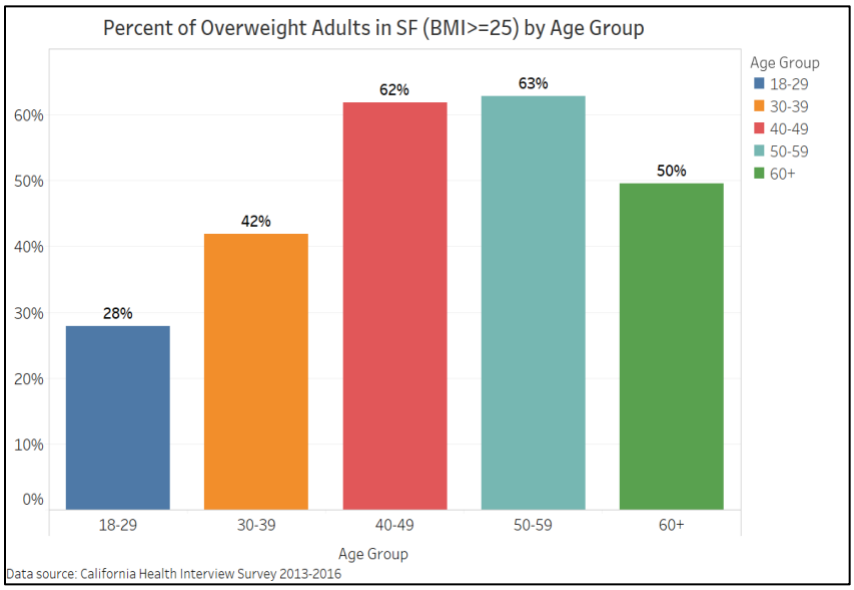




Obesity is concentrated in parts of Bayview Hunters Point, Tenderloin, Western Addition, Hayes Valley, Visitacion Valley, and McLaren Park, coinciding with concentrations of populations at higher risk.[I]

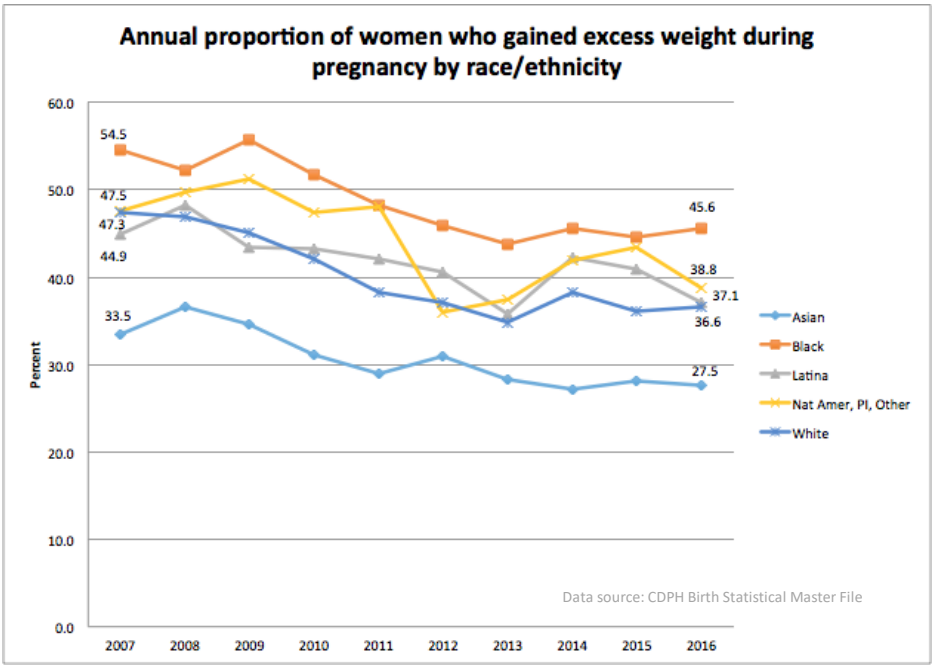
When considering gender, adult males (59%) have a statistically significantly higher prevalence of overweight than females (33%). Nationally, men (71%) have a higher prevalence of overweight than women (59%) as well.



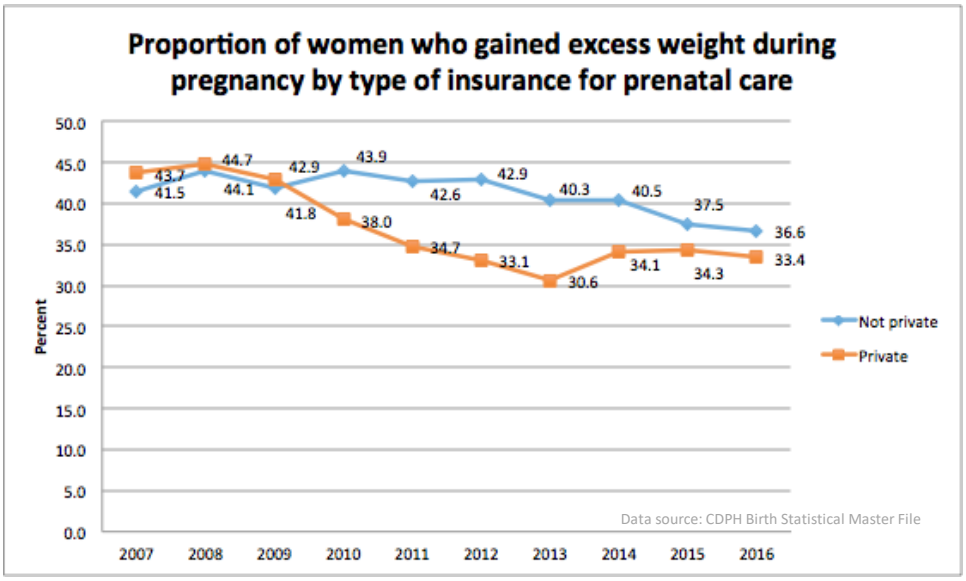


Adults aged 40-59 are overweight at a significantly higher prevalence than 18-39 year olds.

PREGNANT WOMEN – Overweight and Obesity



More than one third of women (34.3%) gained excess weight during pregnancy in San Francisco in 2016, representing a general decline since 2007. Approximately twice as many women who are overweight or obese before pregnancy gain excess weight during pregnancy compared to women who are normal weight before pregnancy.[li] Although there has generally been a decline in excess weight gain during pregnancy, disparities remain. Black/African American are more than 1.5 times as likely as Asian women to gain excess weight during pregnancy compared to Asian women (45.6% vs. 27.5%).



The disparity gap in excess weight gain during pregnancy between mothers with private versus public insurance has narrowed in recent years from 2012 when there was a 9.8 percentage point difference between private and publicly insured women to a 3.2 percentage gap in 2016.

Diabetes

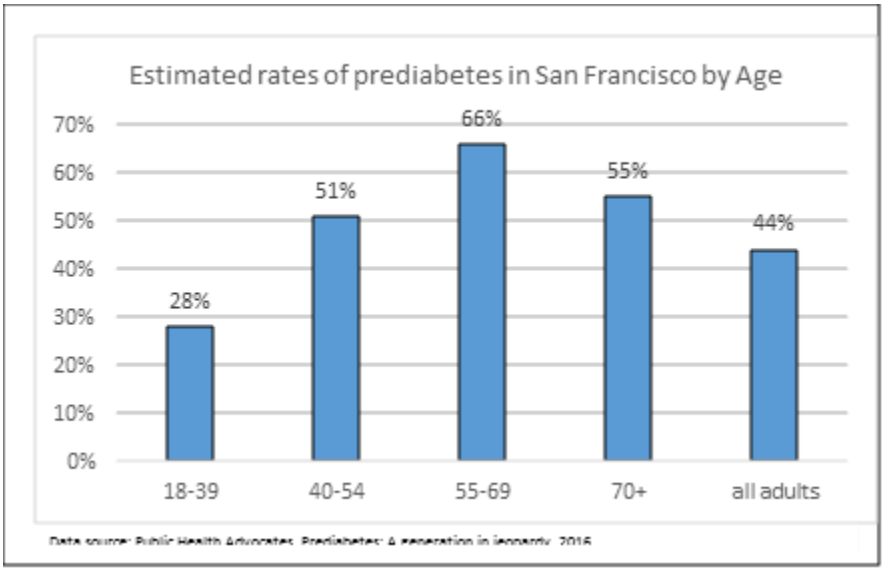
Diabetes is a condition in which the body does not properly process food for use as energy, leading to increased levels of glucose in the blood which can cause damage to tissues and organs throughout the body. The two main types of diabetes are type 1 diabetes and type 2 diabetes.[lii] Type 1 diabetes, previously called insulin-dependent diabetes mellitus or juvenile onset diabetes, accounts for five to 10% of all cases of diabetes and is considered primarily a genetic disease whose onset is not particularly influenced by diet or the environment. In contrast, Type 2 diabetes, previously called non-insulin-dependent diabetes mellitus or adult-onset diabetes, accounts for about 90 to 95% of all diagnosed cases of diabetes. A third type, gestational diabetes, develops only during pregnancy. Babies born to mothers with gestational diabetes may suffer from excessive birth weight, preterm birth, respiratory distress syndrome, low blood sugar, and type 2 diabetes later in life. Women who have gestational diabetes during pregnancy have a 7.5-fold increased risk for the development of type 2 diabetes after delivery. This increased risk persists for their lifetime, even if the diabetes does not develop immediately following pregnancy.[liii] Risk factors for Type 2 diabetes and gestational diabetes include older age, obesity, family history of diabetes, prior history of gestational diabetes, impaired glucose tolerance, unhealthy diet, physical inactivity, and race/ethnicity.

Prediabetes, also referred to as impaired glucose tolerance or impaired fasting glucose, is a condition in which blood glucose levels are higher than normal but not high enough for a diagnosis of diabetes. People with prediabetes have a much higher risk of developing type 2 diabetes, as well as an increased risk for cardiovascular disease.[liv] Without intervention, up to 30 % of people with prediabetes will develop type 2 diabetes within five years, and up to 70 % will develop diabetes within their lifetime.[lv]

Type 2 Diabetes can be prevented or delayed through moderate weight loss, exercise and improved nutrition, yet, type 2 diabetes impacts health and health spending significantly.[lvi, lvii] Diabetes is the eighth leading cause of death in San Francisco which is an underestimate since heart disease, the leading killer, is often worsened by having concurrent diabetes.[lviii] It is also the leading cause of kidney failure and the need for dialysis[lix] and can cause other serious health complications including blindness and lower-extremity amputations. Diabetes reduced the lifespan of San Franciscans by approximately eight years and as estimated by San Francisco's Budget and Legislative Analyst Office, the City and County of San Francisco pays over $87 million for direct and indirect diabetes care costs.[lx]

San Francisco Prediabetes Prevalence

A study conducted by the UCLA Center for Health Policy Research and commissioned by the California Center for Public Health Advocacy (CCPHA) analyzed hemoglobin A1c and fasting plasma glucose findings from the National Health and Nutrition Examination Survey together with California Health Interview Survey data from over 40,000 respondents. The study estimates prediabetes



rates by county and estimated that 44% of adults in San Francisco have prediabetes compared to 46% in California generally.[lxi]

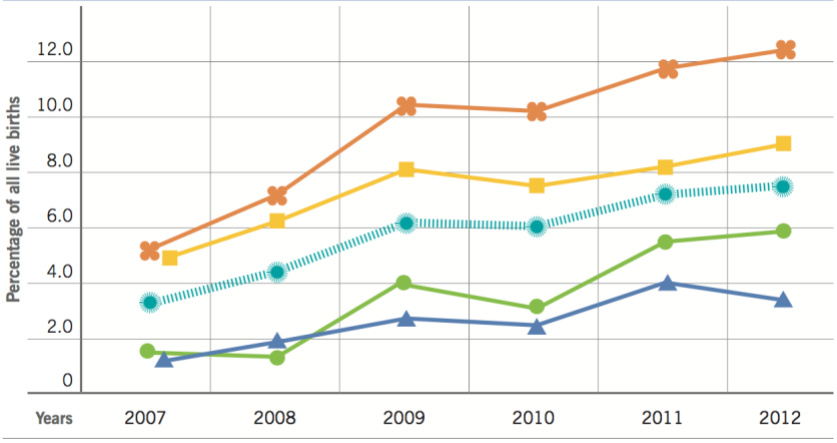
San Francisco Type 2 Diabetes Prevalence

Approximately 4.4% of surveyed San Franciscans reported ever being diagnosed with diabetes on the CHIS survey compared to 8.9% of Californians. However nationally, nearly 1 in 4 people living with diabetes are undiagnosed[lxii] thus the true prevalence of type 2 diabetes in San Francisco is likely higher. The CDC has modeled diabetes prevalence in San Francisco and estimates the prevalence to be closer to 8.6%.[lxiii]

San Francisco Gestational Diabetes Prevalence and Disparities

Despite a likely lower prevalence of diabetes than California in general, gestational diabetes for San Franciscans is increasing for all ethnicities at rates exceeding national rates.

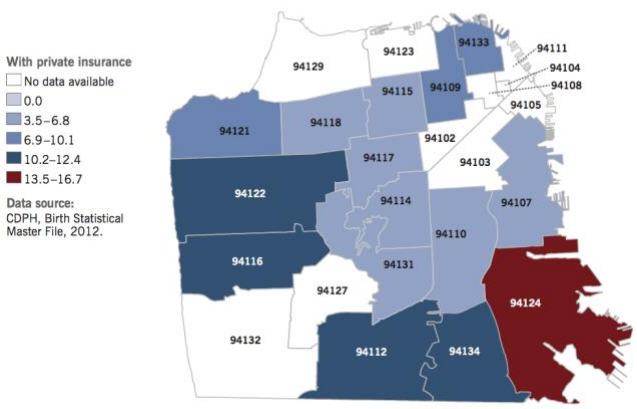
Figure A: Live births to women diagnosed with gestational diabetes, 2007–12



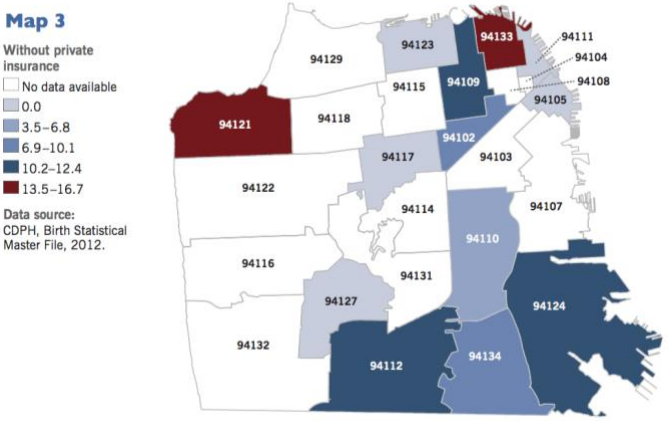
San Francisco, Asian, B/AA, Latino, White. **Data source:** CDPH, Birth Statistical Master File, 2007–12.

Among women with private insurance, those living in the Sunset and Southeast neighborhoods of San Francisco were at highest risk of gestational diabetes. For women with Medi-Cal coverage, the highest concentration of gestational diabetes was in the Richmond and Chinatown/North Beach neighborhoods.

Map 2: Zip code-specific gestational diabetes prevalence among singleton births by insurance status, 2012



Map 3



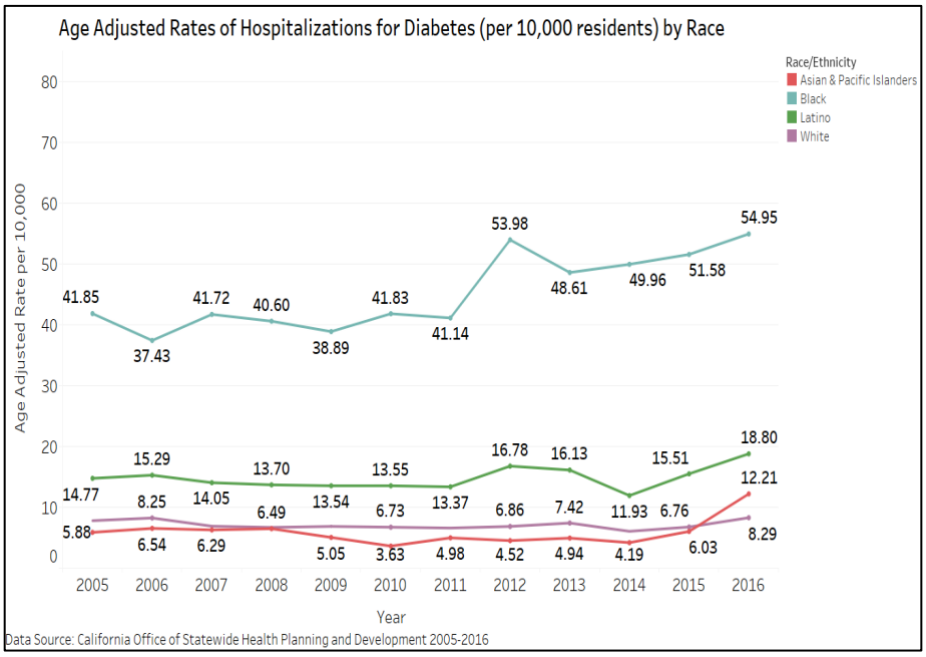
National Ethnic Disparities in Prediabetes and Type 2 Diabetes

Data on disparities in prediabetes and Type 2 diabetes prevalence across ethnicity are lacking in San Francisco but trends are expected to mirror state and national data. There are statistically higher prediabetes rates among young adult (age 18 to 39) Pacific Islanders (43 percent), African-Americans (38 percent), American Indians (38 percent), multi-racial Californians (37 percent), Latinos (36 percent) and Asian Americans (31 percent) than Whites (29 percent).[lxiv]

As for Type 2 diabetes, Latinos, Native Americans, and some Asian Americans and Pacific Islanders have increased risk for type 2 diabetes. Black/African Americans are at particularly high risk for type 2 diabetes. An estimated one out of every two Black/African American and Latino children born after 2000 will have type 2 diabetes in their lifetime.[lxv] Over the past 30 years the prevalence of type 2 diabetes among Black/African Americans nationally has quadrupled and Black/African Americans are 1.7 times as likely to develop type 2 diabetes as Whites.[lxvi] Black/African Americans are not only more likely than Whites to develop type 2 diabetes but also experience greater disability from diabetes-related complications such as amputations, adult blindness, kidney failure, and increased risk of heart disease and stroke; death rates for Blacks with type 2 diabetes are 27 % higher than for Whites.

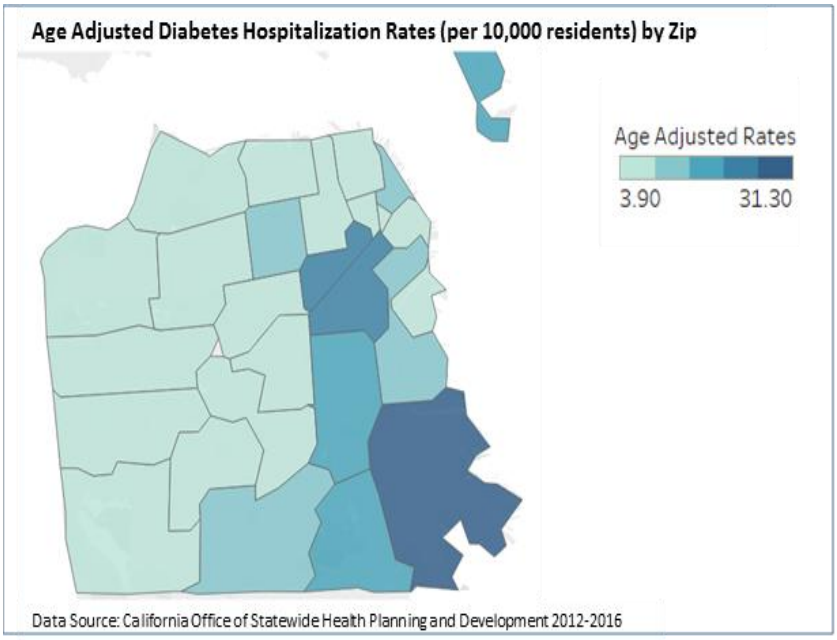
San Francisco Disparities in Diabetes

The diabetes specific data available for San Francisco that can be stratified by ethnicity pertains to hospitalizations due to diabetes.

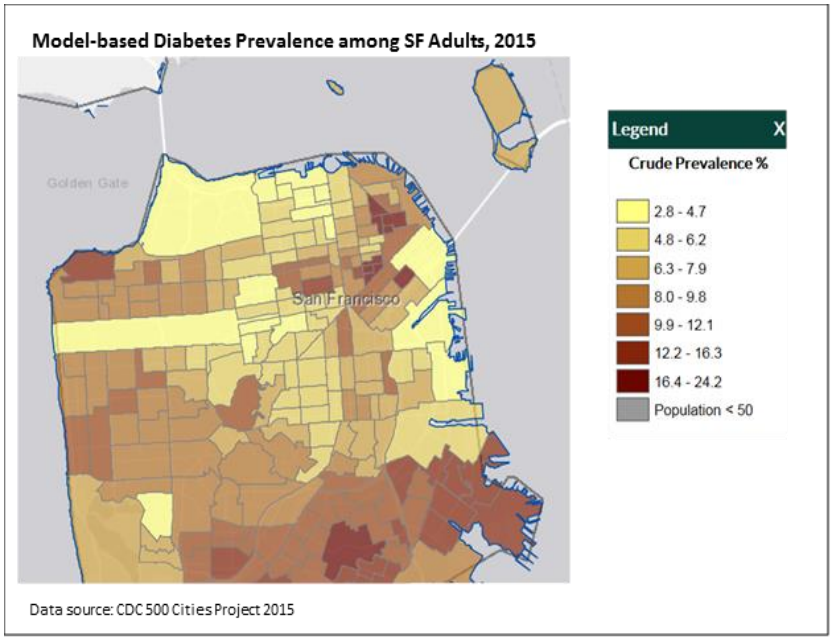


Diabetes hospitalization rates (shown here as cases per 10,000 residents) were markedly higher among Black/African Americans (55 per 10,000 residents) and Latinos (19 per 10,000 residents) than Whites (8 per 10,000 residents) and Asian Pacific Islanders (12 per 10,000 residents). Hospitalization rates for Black/African Americans, Latinos, and Asian/Pacific Islanders have all increased since 2014.[lxvii]

Residents in the eastern zip codes (94102, 94110, 94115, 94124, and 94130) are more likely to be hospitalized due to diabetes than those living elsewhere in San Francisco.



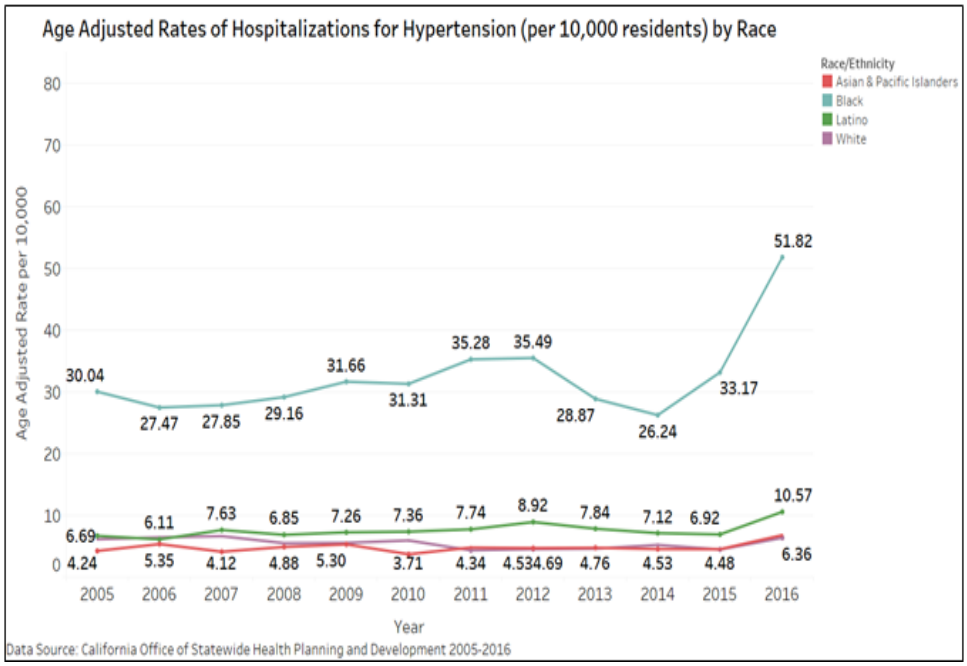
The CDC's modeled data estimates that the highest prevalence of diabetes occurs in the southeast regions of San Francisco.[lxviii]



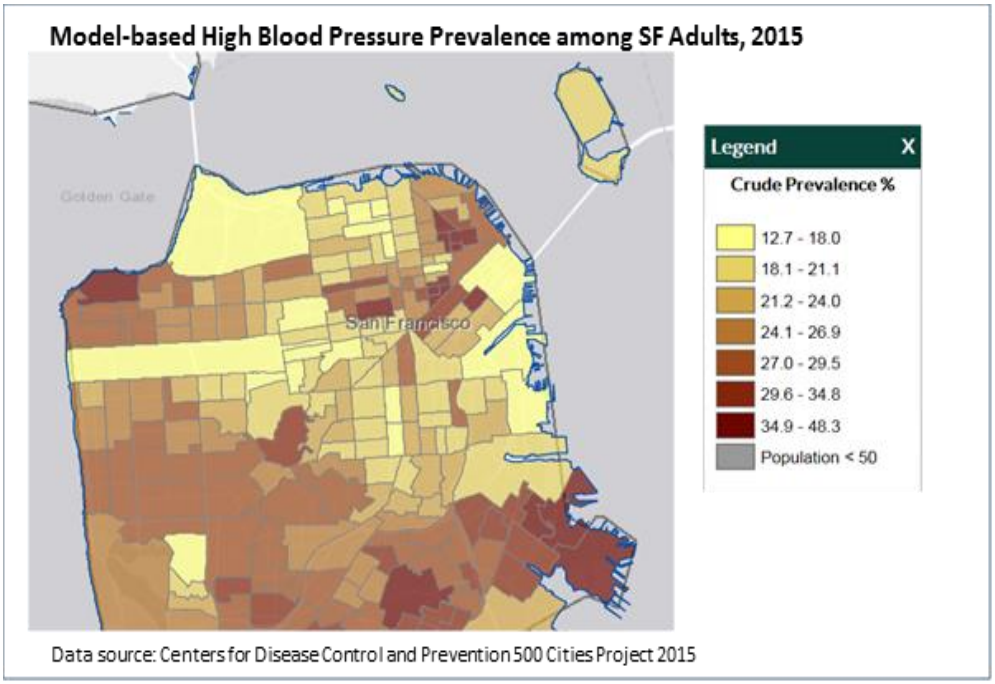
Hypertension

Hypertension, also called high blood pressure, is a condition in which the force of blood pushing against the vessel walls is higher than normal. This increased pressure damages blood vessel walls and can lead to complications such as cardiovascular disease (including heart attack and stroke), kidney disease, and blindness. Hypertension is the second leading cause of kidney failure.[lxix] Along with diabetes, hypertension is the major risk factor and contributor to cardiovascular disease which is the leading cause of death in San Francisco and nationally. Diet, physical activity, smoking, stress, family history, and genetics all contribute to the development and management of hypertension.

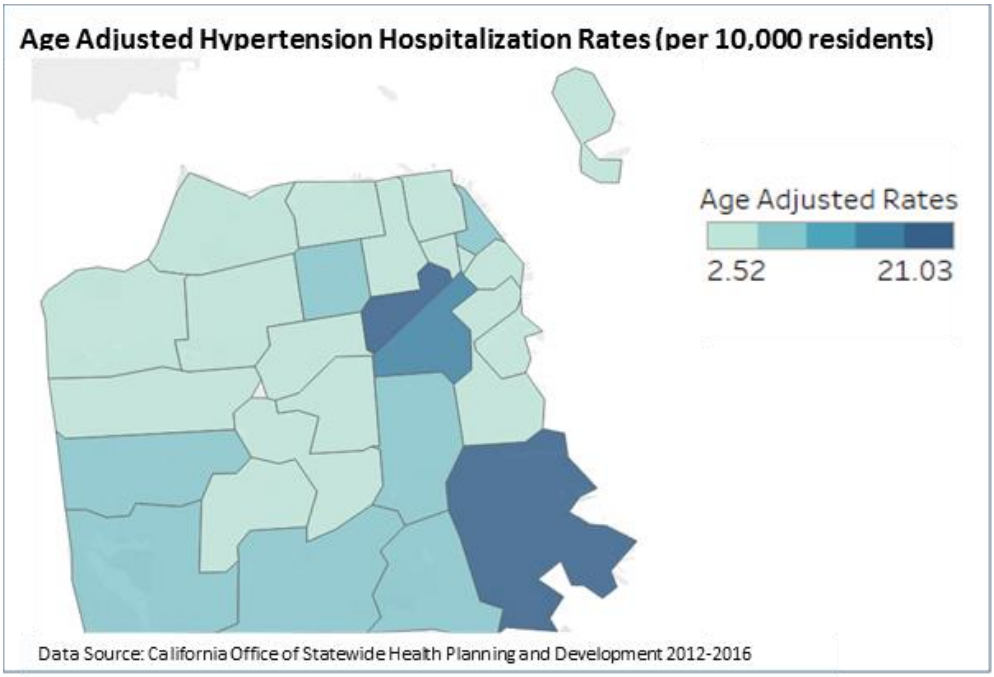
Approximately 18% surveyed San Franciscans reported ever being diagnosed with hypertension on the CHIS survey compared to 28.4% of Californians. However, nationally, nearly half of people living with diabetes are undiagnosed[lxx] thus the true prevalence of hypertension in San Francisco is likely higher. The CDC has modeled hypertension prevalence in San Francisco and estimates the prevalence to be closer to 25%.[lxxi]



As with other chronic disease, disparities are seen across income, ethnicity, and geography. Black/African Americans have a hypertension hospitalization rate (51.82) that is nearly 5 times higher than the next highest group: Latinos (10.57).



Estimates of hypertension prevalence and hospitalization rates due to hypertension are highest in the Tenderloin/SOMA and Bayview Hunters Point neighborhoods.[lxxii]



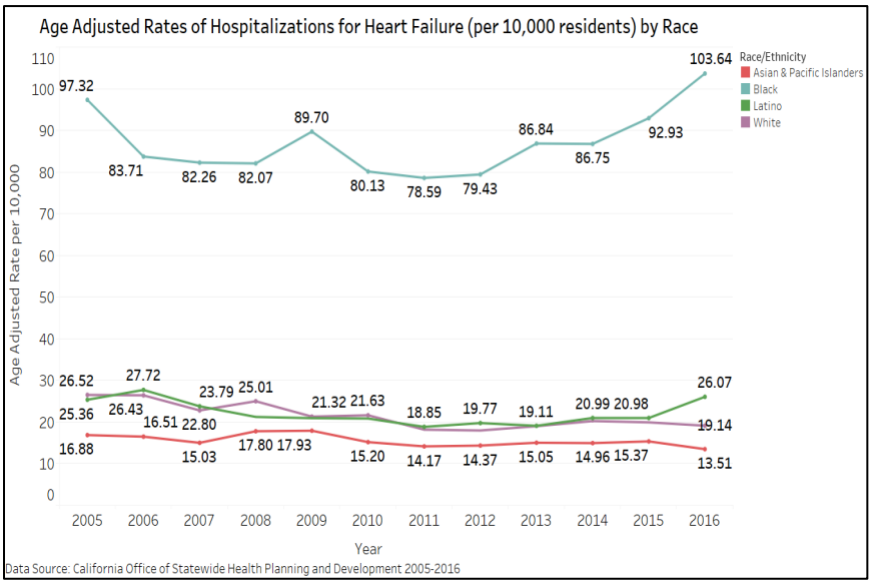
Cardiovascular disease

Cardiovascular disease refers to a class of diseases that involve the heart and blood vessels and is the leading cause of death in San Francisco and nationally. Many of these diseases are attributed to atherosclerosis, a condition where excess plaque builds up in the inner walls of the arteries. This buildup narrows the arteries and constricts blood flow. Diet, physical inactivity, being overweight/obese, cigarette smoking, diabetes, stress, and hypertension all contribute to cardiovascular disease.[lxxiii] Common types of cardiovascular diseases include:

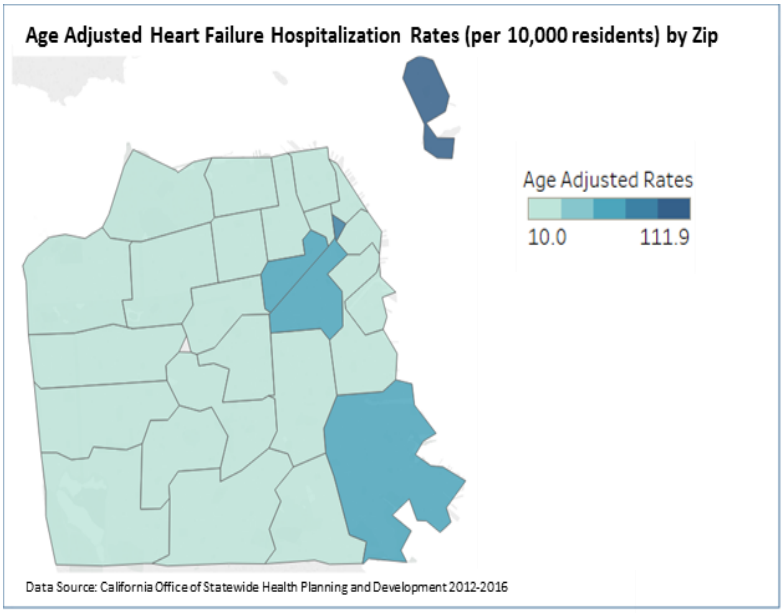
- Coronary heart disease which can lead to heart attack (when blood flow to the heart is blocked)
- Heart failure which is when the heart is not functioning at its full potential and the body is not receiving all of the blood and oxygen it requires.
- Stroke which occurs when not enough blood is getting to the brain which can be due to a blocked blood vessel or a burst blood vessel.

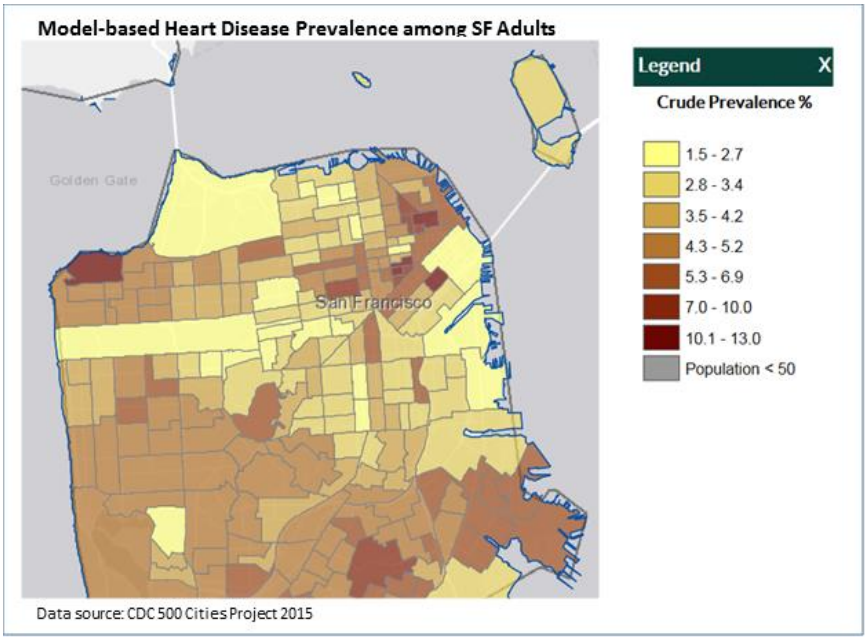
In 2013 –14, 4.7% of adults living in San Francisco reported being told that they had any kind of heart disease, compared to 6.2 % of adults in all of California.[lxxiv]

Hospitalization rates due to heart failure are highest among Black/African Americans. In 2016, Black/African American hospitalization rate (104 per 10,000 residents) for heart failure was more than five times higher than White San Franciscans (19 per 10,000 residents). Hospitalization rates due to heart failure among Latinos (26 per 10,000 residents) was approximately 1.4 times that of White San Franciscans.[lxxv]



Residents living in the zip codes 94124, 94102, 94103, and 94105 have the highest hospitalization rates for chronic heart failure, with rates ranging from 29 to 48 per 10,000 adults.





The CDC's modeling of heart disease also shows geographic disparities across San Francisco, with a higher prevalence of heart disease in the Tenderloin/SOMA area as well as the southeast region of San Francisco.[lxxvi]

ADVISORY COMMITTEE PROCESS

The San Francisco Sugary Drinks Distributor Tax Advisory Committee (SDDTAC) was appointed in September of 2017, and was first convened by the City Administrator's Office on December 21, 2017. The committee was informed at this meeting that the Mayor's Office and the Board of Supervisors had already allocated most of the funds for Fiscal Year 2017-2018 (please see page 5)—taxes that would be collected from January 1, 2018 through June 30, 2018. The City decided it was necessary to allocate those funds during budget planning in June of 2017, adhering to the spirit of Proposition V, and without the benefit of a seated SDDTAC. At this first meeting, the Committee elected co-chairs and made amendments to the Committee rules and structure.

In early January, the Mayor's office presented the Committee with the charge to collectively determine recommendations and allocations for the City's budget for the remainder of fiscal year 2017-2018 ($200,000) and for FY 2018-2020 with a projection of $10.4 million annually for FY 2018-2020. In order to be considered for the City budget in time, the Committee recommendations and allocations for funding needed to be submitted by early to mid-March. Despite the time constraints and scheduling conflicts, the Committee met as a full committee almost every ten days and averaged a meeting per week for subcommittees.

There were three subcommittees: Data and Evidence, Community Input, and Infrastructure. Each Committee member agreed to participate in at least one subcommittee. Each subcommittee gathered input from experts, stakeholders, community groups, and sugary beverage tax advisors from other cities. Based on the evidence and areas of needs, the subcommittee purposed several iterations of its recommendations and allocations of the tax revenue at each full Committee meeting. The full Committee also heard community input at each meeting, during public comment, and even after discussion of most agenda items and each subcommittee was encouraged to incorporate public feedback in its edits.

The Committee had challenges coming to final recommendations for strategies and allocations and had many discussions. Numerous proposals were shared with the SDDTAC. These proposals totaled much more than the Committee could allocate. The Committee was faced with having to allocate less than each constituency had requested. Ultimately, the Committee voted on and approved the strategies and allocations in this report with a vote of 11 in favor, one "no", 1 abstention, and three absences.

Data and Evidence Subcommittee

The Data and Evidence Subcommittee is one of three subcommittees including the Community Input and the Infrastructure Subcommittees created to address the above charges of the SDDTAC.

The dual purpose of the Data and Evidence Subcommittee is to:

1. Navigate, summarize, and disseminate existing scientific evidence-based data to the greater Committee to help inform the Committee's recommendations to the Mayor. (Appendix C & D)
2. Evaluate the information provided by the SFDPH and other research bodies and community based evaluation data to analyze the impact of the SDDT on sugary drink pricing, consumer purchasing behavior, as well as the impact of the SDDT on the health of the public by helping to develop an evaluation system for potential programs and departments funded by the SDDT. Inherent in this task is an evaluation of the impact of the recommendations on the final allocations as determined by the Mayor's Budget.

The Data and Evidence Subcommittee consists of advisory committee members, SF Department of Public Health representatives, and UC San Francisco scientists:

Roberto Vargas, SDDTAC Co-chair
Joi Jackson-Morgan, SDDTAC Co-chair
Jonathan Butler, SDDTAC member, Sub-committee chair
Lyra Ng, SDDTAC member
Rita Nguyen, SDDTAC member
Saeeda Hafiz, SDDTAC member
Libby Albert, SDDTAC member
Irene Hilton, SDDTAC member
Laura Schmidt, UCSF
Margaret Fisher, SFDPH
Christina Goette, SFDPH
Jodi Stookey, SFDPH

The Data and Evidence Subcommittee met weekly (2/12, 2/20, 2/26) and during SDDTAC meetings to discuss evidence-based recommendations for the following domains: (1) awareness, public education, and promotion (2) increase water access, (3) food access, (4) clinical interventions, (5) oral health (6) physical activity, and (7) policy.

The details of the framework were distilled from a list of approximately 70 intervention studies provided by UC Berkeley, UCSF, Stanford, and the San Francisco Department of Public Health.

Subcommittee members selected 21 interventions to highlight that we felt had the greatest potential impact on San Francisco population health and wellness in the context of these first few years of funding (Appendix C & D). The overall subcommittee recommendations aligned with previously established priority populations and priority strategies of implementation.

As a subcommittee we recognize the value of understanding and consulting evidence based practices to reduce sugary drink consumption and health disparities. However, we also recognize that existing data, evidence, and literature do not fully capture the range of effective interventions that could be of benefit to low income and communities of color and studies often do not include participants that are representative of these communities, thus limiting its generalizability to our focus populations in San Francisco. Therefore we encourage the promotion of evidence based practices that are informed by the local cultural, political, and demographic context.

We of the Data and Evidence Subcommittee, respectfully pledge to continue to practice our dual purpose with objectiveness and dedication to evidence-based scientific information in the context of our community throughout the remaining time of the SDDTAC on behalf of the people of San Francisco.

Community Input Committee

Community Input Subcommittee Members and Timeline

The Community Input Subcommittee is made up of seven SDDTAC members, including Vanessa Bohm, Jonathan Butler, Areeya Chananudech, Janna Cordeiro, Joi Jackson-Morgan, Ryan Thayer, and Kent Woo. The co-chairs for the committee were Vanessa Bohm and Ryan Thayer. Subcommittee members represented a variety of SDDTAC seats, including representation from community based organizations/non-profits, SFUSD youth and parent, food security and medical experts. Almost all of the subcommittee members had also participated in one or both the 2014 and 2016 SSB tax campaigns. This experience gave them the opportunity to talk with voters, understand some of the concerns, and informed the subcommittee's recommendations. Between January and March the majority of subcommittee members were able to meet five times on 2/9, 2/20, 2/23, 2/27, and 3/8. During these meetings, subcommittee

members met for 1-2 hours. In addition, co-chairs met separately several times to prepare for subcommittee meetings. Individual subcommittee members also spent additional hours gathering community input during this time period. Each subcommittee member also spent significant time creating and reviewing documents and presentations as part of the SDDTAC.

Community Engagement Process

Community Input Subcommittee members were tasked with gathering input from community members on how SDDT revenue should be spent in order to effectively reduce the consumption of sugary drinks among populations facing the largest health disparities in chronic diseases related to the consumption of sugary drinks. Given the short timeline to gather input, the subcommittee engaged community members through three approaches; subcommittee members (1) gathered input from the coalitions and groups they represent (2) invited other community representatives to give input and feedback during subcommittee meetings and (3) engaged community members directly at SDDTAC meetings.

As a result of subcommittee efforts to gather input from community-based coalitions and groups, several key health equity coalitions were able to create and submit recommendations and priorities for SDDT spending. The San Francisco African American Community Health Equity Council, Faith-Based Liaison Committee, Asian and Pacific Islander Health Parity Coalition, and the Chicano Latino Indigena Health Equity Coalition all submitted official recommendations to the SDDTAC.

Recommendations from SFUSD's Parent Advisory Council and students were also incorporated through their representatives on the subcommittee. Several community-based organization representatives joined subcommittee meetings to give an overview of the most pressing needs affecting communities they work with, as well as their perspective on the priority strategies that could effectively address these needs. Community members also had a chance to give input directly to subcommittee members during SDDTAC meetings, one of which included a subcommittee working session.

Successes and Challenges

The concerted effort and commitment of subcommittee members to gather community input alongside the openness and committed effort of community coalitions, groups, and members to engage in this process, led to the development of comprehensive and thoughtful recommendations to be considered by the SDDTAC. As mentioned above, several key community coalitions and groups, representing communities facing significant health disparities and which are disproportionately targeted by the sugary beverage industry, submitted robust recommendations that were used to develop an initial proposal by the subcommittee. Input from other engaged groups and community members was incorporated into this initial proposal. Based on this work, the final subcommittee proposal reflected a broad range of community perspectives and key common strategies and principles from those most impacted by the consumption of sugary beverages.

Despite the limited timeline, the process was successful in engaging community members to participate directly in SDDTAC meetings. Community members attended several SDDTAC meetings and remained during long hours in order to give their input during public comment. Their input has been essential and an invaluable part of the process of gathering community input, as well as engaging community in the full SDDTAC.

In the coming year, we look forward to continue to expand engagement of community members with more forums and other input strategies.

Infrastructure Committee

The goals of the Infrastructure Subcommittee were to provide recommendations regarding the resources need to support implementation of the SDDT including:

- Infrastructure to support the SDDTAC (including backbone and administrative staff)
- Infrastructure to support the creation of this annual report (including staff for evaluation and data purchases)
- Infrastructure to provide technical assistance to help:
  - merchants comply with the tax
  - CBOs to respond to City RFPs related to SDDT funds
  - CBOS to evaluate the impact of programs and initiatives utilizing SDDT funds
- Infrastructure to support collaboration across City agencies and funded CBOs
- Infrastructure to support media and communications

As a subcommittee, we met twice (February 20th and February 27th) for two hours each, for a total of 4 hours in addition to the larger SDDTAC meetings. Not all subcommittee met during the two meetings due to scheduling conflicts.

Subcommittee members included Michelle Kim – chair (DCYF), Rita Nguyen (DPH), Bob Palacio (Rec and Park), Jorge Rivas (OEWD), and Roberto Vargas (UCSF).

The subcommittee also worked with other community members (as members of the public) who were interested in the infrastructure component. We referenced the Berkeley tax report during our discussions and consulted with DPH staff regarding evaluation needs.

ADVISORY COMMITTEE RECOMMENDATIONS

The SDDTAC's recommendations were informed by data, evidence, evidence-based interventions, community-informed practices, and the learnings from other jurisdictions that have implemented similar taxes. Because low income and ethnic minority populations consume more sugary drinks than the general population and disproportionately suffer from chronic health conditions, equity was a foundational pillar for the SDDTAC's work and recommendations.

The SDDTAC identified the following priority populations to be served by SDDTAC funding:

- Low income San Franciscans, and/or
- Populations[2] shown to be consuming sugary drinks at a high rate, and/or
- Populations[2] disproportionately affected by diet sensitive chronic diseases (such as diabetes, obesity, heart disease, and/or tooth decay

If a program, proposal, or initiative does not serve these specifically named populations, the SDDTAC would be supportive of work that included a rationale or evidence that the work is serving a population that consumes sugary drinks at a high rate or is disproportionately affected by diet sensitive chronic disease.

In addition, to capture the spirit of the SDDTAC, the Advisory Committee made the following recommendations regarding how funds from the SDDT should be spent. Expenditures should:

1) **Support the aims of the tax itself by reducing sugary drink consumption and supporting public health through a reduction of diet related diseases.** Examples include but are not limited to:
   - Adding new services/programming (preferred)
   - Improving/augmenting existing services/programming
   - Providing replacement funding to fill gaps caused by a well-documented recent cut in funding
   - Supporting primary and secondary prevention efforts and not for medical treatment of disease (medications, surgeries, etc.)

   Priority categories for the expenditures (in no particular order) are:
   - Decreasing consumption of sugary drinks
   - Increasing water consumption
   - Oral health
   - Healthy food access
   - Physical activity
   - Other (e.g. research/CBPR, new innovations, etc.)

2) **Support implementation of the SDDT and the work of the SDDTAC**, such as:
   - Infrastructure to support the SDDTAC
   - Infrastructure needed to support evaluation of the SDDTAC, including beverage prices, consumer purchasing behavior, and diet related chronic disease
   - Technical assistance to help merchants comply with the tax
   - Technical assistance to CBOs to respond to City RFPs related to SDDT funds
   - Technical assistance to CBOs around how to evaluate the impact of programs utilizing SDDT funds
   - Media and communications

[2] Including but not limited to African Americans, Asian, Latino, Native American, and Pacific Islander populations as well as youth and young adults, particularly adolescent males.

The Sugary Drinks Distributor Tax Advisory Committee voted on February 14, 2018 to make the following funding recommendations for the remaining $200,000 that had not yet been designated for FY 17-18.

Amount	Title	Description
$28,000	Data	Access to data on sugary drink purchasing behavior
$50,000	Community Outreach	Use to elicit community input on short- and long-term spending strategies
$122,000	Marketing & Education	Marketing/storytelling + development of longer-term campaign
		Sugary drink tax education & materials for corner store owners
		Campaign to showcase the benefits of water stations
Total= $200,000		

These funding recommendations are to be allocated to the San Francisco Department of Public Health.

ADVISORY COMMITTEEE RECOMMENDATIONS

The Sugary Drinks Distributor Tax Advisory Committee voted on March 9, 2018 to make the following funding recommendations for FY 18-20, in association with allocation descriptions and principles that immediately follow the table:

*Funds for water access are intended only for FY18-19. Recommendations for this 4% of SDDT money for FY19-20 will be made prior to the next SDDTAC report in 2019.

Item	Amount	Funding	Department
Community-Based Grants	$4,680,000	45% (7% School-based)	DPH/CHEP
School Food, Nutrition Education & Student Led Action	$1,000,000	15.0%	SFUSD
	$500,000		SFUSD
Food Access	$1,000,000	9.6%	DPH
Healthy Retail	$150,000	1.4%	OEWD
Oral Health	$1,000,000	10.0% (5.5% School-based)	DPH
Infrastructure	$1,000,000	10.0%	DPH/CHEP
Water Access - SFUSD	$300,000	4.0% (3% School-based)	SFUSD
Water Access – Public Spaces	$150,000		PUC/DPH
SF Recreation & Parks	$520,000	5.0%	SF Rec & Parks
Total	$10,400,000	100%	

SDDTAC Allocation Descriptions & Principles

Community Based Organizations
Funding: 45% **(7% school-based)**
$4,680,000
Dept: DPH/CHEP

Funding should support community-based programs and services that address the health inequities of those most targeted by the beverage industry. Funding should go directly to Community Based Organizations (CBOs) and Faith Based Organizations (FBOs) for the following strategies:

1. **Health Education** activities including, chronic disease prevention, healthy eating and active living, water promotion, oral health and food systems
2. **Physical Activity** opportunities, including dance and movement, sports, yoga, walking groups, biking, etc.
3. **Food Access**, including community-based food systems approaches, community-based pantries, community-based hot meals, community kitchens and community home delivery services
4. **Media/Awareness Campaigns** that include local and city-wide campaigns. Examples are grassroots print, online, and social media campaigns led by community and peer leaders.

Approximately 10% of the funds allocated to CBOs will be used to support media campaigns.

Priority will be given to proposals that follow these guiding principles:

1. Community-Led & Informed
2. Culturally Relevant
3. Peer-Led/Promotora Approach
4. Implementation provides training and employment for target community members (Workforce Development)
5. Collaborations & Partnerships
6. Leadership Development
7. Accessible - Free & Low Cost Services
8. Intersection of Strategies and Program Areas

City Departments should contract directly with community-based organizations through an RFP process that is developed in partnership with and has oversight from the SDDTAC.

The Community Health Equity and Promotion (CHEP) Branch of the Department of Public Health should provide staffing to support the implementation of a CBO grant program, as well as provide technical assistance to CBOs on developing evaluation methods to track and measure impact of funded programs and services. CBOs should be able to describe how their approaches meet the needs of their communities, including a justification for modifying these approaches to meet community needs.

San Francisco Unified School District
Funding: 15%
$1,500,000

- $1,000,000 – Food Improvement
- $500,000 – Nutrition Education & Student Led Action

Dept: SFUSD

Funding should go to improve the quality of school meals, support nutrition education, and student led efforts to decrease consumption of sugary beverages and increase awareness of sugary beverage consumption among students. Funding should target schools with the largest populations of high-risk students that are disproportionately targeted by the sugary beverage industry. SFUSD should provide to the SDDTAC a proposal of how funding will be spent to improve the quality of school meals and increase awareness of sugary beverage consumption.

Food Access
Funding: 9.6%
$1,000,000
Dept: DPH

Funding should support programs and services that increase access to healthy fruits and vegetables while minimizing processed foods for high-risk communities. Priority programs should incorporate a community-based food security perspective and have demonstrated the ability to increase consumption of healthy, fresh, low to no cost, and culturally appropriate foods that are reflective of specific community needs, including food vouchers/incentives.

Healthy Retail
Funding: 1.4%
$150,000
Dept: OEWD

Funding to further support healthy retail work targeting high risk and impacted communities and neighborhoods.

Oral Health
Funding: 10% **(5.5% School-based)**
$1,000,000 includes (see CavityFree SF recommendations):

- $450,000 to three oral health community task forces (RFP)
- $350,000 to School-based and School-linked preventative programs
- $200,000 to SFUSD dedicated oral health staffing

Dept: DPH

Funding should go to support (1) development of community infrastructure that incorporates diverse stakeholders for outreach, education, and interventions that address the oral health needs of children in high risk target populations (2) preventative oral health care within underserved SFUSD schools serving high risk target populations.

Infrastructure
Funding: 10%
$1,000,000
Dept: DPH

Funding should support

(1) Backbone staffing to support SDDTAC and SDDT implementation
    a. 1.0 FTE to support a program manager to coordinate among city agencies and funded CBOs to promote collective impact, including: guide vision and strategy, support aligned activities,

establish shared measurement practices

b. A strategic planning consultant to inform the implementation of the SDDT, ensuring activities span across the 10 essential public health services

(2) Development and implementation of CBO RFP process and technical assistance for CBOs and merchants, including evaluation
   a. 1.0 FTE to support a program manager to manage the RFP process and provide guidance and TA to funded organizations to promote collective impact in coordination with SDDTAC and City Agencies.
   b. 1.0 FTE program assistant to assist w oversight, technical assistance to CBOs to apply for and implement work related to SSB tax, provide administrative support to SDDTAC, and assist Program Manager in coordinating funded CBOs.

(3) Research and evaluation of SDDT impact, including data purchases as necessary.
   a. Funding should support evaluation which should include data purchases.
   b. At least 1.0 FTE epidemiologist.
   c. At least 1.0 FTE consultant to provide evaluation technical assistance to funded CBOs and FBOs.

Water Access
Funding: 4% **(3% School-based)**
$450,000

- $300,000 (3%) – Safe water access at SFUSD
- $150,000 (1%) – Safe water access in community identified public spaces

Funding should go to increase safe water access, including installing water filling stations in strategic areas within SFUSD and in public spaces that target high-risk populations that are disproportionately targeted by the sugary drink industry.

SF Recreation and Parks
Funding: 5%
$520,000

Funding should go to support Peace Parks, which serves target populations.

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San Francisco
Sugary Drink Distributors Tax Advisory Committee
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APPENDICES

San Francisco
Sugary Drink Distributors Tax Advisory Committee
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APPENDIX A: ARTICLE 8: Sugary Drinks Distributor Tax Ordinance (San Francisco Business and Tax Regulations Code)

Print

San Francisco Business and Tax Regulations Code

ARTICLE 8:
SUGARY DRINKS DISTRIBUTOR TAX ORDINANCE

Sec. 550. Short Title.
Sec. 551. Findings and Purpose.
Sec. 552. Definitions.
Sec. 553. Imposition of Tax; Deposit of Proceeds.
Sec. 554. Registration of Distributors; Documentation; Administration.
Sec. 555. Credits and Refunds.
Sec. 556. Technical Assistance to the Tax Collector.
Sec. 557. Municipal Affair.
Sec. 558. Not a Sales and Use Tax.
Sec. 559. Severability.
Sec. 560. Amendment.

SEC. 550. SHORT TITLE.

This Article shall be known as the "Sugary Drinks Distributor Tax Ordinance."

(Added by Proposition V, 11/8/2016)

SEC. 551. FINDINGS AND PURPOSE.

The U.S. Department of Health and Human Services, the U.S. Department of Agriculture, and the World Health Organization, based on a summary of the available evidence linking intake of added sugar and sugar-sweetened beverages (SSBs) to adverse health outcomes including obesity and diabetes, have recommended that Americans consume no more than 10% of their daily calories in the form of added sugar. Yet, standard single serving sizes of SSBs provide all (in a 20-ounce serving of many SSBs) or nearly all (in a 12-ounce serving) of the recommended maximum daily added sugar amount for most adults, and generally exceed the recommended maximum daily added sugar amount for children.

Numerous organizations and agencies, includ ing the American Heart Association, American Diabetes Association, American Academy of Pediatrics, Institute of Medicine of the National Academies, American Medical Association, and the Centers for Disease Control, recommend limiting intake of added sugar and SSBs to improve health. Sugary beverages, though they can contain hundreds of calories in a serving, do not signal "fullness" to the brain and thus facilitate over-consumption.

Studies show that sugary beverages flood the liver with high amounts of sugar in a short amount of time, and that this "sugar rush" over time leads to fat deposits and metabolic disturbances that cause diabetes, cardiovascular disease, and other serious health problems. Diseases connected to sugary beverages disproportionately impact minorities and low-income communities. For example, diabetes hospitalizations are more than triple in low-income communities as compared with higher income areas. African American death rates from DM2 are five times higher than San Francisco's overall rate. DM2 is the fifth leading

cause of death in SF (which is an underestimate, since heart disease, the leading killer, is often a result of DM2); DM2 reduces the lifespan of San Franciscans by eight to ten years.

As recently as 2010, nearly a third of children and adolescents in San Francisco were obese or overweight; and in San Francisco, 46.4% of adults are obese or overweight, including 61.7% of Hispanics and 51.3% of African Americans. Nationally, childhood obesity has more than doubled in children and tripled in adolescents in the past 30 years; in 2010, more than one-third of children and adolescents were overweight or obese. Every additional sugary beverage consumed daily can increase a child's risk for obesity by 60%; and one or two sugary beverages per day increases the risk of Type II diabetes by 26%.

Sugary beverages, including sweetened alcoholic drinks, represent nearly 50% of added sugar in the American diet, and, on average, 11% of daily calories consumed by children in the U.S.

Seven percent of San Franciscans are diagnosed with diabetes, and it is estimated that the City and County of San Francisco pays over $87 million for direct and indirect diabetes care costs.

This Article 8 is intended to discourage the distribution and consumption of sugar-sweetened beverages in San Francisco by taxing their distribution. Mexico, where an average of 163 liters of sugar-sweetened beverages are consumed per person each year, enacted an excise tax on sugary drinks, with the result that the purchase of taxed sugar sweetened beverages declined by 12% generally and by 17% among low-income Mexicans. The Mexico data indicate that, when people cut back on SSBs, to a significant extent they choose lower-caloric or non-caloric alternatives. This body of research demonstrates that taxation can provide a powerful incentive for individuals to reduce their consumption of SSBs, which in turn will reduce obesity and DM2.

The City of Berkeley became the first city in the United States to follow in Mexico's footsteps, by passing a one-cent-per-ounce general tax on distributors of SSBs within the city limits. It is estimated that the City of Berkeley, which began implementing the tax in March 2015, will collect at least $1.2 million from the tax annually.

(Added by Proposition V, 11/8/2016)

SEC. 552. DEFINITIONS.

Unless otherwise defined in this Article 8, terms that are defined in Article 6 of the Business and Tax Regulations Code shall have the meanings provided therein. For purposes of this Article, the following definitions shall apply.

"Beverage for Medical Use" means a beverage suitable for human consumption and manufactured for use as an oral nutritional therapy for persons who cannot absorb or metabolize dietary nutrients from food or beverages, or for use as an oral rehydration electrolyte solution formulated to prevent or treat dehydration due to illness. "Beverage for Medical Use" also means a "medical food" as defined in Section 109971 of the California Health and Safety Code. "Beverage for Medical Use" shall not include beverages commonly referred to as "sports drinks," or any other similar names.

"Bottle" means any closed or sealed container regardless of size or shape, including, without limitation, those made of glass, metal, paper, plastic, or any other material or combination of materials.

"Bottled Sugar-Sweetened Beverage" means any Sugar-Sweetened Beverage contained in a Bottle that is ready for consumption without further processing, such as, and without limitation, dilution or carbonation.

"Caloric Sweetener" means any substance or combination of substances that is suitable for human consumption, that humans perceive as sweet, and that adds calories to the diet of any human who consumes it. "Caloric Sweetener" includes, but is not limited to, sucrose, fructose, glucose, other sugars, and high fructose corn syrup.

"City" means the City and County of San Francisco.

"Distribution" includes:

(a) The transfer in the City, for consideration, of physical possession of Sugar- Sweetened Beverages, Syrup, or Powder by any person other than a common carrier. "Distribution" also includes the transfer of physical possession in the City by any person other than a common carrier, without consideration, for promotional or any other commercial purpose.

(b) The possession, storage, ownership, or control in the City, by any person other than a common carrier, of Sugar-Sweetened Beverages, Syrup, or Powder for resale in the ordinary course of business, obtained by means of a transfer of physical possession outside the City or from a common carrier in the City.

"Distribution" does not include:

(a) The return of any Sugar-Sweetened Beverages, Syrup, or Powder to a person, if that person refunds the entire amount paid in cash or credit.

(b) A retail sale or use.

"Distributor" means any person engaged in the business of Distribution of Bottled Sugar- Sweetened Beverages, Syrup, or Powder. A Distributor does not include a common carrier. Where a common carrier obtains physical possession of Sugar-Sweetened Beverages, Syrup, or Powder outside the City and transfers physical possession of the Sugar-Sweetened Beverages, Syrup, or Powder in the City, the transferee of the Sugar-Sweetened Beverages, Syrup, or Powder is a Distributor.

"Milk Product" means: (a) any beverage whose principal ingredient by weight is natural liquid milk secreted by an animal. "Milk" includes natural milk concentrate and dehydrated natural milk, whether or not reconstituted; and (b) any plant-based substance or combination of substances in which (1) water and (2) grains, nuts, legumes, or seeds constitute the two greatest ingredients by volume. For purposes of this definition, "Milk Product" includes, but is not limited to, soy milk, almond milk, rice milk, coconut milk, hemp milk, oat milk, hazelnut milk, or flax milk;

"Natural Fruit Juice" means the original liquid resulting from the pressing of fruit, the liquid resulting from the complete reconstitution of natural fruit juice concentrate, or the liquid resulting from the complete restoration of water to dehydrated natural fruit juice.

"Natural Vegetable Juice" means the original liquid resulting from the pressing of vegetables, the liquid resulting from the complete reconstitution of natural vegetable juice concentrate, or the liquid resulting from the complete restoration of water to dehydrated natural vegetable juice.

"Nonalcoholic Beverage" means any beverage that is not subject to tax under California Revenue and Taxation Code sections 32001 *et seq.* as "beer, wine or distilled spirits."

"Powder" means any solid mixture, containing one or more Caloric Sweeteners as an ingredient, intended to be used in making, mixing, or compounding a Sugar-Sweetened Beverage by combining the Powder with one or more other ingredients.

"Sugar-Sweetened Beverage" means any Nonalcoholic Beverage intended for human consumption that contains added Caloric Sweetener and contains more than 25 calories per 12 fluid ounces of beverage, including but not limited to all drinks and beverages commonly referred to as "soda," "pop," "cola," "soft drinks," "sports drinks," "energy drinks," "sweetened ice teas," or any other similar names. "Sugar-Sweetened Beverage" does not include:

(a) Any beverage sold for consumption by infants, which is commonly referred to as "infant formula" or "baby formula," or any product whose purpose is infant rehydration.

(b) Any Beverage for Medical Use.

(c) Any beverage designed as supplemental, meal replacement, or sole-source nutrition that includes proteins, carbohydrates, and multiple vitamins and minerals (this exclusion does not include beverages commonly referred to as "sports drinks," or any other similar names, which are defined as Sugar-Sweetened Beverages).

(d) Any Milk Product.

(e) Any beverage that contains solely 100% Natural Fruit Juice, Natural Vegetable Juice, or combined Natural Fruit Juice and Natural Vegetable Juice.

"Sugary Drinks Distributor Tax" or "Tax" means the general excise tax imposed under Section 553.

"Syrup" means any liquid mixture, containing one or more Caloric Sweeteners as an ingredient, intended to be used, or actually used, in making, mixing, or compounding a Sugar-Sweetened Beverage by combining the Syrup with one or more other ingredients.

(Added by Proposition V, 11/8/2016)

SEC. 553. IMPOSITION OF TAX; DEPOSIT OF PROCEEDS.

(a) Effective January 1, 2018, for the privilege of engaging in the business of making an initial Distribution within the City of a Bottled Sugar-Sweetened Beverage, Syrup, or Powder, the City imposes a Sugary Drinks Distributor Tax, which shall be a general excise tax, on the Distributor making the initial Distribution of a Bottled Sugar-Sweetened Beverage, Syrup, or Powder in the City.

(b) The Tax shall be calculated as follows:

(1) One cent ($0.01) per fluid ounce of a Bottled Sugar-Sweetened Beverage upon the initial Distribution within the City of the Bottled Sugar-Sweetened Beverage; and

(2) One cent ($0.01) per fluid ounce of a Sugar-Sweetened Beverage that could be produced from Syrup or Powder upon the initial Distribution of Syrup or Powder. The Tax for Syrups and Powders shall be calculated using the largest volume of Sugar-Sweetened Beverage that would typically be produced by the amount of Syrup or Powder based on the manufacturer's instructions or, if the Distributor uses the Syrup or Powder to produce a Sugar-Sweetened Beverage, the regular practice of the Distributor.

(c) The Tax is a general tax. Proceeds of the Tax are to be deposited in the General Fund.

(Added by Proposition V, 11/8/2016)

SEC. 554. REGISTRATION OF DISTRIBUTORS; DOCUMENTATION; ADMINISTRATION.

(a) Each Distributor shall register with the Tax Collector according to rules and regulations of the Tax Collector, but no earlier than 30 days after the effective date of Article 8.

(b) Each Distributor shall keep and preserve all such records as the Tax Collector may require for the purpose of ascertaining compliance with Article 8.

(c) Except as otherwise provided under Article 8, the Tax shall be administered pursuant to Article 6 of the Business and Tax Regulations Code.

(Added by Proposition V, 11/8/2016)

SEC. 555. CREDITS AND REFUNDS.

The Tax Collector shall refund or credit to a Distributor the Tax that is paid with respect to the initial Distribution of a Bottled Sugar- Sweetened Beverage, Syrup, or Powder: (a) that is shipped to a point outside the City for Distribution outside the City; or (b) on which the Tax has already been paid by another Person; or (c) that has been returned to the Person who Distributed it and for which the entire purchase price has been refunded in cash or credit.

(Added by Proposition V, 11/8/2016)

SEC. 556. TECHNICAL ASSISTANCE TO THE TAX COLLECTOR.

(a) The Department of Public Health shall provide to the Tax Collector technical assistance to identify Bottled Sugar-Sweetened Beverages, Syrups, and Powders subject to the Tax.

(b) All City Departments shall provide technical assistance to the Tax Collector to identify Distributors of Bottled Sugar-Sweetened Beverages, Syrups, and Powders.

(Added by Proposition V, 11/8/2016)

SEC. 557. MUNICIPAL AFFAIR.

The People of the City and County of San Francisco hereby declare that the taxation of the distribution of Sugar-Sweetened Beverages, Syrups and Powders, and that the public health impact of Sugar-Sweetened Beverages, separately and together constitute municipal affairs. The People of the City and County of San Francisco hereby further declare their desire for this measure to coexist with any similar tax adopted at the local or state levels.

(Added by Proposition V, 11/8/2016)

SEC. 558. NOT A SALES AND USE TAX.

The tax imposed by this measure is a general excise tax on the privilege of conducting business within the City and County of San Francisco. It is not a sales tax or use tax or other excise tax on the sale, consumption, or use of sugar-sweetened beverages.

(Added by Proposition V, 11/8/2016)

SEC. 559. SEVERABILITY.

If any provision of this measure, or part thereof, or the applicability of any provision or part to any person or circumstances, is for any reason held to be invalid or unconstitutional, the remaining provisions and parts shall not be affected, but shall remain in full force and effect, and to this end the provisions and parts of this measure are severable. The voters hereby declare that this measure, and each portion and part, would have been adopted irrespective of whether any one or more provisions or parts are found to be invalid or unconstitutional.

(Added by Proposition V, 11/8/2016)

SEC. 560. AMENDMENT.

The Board of Supervisors may by ordinance amend or repeal Article 8 of the Business and Tax Regulations Code without a vote of the people except as limited by Article XIIIC of the California Constitution.

(Added by Proposition V, 11/8/2016)

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APPENDIX B: ARTICLE XXXIII: Sugary Drinks Distributor Tax Advisory Committee (San Francisco Administrative Code)

Print

San Francisco Administrative Code

ARTICLE XXXIII: SUGARY DRINKS DISTRIBUTOR TAX ADVISORY COMMITTEE

Sec. 5.33-1. Creation of Advisory Committee.
Sec. 5.33-2. Membership.
Sec. 5.33-3. Organization and Terms of Office.
Sec. 5.33-4. Powers and Duties.
Sec. 5.33-5. Meetings and Procedures.
Sec. 5.33-6. Sunset.

SEC. 5.33-1. CREATION OF ADVISORY COMMITTEE.

There is hereby established the Sugary Drinks Distributor Tax Advisory Committee (the "Advisory Committee") of the City and County of San Francisco.

(Added by Proposition V, 11/8/2016)

SEC. 5.33-2. MEMBERSHIP.

The Advisory Committee shall consist of the following 16 voting members.

(a) Seats 1, 2, and 3 shall be held by representatives of nonprofit organizations that advocate for health equity in communities that are disproportionately impacted by diseases related to the consumption of Sugar-Sweetened Beverages, as defined in Business and Tax Regulations Code Section 552, appointed by the Board of Supervisors.

(b) Seats 4 and 5 shall be held by individuals who are employed at medical institutions in San Francisco and who have experience in the diagnosis or treatment of, or in research or education about, chronic and other diseases linked to the consumption of Sugar-Sweetened Beverages, appointed by the Board of Supervisors.

(c) Seat 6 shall be held by a person who is under 19 years old at the time of appointment and who may be a member of the Youth Commission, nominated by the Youth Commission and appointed by the Board of Supervisors. If the person is under legal voting age and unable to be an elector for that reason, the person may hold this seat, but upon reaching legal voting age, the person shall relinquish the seat unless he or she becomes an elector, in which case the person shall retain the seat.

(d) Seat 7 shall be held by a person appointed by the Director of the Office of Economic and Workforce Development or any successor office.

(e) Seats 8 and 9 shall be held by persons appointed by the Board of Education of the San Francisco Unified School District. If at any time the Board of Education declines to appoint a member to Seat 8 or 9 and leaves the seat vacant for 60 days or longer, the Board of Supervisors may appoint a member of the public to fill the seat until such time as the Board of Education appoints a member.

(f) Seat 10 shall be held by an employee of the Department of Public Health who has experience or expertise in the field of chronic disease prevention or treatment, appointed by the Director of Health.

(g) Seat 11 shall be held by a person with experience or expertise in the field of oral health, appointed by the Director of Health.

(h) Seat 12 shall be held by a person with experience or expertise in the field of food security or access, appointed by the Director of Health.

(i) Seat 13 shall be held by an employee of the Department of Children, Youth & Their Families, appointed by the Director of that Department.

(j) Seat 14 shall be held by an employee of the Recreation and Park Department, appointed by the General Manager of that Department.

(k) Seat 15 shall be held by a parent or guardian of a student enrolled in the San Francisco Unified School District at the time of appointment, nominated by the San Francisco Unified School District's Parent Advisory Council, and appointed by the Board of Supervisors. If at any time the Parent Advisory Council declines to nominate a member to a vacant seat for 60 days or longer, the Board of Supervisors may appoint a member of the public to fill the seat until the seat becomes vacant again.

(l) Seat 16 shall be held by a person with experience or expertise in services and programs for children five and under, appointed by the Board of Supervisors.

(Added by Proposition V, 11/8/2016)

SEC. 5.33-3. ORGANIZATION AND TERMS OF OFFICE.

(a) Members of the Advisory Committee shall serve at the pleasure of their respective appointing authorities, and may be removed by the appointing authority at any time.

(b) Appointing authorities shall make initial appointments to the Advisory Committee by no later than September 1, 2017. The initial term for each seat on the Advisory Committee shall begin September 1, 2017 and end December 31, 2018. Thereafter, the term for each seat shall be two years. There shall be no limit on the number of terms a member may serve. A seat that is vacant on the Advisory Committee shall be filled by the appointing authority for that seat.

(c) Members of the Advisory Committee shall receive no compensation from the City, except that the members in Seats 4, 5, 7, 10, 11, 12, 13, and 14 who are City employees may receive their respective City salaries for time spent working on the Advisory Committee.

(d) Any member who misses three regular meetings of the Advisory Committee within any 12-month period without the express approval of the Advisory Committee at or before each missed meeting shall be deemed to have resigned from the Advisory Committee 10 days after the third unapproved absence. The Advisory Committee shall inform the appointing authority of any such resignation.

(e) The City Administrator shall provide administrative and clerical support for the Advisory Committee, and the Controller's Office shall provide technical support and policy analysis for the Advisory Committee upon request. All City officials and agencies shall cooperate with the Advisory Committee in the performance of its functions.

(Added by Proposition V, 11/8/2016)

SEC. 5.33-4. POWERS AND DUTIES.

The general purpose of the Advisory Committee is to make recommendations to the Mayor and the Board of Supervisors on the effectiveness of the Sugary Drinks Distributor Tax in Business Tax and Regulations Code Article 8. Starting in 2018, by March 1 of each year, the Advisory Committee shall submit to the

Board of Supervisors and the Mayor a report that (a) evaluates the impact of the Sugary Drinks Distributor Tax on beverage prices, consumer purchasing behavior, and public health, and (b) makes recommendations regarding the potential establishment and/or funding of programs to reduce the consumption of Sugar-Sweetened Beverages in San Francisco. Within 10 days after the submission of the report, the City Administrator shall submit to the Board of Supervisors a proposed resolution for the Board to receive the report.

(Added by Proposition V, 11/8/2016)

SEC. 5.33-5. MEETINGS AND PROCEDURES.

(a) There shall be at least 10 days' notice of the Advisory Committee's inaugural meeting. Following the inaugural meeting, the Advisory Committee shall hold a regular meeting not less than four times each year.

(b) The Advisory Committee shall elect officers and may establish bylaws and rules for its organization and procedures.

(Added by Proposition V, 11/8/2016)

SEC. 5.33-6. SUNSET.

Unless the Board of Supervisors by ordinance extends the term of the Advisory Committee, this Article XXXIII shall expire by operation of law, and the Advisory Committee shall terminate, on December 31, 2028. In that event, after that date, the City Attorney shall cause this Article XXXIII to be removed from the Administrative Code.

(Added by Proposition V, 11/8/2016)

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APPENDIX C: Data and Evidence Subcommittee Priority Strategies Recommendations

To: Joi Jackson-Morgan, Robert Vargas, SDDTAC Co-chairs

From: Data and Evidence Subcommittee

CC: Roberto Vargas, SDDTAC Co-chair
Joi Jackson-Morgan, SDDTAC Co-chair
Jonathan Butler, SDDTAC member
Lyra Ng, SDDTAC member
Rita Nguyen, SDDTAC member
Saeeda Hafiz, SDDTAC member
Libby Albert, SDDTAC member
Irene Hilton, SDDTAC member
Laura Schmidt, UCSF
Margaret Fisher, SFDPH
Christina Goette, SFDPH
Jodi Stookey, SFDPH

Date: March 1, 2018

Re: Priority Strategies Recommendations

AWARENESS, PUBLIC EDUCATION, PROMOTION

- Launch public awareness campaign (multi-media; multi-lingual; multi-platform; in and out of schools)
- Raise awareness regarding marketing strategies that target vulnerable populations and communities of color
- Develop counter-advertising media approaches against unhealthy products to reach youth (i.e., anti-tobacco campaigns)
- Hire, train, promote Lay Health Workers/ Promotoras /Community Health Workers to educate and engage impacted communities about food justice (access, food insecurity, healthy retail, etc.); sugary drinks/water; physical activity benefits (mental and physical)

INCREASE ACCESS TO HEALTH ALTERNATIVES

WATER

- Making water readily available and promoting its consumption increases water intake
- Provide alternative water delivery systems such as filtered water dispensers or water cooler stations, than with added traditional water fountains
- Childhood (<age 5) obesity prevention interventions (water consumption)

- Collaborate with state, local, and city government officials to establish, promote, and enforce policies to ensure ready access to potable drinking water.

FOOD ACCESS

- Create incentive programs to enable current small food store owners to carry healthier options (eg. Provide refrigerators; currently provided by soda distributors)
- Healthy Retail: Fund neighborhood based, community engagement work for Healthy Retail SF
- SFUSD provide higher quality food, especially fruit, which can decrease the consumption of SSBs. Use student-led projects to have youth more engaged in eating school food

CLINICAL INTERVENTIONS

- Application of fluoride varnish on children 0-5 years old
- Counseling on fluoride coverage (tap water and appropriate fluoride toothpaste) in additional to counseling already provided on SBB & food choices

ORAL HEALTH

- Expand dental sealant programs in schools
- Restrict sugary food and drink availability in schools to improve oral health

PHYSICAL ACTIVITY

- Fund SFUSD to meet state PE mandates by hiring PE teachers especially in schools with high proportion of students most impacted by CD and SSBs
- Fund community physical activity programs to provide equitable, free and very low-cost physical activities in San Francisco that are offered at times that are convenient for families

POLICY

- Establish and implement nutrition education and standards in schools, child care facilities, worksites and hospitals.
- Collaborate with state and local policymakers to eliminate advertising of SSBs aimed at children (especially near schools)

OTHER

- Fund local community conveners to build capacity of community members to conduct research, implementation, etc. of HEAL and COH activities.
- Fund infrastructure/backbone support for collective impact efforts to impact HEAL work at neighborhood and citywide level

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Sugary Drink Distributors Tax Advisory Committee
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APPENDIX D: Data and Evidence Strategies

Data and Evidence STRATEGIES

Education

Public Education

- Launch public awareness campaign (multi-media; multi-lingual; multi-platform; in and out of schools)
- Raise awareness regarding marketing strategies that target vulnerable populations and communities of color
- Develop counter-advertising media approaches against unhealthy products to reach youth (i.e., anti-tobacco campaigns)
- Hire, train, promote Lay Health Workers/ Promotoras /Community Health Workers to educate and engage impacted communities about food justice (access, food insecurity, healthy retail, etc); sugary drinks/water; physical activity benefits (mental and physical);

Capacity Building/ Educating Providers

- Raise awareness regarding marketing strategies that target vulnerable populations and communities of color
- Expand knowledge and skills of medical care providers regarding screening and counseling of SSB consumption
- Medical schools provide nutrition education to improve counseling skills of medical students as a part of their curricula.

Increase Access to Healthy Alternatives

Water

- Making water readily available and promoting its consumption increases water intake
- Water consumption increases more with the introduction of alternative water delivery systems such as filtered Water dispensers or water cooler stations, than with added traditional water fountains
- Install water-filling stations throughout high-traffic areas
- Provide mobile potable water options for public events
- Fund lead testing in low income homes (that don't qualify for WIC) to assure water safety
- Regular lead/safety testing and promotion of said testing of public water stations/fountains.
- Provide multi-lingual water station information about the safety and health benefits of SF water
- Childhood (< age 5) obesity prevention interventions (water consumption)
- Increase access to public restrooms to encourage consumption of public water
- Grab a Cup, Fill It Up" campaign, a cafeteria-based intervention featuring signage promoting water and installation of disposable cups near water fountains. The percentage of students drinking water more than doubled in intervention schools, and students drank significantly more water and had fewer sugary drinks with their lunch as a result of the intervention.
- Complete a needs assessment to identify where access to potable drinking water is limited. Provide public map
- Public and private partnerships to improve infrastructure to increase access to potable drinking water

- Collaborate with state, local, and city government officials to establish, promote, and enforce policies to ensure ready access to potable drinking water.

Food Access

- Create incentive programs to enable current small food store owners to carry healthier options (e.g.. Provide refrigerators; currently provided by soda distributors)
- Healthy Retail: Fund neighborhood based, community engagement work for Healthy Retail SF
- Healthy Retail: expand Healthy Corner Store incentives for markets
- Healthy Retail: Support the establishment of local grocers/farmers markets in areas that are food insecure
- Food Subsidy: Increase access/funding for food voucher programs (EAT SF, Market Match, etc)
- Food Subsidy: Increase SNAP/WIC participation
- Improve school lunches to increase participation
- Food suppliers formulate what they serve (evidence is for salt interventions)
- Create incentive and recognition programs to encourage grocery and convenience stores to reduce POS marketing (i.e., "candy-free" checkout aisle)

Clinical interventions

- IT systems support and training to address barriers to FV application in the primary care medical setting
- Primary care provider screening for early oral effects of SSB consumption (white spot lesion, early cavities) and preventive factors (tap water consumption & appropriate fluoride tooth paste use)
- Application of fluoride varnish on children 0-5
- Counseling on fluoride coverage (tap water and appropriate fluoride toothpaste) in additional to counseling already provided on SBB & food choices
- Routine referral to dental home for preventive care
- Support efforts to ensure reimbursement for practitioner time spent providing nutrition counseling.
- Support the implementation of the recommendation from the Expert Committee on Assessment, Preventions, and Treatment of Child and Adolescent Overweight to ensure screening and counseling for high SSB consumption as part of all well child visits.
- Support preventive lifestyle services within the health care system, such as coverage for weight management; nutrition education; and diabetes, blood pressure, and cholesterol screening and management.
- Support “baby friendly” hospital programs that encourage breast feeding and provide peer-to-peer breastfeeding support programs.
- Reduce fetal risk of metabolic dysregulation by increasing eligibility of services beyond women who have pre or diagnosed gestational diabetes

- Intensive lifestyle interventions for patients with type 2 diabetes to improve glycemic control and reduce risk factors for cardiovascular disease. (CPSTF Finding and Rationale Statement)

Oral Health

- Fluoridated water: Peer to peer training and education
- Fluoridated water: Mass media marketing to increase public awareness
- Fluoridated water: Culturally appropriate messaging including safety of SF tap water
- Expand dental sealant program in schools
- Fluoride Varnish program in pre-school settings
- Restrict sugary food and drink availability in schools to improve oral health
- IT systems support and training to address barriers to application in the primary care medical setting

Physical Activity

- Fund SFUSD to meet state PE mandates by hiring PE teachers especially in schools with high proportion of students most impacted by CD and SSBs
- Fund community physical activity programs to provide equitable, free and very low-cost physical activities in San Francisco that are offered at times that are convenient for families
- Identify ways to address cost barriers for 'club'/private sports (that require fees to participate) that aren't otherwise available to low income families.

Other

- Urban Agriculture: Support efforts to expand equitable access to community gardens and farms so that all SF residents live within "x" distance of a community garden
- Fund local community conveners to build capacity of community members to conduct research, implementation, etc. of HEALand COH activities.
- Fund infrastructure/backbone support for collective impact efforts to impact HEAL work at neighborhood and citywide level

Policy

- Collaborate with state and local policymakers to develop or adopt policies that limit advertising of SSBs in public service venues.
- Establish and implement nutrition education and standards in schools, child care facilities, worksites and hospitals.
- Limit pouring rights contracts
- Warning Labels
- Collaborate with state and local policymakers to eliminate advertising of SSBs aimed at children.
- Portion size - On a given day, the portion-size cap would affect 7.2% of children and 7.6% of adults. If 80% of affected consumers choose a 16-oz beverage, the policy would result in a change of - 57.6 kcal for affected consumers aged 2 - 19 years and - 62.6 kcal for affected consumers≥ 20 years
- Systematic Review and Meta-analysis of the Impact of Restaurant Menu Calorie Labeling.
- Collaborate with food manufacturers, retailers, restaurants and others to adopt guidelines for responsible food marketing to children.

- Label SSBs with health risks (i.e., surgeon general warning on tobacco products)
- Eliminate advertisements near schools
- Implement a tax on SSBs (DONE)

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APPENDIX E: Recommendations Draft Infrastructure Subcommittee_3.2.18

Recommendations_draft_Infrastucture Subcommittee_3.2.18

Categories	Who (Dept/CBO/s)	$ details	$ Estimate allocation	%
Decrease consumption of SSB				
marketing		$100,000.00		
health education	DPH			
Total decrease consumption of SSB		**$100,000.00**	**$ 1,040,000.00**	**10%**
Increase water consumption				
Marketing	DPH	$100,000.00		
Water stations at schools and	SFUSD			
Total increase water		**$100,000.00**	**$ 1,040,000.00**	**10%**
Oral Health				
Total Oral Health		**$0.00**	**$ -**	**0%**
Healthy Food Access				
school lunch	SFUSD			
food vouchers		$1,400,000.00		
healthy corner stores	OEWD/DPH	$150,000.00		
food pantries, particularly for				
increase home delivered meals				
restaurant gift cards for				
increase food programs for				
Total Healthy Food Access		**$1,550,000.00**	**$ 4,888,000.00**	**47%**
Physical Activity				
Physical Activity programs	Rec and Park			
Outdoor Active Living	Rec and Park			
Dance	Rec and Park			
Healthy Food Prep	Rec and Park			
Aquatics Learn To Swim Expansion	Rec and Park			
Lets Move Recess and before scho	Rec and Park			
Transportation to physical activity	Rec and Park			
After School Exercise Fitness for D	Rec and Park			
Total Physical Activity		**$0.00**	**$ 2,288,000.00**	**22%**
Infrastucture				
Data Collection and Eval	DPH	$600,000.00		
Admin support - liasion for diff.	DPH	$100,000.00		
Marketing/Media (i.e. handle	DPH	$200,000.00		
Outreach - general community	DPH	$100,000.00		
T.A. for merchants - outreach	DPH/OEWD	$140,000.00		
Total Infrastucture		**$1,140,000.00**	**$ 1,140,000.00**	**11%**
Other			**$ -**	**0%**
Total			**$ 10,396,000.00**	**100%**
Max available			**$ 10,400,000.00**	**100%**
Balance			**$ (4,000.00)**	**0%**

From Prop E		
SFUSD	40%	$4,160,000.00
Rec and Park	25%	$2,599,000.00

Expense	Cost
EVALUATION	
Data	
IRI data Additional data sources which may include CHIS oversample, strengthened screening programs	$28,000 >$200,000
Staff	
1.0 FTE Epidemiologist 1.0 FTE Evaluation consultant to provide evaluation TA to CBOs	$150-200,000 $150,000
Total Evaluation Costs	$503,000-700,000
INFRASTRUCTURE	
1.0 FTE Program Manager to coordinate among city agencies and funded CBOs to promote collective impact	$125,000
1.0 Program Assistant to assist w oversight, TA to CBOs to apply for and implement work related to SSB tax, provide administrative support to SDDTAC, assist Program Manager in coordinating funded CBOs	$100,000
Strategic planning consultant to inform the implementation and RFP process; ensuring activities span across the 10 essential public health services	$25,000
Total Infrastructure Costs	$225,000

Recommended Infrastructure Expenditures

Expense	Cost
EVALUATION	
Data	
IRI data Additional data sources which may include CHIS oversample, strengthened programs, etc	$28,000 >$200,000
Staff	
1.0 FTE Epidemiologist 1.0 FTE Evaluation consultant to provide evaluation TA to CBOs	$150-200,000 $150,000
Total Evaluation Costs	$503,000-700,000
INFRASTRUCTURE	
1.0 FTE Program Manager to coordinate among city agencies and funded CBOs to promote collective impact	$125,000
1.0 Program Assistant to assist w oversight, TA to CBOs to apply for and implement work related to SSB tax, provide administrative support to SDDTAC, assist Program Manager in coordinating funded CBOs	$100,000
Strategic planning consultant to inform the implementation and RFP process; ensuring activities span across the 10 essential public health services	$25,000
Total Infrastructure Costs	$225,000
TOTAL RECOMMENDATIONS	925,000

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APPENDIX F: Community Input Subcommittee Strategy Recommendations

Community Input Subcommittee
Strategy Recommendations

Introduction

Low-income communities, communities of color, and others have historically suffered from health inequities and disparities. Despite the belief that health inequities are caused by individual behaviors, these inequities are a result of structural discrimination and systemic racism that includes policies, practices, and resource allocations that create grossly unequal conditions in which people live. The cumulative impact of living under these oppressive systems, and the consistent trauma that is experienced as a result, leads to not only poor physical health but also poor mental health, including depression, anxiety, post-traumatic stress, substance abuse and addiction.

The City of San Francisco is not an exception but a reflection of these entrenched inequities and health disparities among low-income, communities of color and other discriminated groups. Data shows that within San Francisco these populations experience the highest rates of chronic diseases such as type 2 diabetes, obesity, heart disease and tooth decay. These same communities have the highest concentration of sugary beverage consumption and are disproportionally targeted by aggressive and exploitative marketing campaigns by the soda and sugary drinks industry. It is also the case that San Francisco is one of the cities in which the wealth gap between rich and poor is growing the fastest. The top 5% of the City's wealthiest make 16.6 times more than the middle class (middle 20 percent) and even greater in comparison to the City's poorest. [1]

It is imperative to address poverty and social exclusion as a root cause of health inequites while also working to address social determinants of health, including reducing barriers to housing, healthy food and beverages, education, safe neighborhoods and environments, employment, healthcare, among others. In addition, it is necessary to address health disparities from holistic approaches such as bio-psycho-social models and mind, body, spirit models that take into account the whole person and the communities in which they live.

Sugary Drinks Consumption

Sugary drinks are the number one source of calories and added sugars in the American diet and an important contributor to the development of chronic diseases including type 2 diabetes, obesity, heart disease, and tooth decay. According to research, low-income and people of color are the highest consumers of sugary drinks, including soda. Moreover, the soda industry and other sugary drink companies unfairly target their marketing strategies to low-income, communities of color, children and youth.

Importance of Community-Based Strategies

Low-income and communities of color, as well as the community-based organizations that represent them, have been historically excluded from decision-making processes. As a result, efforts to address health inequities and disparities have been disconnected from the needs of community members, are not reflective of cultural identities, and thus have failed to impact communities in meaningful ways to create long-lasting change.

Community-based organizations play a crucial role in advancing health equity. These institutions help create new policies, plans, and programs that improve neighborhoods and opportunities for low-income communities, communities of color, and others unjustly burdened by poor health. They not only have a deep understanding of the unique needs and barriers that communities face, they also lift up community voices and support the self-empowerment of community members to create the social change they want to see. Despite this, community-based organizations have been under funded and under resourced.

[1] https://www.sfgate.com/bayarea/article/In-growth-of-wealth-gap-we-re-No-1-5281174.php

Community Input Subcommittee
Strategy Recommendations

It is critical to invest resources and funding in community-based and community-informed strategies to more effectively maximize impact in low-income, communities of color, and other under resourced communities facing health inequities and disparities. Recognizing that structural, environmental, and behavioral change takes time, there should be a long-term commitment of resources to support community-based organizations. Funding should be allocated not only to support programs, but to support the self-empowerment and self-determination of communities to address issues themselves. It is essential that this funding is reinvested back into the communities that are most impacted.

Priority Strategies
We believe the following strategies will maximize impact of SSDT funded programs and activities:

1. **Community-Based & Community-Informed –** Funded activities should value and involve communities in determining how activities are shaped and implemented in advancing health outcomes. Community-led and informed activities incorporate vision and priorities created by the people who live in a particular geographic community, put local voices in the lead, build on local strengths, and collaborate across sectors in intentional and adaptable ways that build community power and works to address root causes of inequities. Community-based organizations, programs and services have concrete ties to community members, demonstrated experience working in target communities, and have staff and governance that reflect those they serve. The most effective community-based programs and services are also community endorsed, evidence based and/or include practice-based evidence.
2. **Culturally-Relevant & Culturally-Informed –** Funded activities should be shaped and informed by languages, cultural practices, traditional knowledge, perspectives, and expressions that reflect the communities and populations targeted by the activities, including being multi-cultural and multi-generational.
3. **Peer-Led/Promotora Led –** Funds should support activities that incorporate peer led and/or promotora (community health worker) led interventions. Peer/promotora led approaches value community members as vehicles for promoting and enhancing change among peers by educating and sharing information with those who share the same language, culture, ethnicity and life experiences as them. By doing so, peer educators/promotoras are able to remove barriers to information and services. They are natural advocates and committed to equity and social justice.
4. **Workforce Development –** Activities should support development opportunities that lead to increased employability and employment, including but not limited to local hiring, job readiness training, skill and capacity building, career path development, and entrepreneurial opportunities.
5. **Collaborations & Partnerships –** Funding should support existing and new community-based partnerships and collaborations that leverage resources in order to increase capacity, effectiveness and impact of strategies, programs and services.
6. **Leadership Development –** Funding should support activities that promote the development of skills and capacity of community members to become more effective leaders in their communities; enhance leadership skills to create and implement purposeful desired community change; and build capacity of community members to work effectively with a broad range of community issues.
7. **Intersection of Strategies & Program Areas –** Funding should support activities that incorporate multiple strategies or program areas that represent holistic approaches addressing health disparities and inequities.
8. **Accessible Free and/or Low Cost –** Funding should support programs and activities that offer free and/or low-cost services to target populations to ensure accessibility and engagement with community members.

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APPENDIX G: San Francisco African American Community Health Equity Council Recommendations & Priorities for Soda Tax Revenue FY 18/19 – 19/20

SAN FRANCISCO AFRICAN AMERICAN COMMUNITY
HEALTH EQUITY COUNCIL

African American Community Health Equity Council
Recommendations & Priorities for Soda Tax Revenue FY 18/19-19/20
February 6, 2018

The African-American Health Equity Council (AACHEC) is an independent community body comprised of community members, churches and community-based organizations. The mission of AACHEC is to be a powerful advocate for health in San Francisco and to close the gap of negative health disparities affecting people of African descent by gathering and sharing health information and resources that promote effective health policies, community action and well-being.

Recommendations

Funding Distribution

1. **At least 50% of total Soda Tax revenue should go to community-based organizations/non-profits** to support culturally and linguistically accessible programs that are community-based, evidence-based and/or based on promising practices. Of those, funding should be given (ranked) to programs with concrete ties to the impacted communities, with a focus on (1) history of service to the targeted population, (2) staff and governance that reflects the target community, and (3) the interventions should include both community endorsed/ practice based evidence or evidence based.

Areas of funding should include: (1) **Health Education** activities including, chronic disease prevention, healthy eating and active living, water promotion, oral health & food systems; (2) **Physical Activity**, including dance & movement, sports, yoga, walking groups, biking, etc.; (C3) **Food Access**, including community-based food systems approaches, community-based pantries, community-based hot meals, community kitchens and community home delivery services, and (4) **Media/Awareness Campaigns** that include local and citywide campaigns. Examples are grassroots print, online, and social media campaigns led by community and peer leaders.

2. **10-15% should be allocated to support evaluation** of all strategies to measure impact. We support the higher percentage (15%) if there are investments in participatory community assessment, evaluation and research. Evaluation should also include community-informed outcomes.

Effective Frameworks

3. **Focus on Continuum of Care** — AACHEC recognizes that the Black/African American community is in need of programs that provide early intervention, prevention, and/or management of chronic disease in order to address the disproportionate rates of diabetes, obesity, early childhood cavities, and other chronic diseases linked to the consumption of sugary drinks. While treatment and management is important, funding should lean towards prevention and early intervention programs that are

community-based and holistic in their approach. Holistic approaches include incorporation of mind/body/spirit, biopsychosocial perspectives, diverse languages, empowerment, and should not only focus on capacity and relationship building but also be culture-specific.

4. **Prioritize Funding in Wellness Navigation Model** — Wellness Navigation is an evidence-based model that is effective in creating positive health outcomes. Its model is rooted in community and emphasizes the development of community leadership. Navigators are trusted community members who share relevant information with their community, provide linkages to resources, and strive to build enduring relationships and participation among community members in order to create positive social change. The model is also rooted in popular education that values lived experiences as integral to creating effective solutions to community challenges.

Effective Strategies

5. **Community-Based Interventions –** Funding should support existing and new community based interventions that connect to high impacted community members in relevant and effective ways that lead to positive health outcomes. Community-based organizations (CBOs) have the flexibility and expertise to more effectively address emerging needs of community members and provide:

a. **Services for Vulnerable Populations:** CBOs are experts in implementing strategies and services that target high-impacted and vulnerable communities. Funding should go to reach communities targeted by the soda industry via marketing and those populations who are high consumers of sugary drinks. Target populations for funding should include Black/African American, Samoan and Latino youth, Mayan and other Indigenous Latino communities, and undocumented communities.

b. **Holistic Approaches**: Approaches including the incorporation of mind/body/spirit, biopsychosocial perspectives, diverse languages, cultural and as well as community building, empowerment, capacity building, and environmental change. These approaches create programming that offer safe, supportive environments for children, youth, and families.

6. **Demonstrated Experience and Track Record**: Funding should be invested in organizations with demonstrated experience and a proven track record working with communities of color, high-impacted populations targeted by the soda industry, and high consumers of sugary drinks.

7. **Community Partnerships and Collaborations:** Funding should support existing and new community-based partnerships and collaborations that provide holistic, culturally and linguistically accessible approaches to prevention and early intervention. Through partnerships and collaborations resources can be leveraged to increase capacity, effectiveness and impact of strategies, which can lead to environmental and policies changes. Partnerships should also offer opportunities to build and strengthen cross-cultural, cross-community collaboration.

SAN FRANCISCO AFRICAN AMERICAN COMMUNITY
HEALTH EQUITY COUNCIL

8. **Media Campaigns** – Funding should support grassroots media campaigns. CBOs should inform and shape citywide media campaigns on health so that messaging is linguistically and culturally accessible and effectively speaks to community members. In addition, funding should support community-based media campaigns to educate and inform high impacted communities affected by chronic diseases linked to the consumption of sugary drinks. An example is funding used to mobilize communities involving youth around social media advocacy, education, and the development of policy and environmental change.

Program Areas to be prioritized:

- Food and water access (water filling stations, food subsidies, etc.)
- Nutrition and healthy eating (education, cooking classes, gardening, etc.)
- Water consumption/reduction of sugary drink consumption (promotion, education)
- Physical activity (free, accessible, in and out of school)
- Food justice (promoting traditional foods with healthier ingredients; increasing awareness of food systems, food processing)
- Chronic disease prevention including diabetes, obesity, hypertension, cardiovascular disease and cavity prevention

Opportunities

- Align advocacy for soda tax funding with AACHEC/Black Agenda, as well as the other health parity coalitions such as the Chicano/Latino/Indigena and the Asian Pacific Islander Parity Coalition Agendas.
- Educate the Board of Supervisors regarding AACHEC soda tax funding recommendations and Priorities.

Chairs
Dr. Monique LeSarre, Rafiki Coalition for Health and Wellness
Bennie Thomas and Jeanne Hogg, Co-Chairs, Physical Health Committee
Jeanette Johnson, Chair, Mental Health Committee
Dr. Ray Thompkins, Chair, Environmental Justice Committee

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APPENDIX H: Asian and Pacific Islander Health Parity Coalition Recommendations & Priorities for Soda Tax Revenue FY 18/19 – FY 19/20

Asian and Pacific Islander Health Parity Coalition
Recommendations & Priorities for Soda Tax Revenue FY 18/19 – FY 19/20
February 26, 2018

Background of Asian and Pacific Islander Health Parity Coalition (APIHPC)

Established in 2006, the Asian and Pacific Islander Health Parity Coalition is comprised of 25 members representing a diverse cross-section of the Asian and Pacific Islander communities in San Francisco. APIHPC evolved from a Mental Health Services Act position paper submitted to and ultimately endorsed by the San Francisco Department of Public Health. APIHPC aims to promote healthy Asian and Pacific Islander communities by educating the community on mental health issues, de-stigmatizing mental illness, and help-seeking behaviors, promoting workforce development, and providing culturally-relevant services to the A&PI communities.

Recommendations

Funding Distribution

1. **At least 50% of total Soda Tax revenue should go to community-based organizations/non-profits** to support culturally and linguistically accessible programs that are community-based, evidence-based, nuance-based, practice-based, and/or based on promising practices.
2. **10-15% should be allocated to support evaluation** of all strategies to measure impact. We support the higher percentage (15%) if there are investments in participatory community assessment, evaluation, and research. Evaluation should also include community-informed outcomes.

Effective Frameworks

3. **Focus on standardizing collection and reporting of disaggregated** Asian & Pacific Islander data to provide a more accurate and detailed picture of the health status of these communities because their experiences and challenges are not homogenous, necessitating tailored approaches.
4. **Focus on Culturally and Linguistically Appropriate Approaches –** APIHPC acknowledges that culture is a strong determinant of health beliefs and practices as well as health seeking behaviors, attitudes, and perceptions. Our approach would incorporate first languages, cultural practices, including community building, community engagement, and empowerment. This will help advance and sustain culturally and linguistically appropriate services that are respectful of and responsive to the diverse Asian & Pacific Islander communities, and thus improving quality of services and health outcomes.
5. **Focus on Prevention and Early Intervention** — APIHPC recognizes that the diverse Asian & Pacific Islander communities demand programs that promote health and wellness, prevention-focused, provide early intervention, and/or management of chronic disease in order to address the disproportionate rates of diabetes, obesity, early childhood cavities, and other chronic diseases linked to the consumption of sugar drinks. While treatment and management is

important, funding should lean towards prevention and early intervention programs that are culturally-informed, community-led, and community-based.

Effective Strategies

6. **Community-Defined -** Funding should support existing and new community-based outreach, education, and interventions that connect to high impacted community members in relevant and effective ways that lead to positive health outcomes. Community-based organizations (CBOs) have the expertise, insights, and flexibility to more effectively address emerging needs of community members and provide:

    a. **Services for Vulnerable Populations:** CBOs are experts in implementing strategies and services that focus on high-impacted and vulnerable communities. Funding should go to reach communities targeted by the soda industry via marketing and those populations who are high consumers of sugary drinks. Priority populations for funding should include Asian & Pacific Islander communities across all ages and gender types, including undocumented communities.

    b. **Whole Health Approaches**: Approaches including the incorporation of mind/body/spirit, bio-psycho-social perspectives, diverse languages, cultural and as well as community building, empowerment, capacity building and environmental change. Implement these approaches create programming that offer safe, supportive environments for children, youth, and families.

    c. **Funding Community Health Worker:** Community health worker models are designed to improve and facilitate access to care, empower individuals with knowledge, and improve health outcomes. A key role of Community health workers is to eliminate health disparities by providing culturally and linguistically appropriate services, providing emotional and practical support, and creating links between resources (among others). Community health workers provide outreach, education, and engagement.

7. **Demonstrated Experience & Track Record:** Funding should be invested in organizations with demonstrated experience and a proven track record working with communities of color, high-impacted populations targeted by the soda industry, and high consumers of sugary drinks.
8. **Community Partnerships and Collaborations:** Cross-community, cross-population approaches to address community-specific concerns and issues.
9. **Media Campaigns** – Funding should support grassroots media campaigns. CBOs should inform and shape citywide media campaigns on health so that messaging is linguistically and culturally accessible and effectively speaks to community members. In addition, funding should support community-based media campaigns to educate and inform high impacted communities affected by chronic diseases linked to the consumption of sugary drinks. An example is funding used to mobilize communities involving youth around social media advocacy, education, and the development of policy and environmental change.

Program Areas to be Prioritized

- Food and water access (ex. water filling stations, food subsidies, etc.)
- Nutrition and healthy eating (education, cooking classes, gardening, etc.)

- Water consumption/reduction of sugary drink consumption (promotion, education)
- Physical activity (free, accessible, in and out of school)
- Food justice (promoting traditional foods with healthier ingredients; increasing awareness of food systems, food processing)
- Chronic disease prevention including diabetes, obesity, hypertension, cardiovascular disease and cavity prevention

Opportunities

- Align advocacy for soda tax funding with APIHPC equity Agenda
- Educate Board of Supervisors regarding APIHPC soda tax funding recommendations and priorities

APIHPC Members:

Asian Pacific Islander American Health Forum
Asian Perinatal Advocates Family Support Services
Cambodian Community Development Inc.
Cameron House
Chinatown Community Children's Center
Chinatown Child Development Center
Chinatown North Beach Mental Health Services
Chinatown Public Health Center
Chinatown YMCA
Chinese Community Health Resource Center
Chinese Hospital
Community Youth Center of San Francisco
Filipino-American Development Fund/Bayanihan Community Center
Japanese Community Youth Council
Kai Ming Headstart
Lao Seri Association
NICOS Chinese Health Coalition
Northeast Medical Services
Richmond Area Multi-Services, Inc.
Richmond District Neighborhood Center
Samoan Community Development Center
UCSF Asian Health Institute
UCSF Center for Community Engagement
Vietnamese Family Services Center
Vietnamese Youth Development Center

Co-chairs:
Christina Shea, LMFT, RAMS Inc.
Amor Santiago, DPM, MPH, APA Family Support Services

Coordinator/Planner:
Natalie T. Ah Soon, MPH, RAMS Inc.

Steering Committee:
Wylie Liu, MPH, MPA, UCSF Center for Community Engagement
Judy Young, Vietnamese Youth Development Center
Kent Woo, MSW, NICOS Chinese Health Coalition
Nancy Lim-Yee, LCSW, Individual member
Jon Osaki, Japanese Community Youth Council
Diana Wong, PsyD, LMFT, Chinatown Child Development Center

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APPENDIX I: Chicano Latino Indigena Healthy Equity Coalition Recommendations & Priorities for Soda Tax Revenue FY 18/19-19/20

Chicano/Latino/
Indigena Health
Equity Coalition

Chicano Latino Indigena Healthy Equity Coalition
Recommendations & Priorities for Soda Tax Revenue FY 18/19-19/20
February 6, 2018

Background of Chicano Latino Indigena Health Equity Coalition (CLI)

> *The Chicano Latino Indigena Health Equity Coalition is made up of over 10 Latino-serving organizations and other community partners working to reduce health disparities and inequalities impacting the Chicano/Latino/Indigena communities in San Francisco. Our goal is to represent and advocate on behalf of CLI communities with respect to policy and program development in order to ensure that there is equitable distribution of resources and investment in strategies that effectively respond and address to the needs of CLI communities.*

Recommendations

Funding Distribution

1. **At least 50% of total Soda Tax revenue should go to community-based organizations/non-profits** to support culturally and linguistically accessible programs that are community-based, evidence-based and/or based on promising practices
2. **10-15% should be allocated to support evaluation** of all strategies to measure impact. We support the higher percentage (15%) if there are investments in participatory community assessment, evaluation and research. Evaluation should also include community-informed outcomes.

Effective Frameworks

3. **Focus on Continuum of Care** — The CLI recognizes that the Latino community is in need of programs that provide early intervention, prevention, and/or management of chronic disease in order to address the disproportionate rates of diabetes, obesity, early childhood cavities, and other chronic diseases linked to the consumption of sugar drinks. While treatment and management is important, funding should lean towards prevention and early intervention programs that are community-based and holistic in their approach. Holistic approaches include incorporation of mind/body/spirit, bio-psycho-social perspectives, diverse languages, cultural and as well as community building, empowerment, and capacity building.

4. **Prioritize Funding in Promotora Model** — The Promotora Model is an evidence-based model that is effective in creating positive health outcomes. Promotoras are not just bi-lingual, bi-cultural outreach workers. The Promotora model is rooted in community and emphasizes the development of community leadership. Promotoras are trusted community members who share relevant information with their community, provide linkages to resources, and strive to build enduring relationships and participation among community members in order to create positive social change. The model is also rooted in popular education that values lived experiences as integral to creating effective solutions to community challenges.

Effective Strategies

5. **Community-Based Interventions –** Funding should support existing and new community-based interventions that connect to high impacted community members in relevant and effective ways that lead to positive health outcomes. Community-based organizations (CBOs) have the flexibility and expertise to more effectively address emerging needs of community members and provide:

    a. **Services for Vulnerable Populations:** CBOs are experts in implementing strategies and services that target high-impacted and vulnerable communities. Funding should go to reach communities targeted by the soda industry via marketing and those populations who are high consumers of sugary drinks. Target populations for funding should include Latino youth, Mayan and other Indigenous Latino communities, and undocumented communities.

    b. **Holistic Approaches**: Approaches including the incorporation of mind/body/spirit, bio-psycho-social perspectives, diverse languages, cultural and as well as community building, empowerment, capacity building, and environmental change. These approaches create programming that offer safe, supportive environments for children, youth, and families.

6. **Demonstrated Experience & Track Record**: Funding should be invested in organizations with demonstrated experience and a proven track record working with communities of color, high-impacted populations targeted by the soda industry, and high consumers of sugary drinks.

7. **Community Partnerships and Collaborations:** Funding should support existing and new community-based partnerships and collaborations that provide holistic, culturally and linguistically accessible approaches to prevention and early intervention. Through partnerships and collaborations resources can be leveraged to increase capacity, effectiveness and impact of strategies, which can lead to environmental and policies changes. Partnerships should also offer opportunities to build and strengthen cross-cultural, cross-community collaboration.

8. **Media Campaigns** – Funding should support grassroots media campaigns. CBOs should inform and shape citywide media campaigns on health so that messaging is linguistically and culturally accessible and effectively speaks to community members. In addition, funding should support community-based media campaigns to educate and inform high impacted communities affected by chronic diseases linked to the consumption of sugary drinks. An example is funding used to mobilize communities involving youth around social media advocacy, education, and the development of policy and environmental change.

Program Areas to be Prioritized

- Food and water access (ex. water filling stations, food subsidies, etc.)
- Nutrition and healthy eating (education, cooking classes, gardening, etc.)
- Water consumption/reduction of sugary drink consumption (promotion, education)
- Physical activity (free, accessible, in and out of school)
- Food justice (promoting traditional foods with healthier ingredients; increasing awareness of food systems, food processing)
- Chronic disease prevention including diabetes, obesity, hypertension, cardiovascular disease and cavity prevention

Opportunities

- Align advocacy for soda tax funding with Latino Equity Agenda
- Educate Board of Supervisors regarding CLI soda tax funding recommendations and priorities

CLI Members:

Asociación Mayab
Day Labor Program
Good Samaritan
Central American Resource Center (CARECEN)
Healthright 360
Horizons Unlimited, Inc.
Instituto Familiar de la Raza
Mission Neighborhood Health Center
National Council on Alcoholism
SF AIDS Foundation Latino Programs
SF Department of Public Health
St. Luke's Hospital
St. Peter's Housing
UCSF Community Resource Center

Co-chairs:

Dr. Estela Garcia, Instituto Familiar de la Raza
Lariza Dugan Cuadra, CARECEN
Dr. Alberto Perez Rendon, Asociación Mayab

San Francisco
Sugary Drink Distributors Tax Advisory Committee
March 2018 Report

APPENDIX J: Faith-Based Liaison Committee – Letter to the Sugary Drinks Distributor Tax Advisory Committee

Faith
It makes things possible, not easy

FAITH-BASED LIAISON COMMITTEE
Advocating for the
needs of the underserved

Affiliated Organizations

Double Rock Baptist Church
Pastor Raynard Hillis
1595 Shafter Ave,
San Francisco CA 94124

Providence Baptist Church

Cornerstone Missionary Baptist Church

Olivet Baptist Church

Calvary Hill Community Church

St. John Missionary Baptist Church

St. Marks Institutional Missionary Baptist Church

All Hallows & Our Lady of Lourdes

St. Paul of the Shipwreck

New Life Fellowship Church

True Hope Church of God in Christ

New Providence Baptist Church

United House of Prayer

Jones Memorial United Methodist Church

Grace Tabernacle Community Church

Without Walls Christian Fellowship

St Paul's Tabernacle Baptist Church

Glide Memorial Church

3rd Baptist Church

Neighborhood Baptist Church

February 10, 2018

To: Sugary Drinks Distributor Tax Advisory Committee

Who we are:

The Faith-Based Liaisons Committee is a health and wellness collaborative of 17 local churches in San Francisco. We are committed to advocating for the needs of the underserved African-American community in the Bayview / District 10 community. We are an independent community body operating under the fiscal sponsorship of the San Francisco Health Foundation.

Why this is important to our constituents:

The Sugary Drinks Distributor Tax Ordinance was designed to curtail and address the adverse health outcomes related to sugar consumption. We supported the measure then and now. However, we cannot address negative health outcomes in isolation. Data suggest that poverty rates, disproportionate chronic illness and uneven mental health and addiction issues contribute greatly to poor health outcomes. And that means improved community health outcomes will require a holistic approach and our recommendations underscore this. For we understand that:

- Poverty, income inequality, forces burdensome choices between shelter, and healthy food consumption. In San Francisco, African-Americans earn $29,800 compared to $101,00 for Whites (1); there are 8,064 adults and 3111 children living below the federal poverty level in the Bay View neighborhood. (2)
- Health inequities, such as disproportionate rates of diabetes, heart disease and metabolic syndrome, will worsen when left unaddressed and result in a shorter life expectancy. For example, in San Francisco, an African American man in the Bayview lives 14 years fewer than a White male in Russian Hill. (3)
- Mental health and addiction illnesses correlate with poor life choices. African-Americans are much less likely than Whites to receive mental health and substance abuse treatment and are at increased risk of severity. (4)

What is needed:

After surveying our various congregations, and in dialogue across congregations, we strongly believe that a funding percentage commensurate with the burden of disease be distributed in the African-American community, and that the following funding recommendations be given your highest consideration, including providing support to the Faith Based Liaisons Committee.

Intervention / Recommendation (1) Improve Food Pantry Services in the Bayview

There are several food pantries in the Bayview, however, most are only open one or two days a week. Our people are hungry every day. Food Pantries in the Bayview most often do not have access to well-balanced or high-quality nutrition. The produce made available to our food pantries are close to expiring. An adequate supply of nutritious food is critically important to lead and maintain a healthy and active lifestyle and improve health outcomes. Equally as important, funding will allow food pantries to hire paid staff to operate pantries seven days a week, so that all citizens in the Bayview can have access to food.

Intervention / Recommendation (2) Improve Food Security by addressing Food Access in the Bayview

Food Security, as defined by the Food and Agriculture Organization states: "When all people, at all time, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and good preferences for an active and healthy life." The African-American community within the Bayview lacks access to healthier foods and funding should help address the mobility needs of the aging and disabled population to acquire food; help address our homeless population which lacks the economic resources to attain a hot meal and help address our pregnant women and infant children, who lack the means to obtain sufficient and nutritious food.

Intervention / Recommendation (3) Increase Food Delivery Programs for Senior and those with Disabilities

There are several programs in the Bayview that provide delivery of a hot meal. However, many have reached capacity and refer new comers to the waiting list. Funding for increased food delivery services will allow feeding programs to deliver groceries and hot meals directly to the door steps of the aging and disabled African-American population in the Bayview seven days a week.

Intervention / Recommendation (4) Establish Restaurant Gift Cards for Homeless Population

The homeless population lacks the economic resources to attain a hot meal, and often times gather outside the local fast-food restaurants crying out for spare change to buy food. Funding could allow for the purchase and distribution of restaurant gift cards to be issued to targeted homeless populations for the purchase of a hot meal.

Intervention / Recommendation (5) Establish Fresh Healthy Food Program for Pregnant Women and Infant Children

Nutrition is important throughout life. Poor nutrition during pregnancy and infancy has been scientifically proven to stunt the physical, mental and social growth of an individual. Pregnant African-American women often suffer from hypertension and obesity, which directly affect the overall health of the child in the womb. We recommend funding a food collective which would allow our pregnant women and infants access to a sufficient source of food that is nutritious and effectively promoting the health of the baby in the womb and after delivery. Further, funding would allow for nutrition education for both mom and baby.

Intervention / Recommendation (6) Cultivate Liaison Advocacy Programs

The needs of the African-American community will continue to be underserved as long as decisions continue to be made on our behalf without thoughtful community input. We know our community

needs best and can recommend solutions that are plausible and prone for measurable impact. Often the voices of the African-American neighborhoods are not heard or considered on issues, policies, programs or legislation that directly affect us. Specifically, funding the advocacy work of the Faith-based Liaison Committee would connect the city to a fresh network of active and concerned citizens who collect primary data in the community for the development of services, programs and policies that improved health outcomes across the target population.

Intervention / Recommendation (7) Develop Culturally Competent Institutions

It is important to support indigenous efforts and solutions that arise out of the community. There should be funding to support organizations that are culturally competent, with services that are designed for, and governed by the target population. To ensure adequate community buy-in, the goal must be encouraged and supported by technical assistance

We need your help:

We sincerely believe that funding in isolation will not have the impact that is needed to improve the health outcomes of our community and solutions must include programs and services that impact poverty, chronic ailments and mental health and addiction conditions. We need the help of allies who understand what is at stake and the impact poor health is having on the vitality of Bayview and all of San Francisco.

Many of our recommendations are linked to food security issues because a growing number of our congregants have said they are hungry, according to surveys polled from within our network of churches. Genetics notwithstanding, doctors say exercise and diet are essential to good health outcomes. Let's not forget to improve the diet recommendations, which range from address hunger to food quality and food access.

Please refer questions or requests for information to Raynard Hillis, Pastor of the Double Rock Baptist Church, Faith-Based Liaison Committee, 1595 Shafter Ave, San Francisco CA 94124 | 415-822-4566 | pastorrh@gmail.com

Respectfully requesting your support,

Raynard Hillis, Pastor
Chair, Faith-Based Liaison Committee

Foot Notes: 1) San Francisco Budget and Legislative Analyst Report on Median Income, May 2017; 2) American Community Survey 2011-15; 3) Community Vital Signs compilation: San Francisco Chronicle Report, September 23, 2010; 4) Gender and Health Research Lab, University of Michigan, Breslau et al., 2005; Schmidt et al., 2006).

San Francisco
Sugary Drink Distributors Tax Advisory Committee
March 2018 Report

APPENDIX K: NICOS Chinese Health Coalition - Sugary Drinks Distributor Tax Advisory Committee – Recommendations

NICOS Chinese Health Coalition 華人健康組織聯會

NICOS Chinese Health Coalition is a public-private-community partnership of more than 30 health and human service organizations and concerned individuals. The mission of NICOS is to enhance the health and well-being of San Francisco's Chinese community.

The acronym, "NICOS," stands for the first initials of the five founding members. Additional organizations and individual members have since joined to form the overall health coalition.

Founding Members:

North East Medical Services

Chinese Community Health Care Association (**I**PA)

Chinese Hospital

On Lok Lifeways

Self- Help for the Elderly

Additional Members:
(partial listing)

American College of Traditional Chinese Medicine
American Red Cross
APA Family Support Services
Asian American Recovery Services
Asian & Pacific Islander American Health Forum
Asian & Pacific Islander Wellness Center
Asian Women's Resource Center
Bay Area Legal Aid
Chinatown Child Development Center
Chinatown Community Development Center
Chinatown/ North Beach Mental Health Services (DPH)
Chinatown Public Health Center (DPH)
Chinatown YMCA
Chinese Community Health Plan
Chinese Community Health Resource Center
Chinese Hospital Medical Staff
Chinese Newcomers Service Center
Community Youth Center
Donaldina Cameron House
Kai Ming Inc.
Kaiser Permanente
National Council of Asian and Pacific Islander Physicians
Newcomers Health Program (DPH)
Richmond Area Multi-Services, Inc.
San Francisco Health Plan
St. Mary's Chinese Day School
University of California, San Francisco-Memory and Aging Center
University of California, Davis-Dept of Psychiatry and Behavioral Science
Wu Yee Children's Services

1208 Mason Street
San Francisco, CA 94108
Phone: (415) 788-6426
Fax: (415) 788-0966

MEMO

TO: Members of the Sugary Drinks Distributor Tax Advisory Committee (SDDT)

FR: Chinatown Task Force on Children's Oral Health

DA: March 2, 2018

RE: Sugary Drinks Distributor Tax Advisory Committee – Recommendations

Members of the Chinatown Task Force on Children's Oral Health (CTFCOH)[1], a public-private partnership of more than 10 health and human service organizations addressing pressing oral health concerns in the Asian American community, convened their monthly meeting on Tuesday, February 13, 2018. Included in the agenda was a discussion on recommendations on funding priorities to be conveyed to the Sugary Drinks Distributor Tax Advisory Committee (SDDTAC). Subsequent discussions followed via email.

In summary, the CTFCOH recommends funding the following initiatives, programs/projects and/or activities. In general, the CTFCOH recommends the majority of funds be allocated to community-based organizations, which are in the best position to reach the affected populations and in a culturally and linguistically appropriate manner. Specifically, CTFCOH recommends funding oral health outreach/ education/ intervention efforts as they are currently woefully under-resourced. This would include allocating funding for:

- Existing initiatives such as neighborhood-based Children's Oral Health Task Forces (of which the CTFCOH is one) which utilize a collective impact approach in addressing oral health disparities in communities of color
- Existing multi-media educational campaigns that seek to effect behavioral change (such as "Re-Think Your Drink" and 'Less Sugar, Sweeter Life")
- Community-based outreach/ education directly to parents regarding the importance of oral health
- Community-School partnerships to provide campus-based education and interventions such as classroom presentations, oral health screenings, fluoride varnishes and sealants
- Research to determine the most effective children's oral health messaging to be used in multi-media campaigns targeting specific populations
- Community-engaged projects such as poster contests, "Weekend Without Sugar" challenges, etc.

Thank you for your consideration. If you have any questions or would like further comments, please feel free to contact Dr. Ben Lui at 415-364-7924 or Yee-Bun.Lui@sfdph.org or Kent Woo at (415) 788-6426.

[1] Lead and fiscal agent for the Chinatown Task Force on Children's Oral Health is NICOS Chinese Health Coalition

San Francisco
Sugary Drink Distributors Tax Advisory Committee
March 2018 Report

APPENDIX L: SFUSD Student Letters

HEALTH EDUCATION

From TCS Tons

Please before Friday :) Gracias!

SUPPORT

February 27, 2018

Dear Sugary Drinks Distributor Tax Advisory Committee,

We, the undersigned, kindly request your assistance in ensuring that the revenues collected from soda tax will be budgeted to support the health of SFUSD students.

We ask that the Soda Tax revenue support SFUSD students with health education and access to clean drinking water and healthy meals. We want to ensure that, instead of choosing soda, SFUSD youth will be empowered to make healthy food and beverage choices. We know that health education can be systematically taught in the classroom setting where we can have the most direct impact on the greatest number of youth in San Francisco.

When the soda tax was promoted to in 2016, voters were told that it would echo the positive changes seen in Berkeley, where 42.5 percent of soda tax revenue has gone to the Berkeley Unified School District for cooking, gardening and nutrition programs.

We are voicing our opinion to show our solidarity in support of directing more funds to SFUSD from the Sugary Drinks Distributor Tax Advisory Committee. Please set aside 40% of the Soda Tax revenue to support the health and wellness of SFUSD students.

Sincerely,

School Site: Tenderloin Community School		
Name	Role	Signature
Kim Burke	Teacher	
B Sizelove	Teacher	
Barbara Velarde-Stiens	Teacher	
Michael Cerier	Social Worker	
Cemily Gill	Teacher	
Jennifer Parrish	Teacher	
Tafaneh Hamilton	School Nurse	

HEALTH EDUCATION

Tenderloin Community School

Student & Family Community SUPPORT

Name	Role	Signature
Min Im	Teacher	
Kara Wright	Family Advocate	
George Saunders	Teacher	
Evelina Sarabia	Intervention Teacher	
Loreta Torres	IRF	

HEALTH EDUCATION

Student Family & Community SUPPORT
San Francisco Unified School District

February 27, 2018

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Sincerely,

School Site:		
Name	Role	Signature
Laine Tagomon	AP	
Shari Balis	Prncpl	
Bryan Twarek	Program Admin	
Liz Fleur	Principal	
Valorie Hoshino	Principal	
Jeremy Ball	Manager, HR Benefits	
Brad Starr	Deputy Supt.	

over

HEALTH EDUCATION

Student, Family & Community SUPPORT
San Francisco Unified School District

Jeanne Dowd	Principal	Jeanne Dowd
Richard Curel	LEAD	
VELMA VEITH	Supervisor	
Benjamin Kraus	Principal	
Patrick West	Principal	
Erica Lingrell	Program Administrator	
Allison Shoule	Teacher	
Cheryl Nelson	Teacher	
Theresa Gandran-Rosales	School Social Worker	
Charlene Lee	Budget Analyst	
Erin Farrell	School Social Worker	
Donna Crew	Admin Asst.	
Mary Lahony	SSW	
Jennifer R. Gozun	DIRECTOR	
Thea Anderson	SSW	
Laurie Vargas	WC	
Christopher Pepper	Teacher	
Catherine Cahmyniim	PARA	
Naomi Chapman	SW	
Celia Bird	SDN	
Karen Tim	SHP	
	SDN	Catherine Fuller
Christine Hardman	Admin	
Christine Maog	Teacher	

HEALTH EDUCATION

SUPPORT

February 27, 2018

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Sincerely,

School Site: Sanchez Elementary School

Name	Role	Signature
ERICA JUNGHANS	Para	
Stephanie Leiva	Mentor	
Marelle Robles	Teacher	
Margarita Muñoz	Community Relations	
Matthew Tow	Teacher	
Mina Paz	Madre	

HEALTH EDUCATION

SUPPORT

Anthony Cancio	Sub Teacher	
Maura Dolan	teacher	
Susan Jassan	parent	
Anibal	Papa	
Jose Ruando Rivera	Sub Teacher	
Erika Villegas	Teacher	
~~DANIEL ZURITA~~	~~DADS~~	
Karen Moran	madre	
Madeline López	tutora	
Lorena Sdorgow	Abuela	
Rosario Hotel	madre	
[illegible] Salcedo	Madre	
Viancy García	Mamá	
Abraham Morales	Mamá	
Axel Cruz	Mamá	
Andrey James	SSW	
Anna Gearon	Para	
Sosie Kamen	Para	
VANESSA Piccioth	SON	

HEALTH EDUCATION

Student, Family & Community SUPPORT
San Francisco Unified School District

February 27, 2018

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Sincerely,

School Site: JEFFERSON ES		
Name	Role	Signature
Heather Golden	JSW	
Mary Gow	Teacher	
Tony Acquarelli	Teacher	
Jill Radwanski	Teacher	
Kim Probst	Teacher	
Morgan Proctor	Teacher	
Allison Lee	Teacher	

HEALTH EDUCATION

Student Family & Community SUPPORT
San Francisco Unified School District

Annie Lum	Teacher	
Shirley Yee	Secretary	
Joseph Phillips	Teacher	
Nikol Juarez	SLP	
Leigh Hickle Miles	Teacher	
connie Ma	Teacher	
Amylee	Teacher	
Victoria Bautista	Teacher	
Marcy Johnson	Teacher	
Arlen Kaufmann	teacher	
Steven O'Reilly	Teacher	
Emily Ellingson	teacher	
Pamela Kahn	Teacher	
Loret Peterson	Teacher	
Natalie Chamion	Sub teacher	
Kelly Carter	Reading Teacher	
SEQUOIA BAIONI	Teacher	
Jennifer L. Tan	Teacher	

HEALTH EDUCATION

February 27, 2018

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Sincerely,

School Site: Daniel Webster Elementary

Name	Role	Signature
Blanca Lopez	Teacher	
Alumna Bolfson	Teacher	
Robin Fletcher	IRF	
Arielle Garcia	Teacher	
Ana Olivar	Teacher	
Rachel Lim	Social Worker	
Jessica Thompson	Teacher	

HEALTH EDUCATION

SUPPORT

Name	Role	Signature
Christine Tucker	Teacher	
Laura Graham	teacher	
Jessica Wilk		
Crystal		

HEALTH EDUCATION

Student, Family & Community SUPPORT
San Francisco Unified School District

February 27, 2018

Dear Sugary Drinks Distributor Tax Advisory Committee (SDDTAC),

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We are voicing our opinion to show our solidarity in support of directing more funds to SFUSD from the Sugary Drinks Distributor Tax Advisory Committee (SDDTAC). Please set aside 40% of the Soda Tax revenue to support the health and wellness of SFUSD students.

Sincerely,

School Site: Burton High School

Name	Role	Signature
Patrick Mulkern	Wellness Coordinator	
Mika Sasaki	CHOW	
Reina Turner	RAMS Therapist	
Alyssa Arney	History teacher	
Yi Song	Chinese teacher	
Liz Kaufman	English Teacher	
Eric Chow	English Teacher	
Jason Pelina	Physics Teacher	
Robert Pablo	Teacher	
Marlene Ligsay	Asst. Principal	
Holly Adler	SPED Teacher	

HEALTH EDUCATION

Student, Family & Community SUPPORT
San Francisco Unified School District

Jeremy Francis	PE Teacher	Jeremy Francis
Ella Bastone	FYS Intern	
Alea Sanidad	student	
A.t	student	
Mariadaga	student	
Quentin Rosby	Student	
Delrycio Dar	Student	
Ajay santiago	student	
Nadia	student	
Sharlyn Dalisay	student	
Mahlia Navas	Student	
Daniela Herazo	student	
Leah Cuevedo	student	
Laure	English teacher	

Dear Advocate of Health Education,

HEALTH EDUCATION

Student, Family & Community SUPPORT
San Francisco Unified School District

February 27, 2018

Dear Sugary Drinks Distributor Tax Advisory Committee (SDDTAC),

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Sincerely,

School Site: Burton High School		
Name	Role	Signature
Erik Nielsen	Teacher	
Stephanie Hanson	Teacher	
Mishiwalee	Substitute Teacher	
Eugene Pearson	Teacher	

HEALTH EDUCATION

Student Family & Community SUPPORT
San Francisco Unified School District

February 27, 2018

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Sincerely,

School Site: Thurgood Marshall Academic H.S.		
Name	Role	Signature
Edith Arias	SPED Teacher	Edith Arias
Elizabeth Quinones	Teacher	
Jessica Oppenheim	Teacher	
Juliet Bolanos	Teacher	
Iris Rivera	Secretary	

HEALTH EDUCATION

Student, Family & Community SUPPORT
San Francisco Unified School District

February 27, 2018

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We are voicing our opinion to show our solidarity in support of directing more funds to SFUSD from the Sugary Drinks Distributor Tax Advisory Committee (SDDTAC). Please set aside 40% of the Soda Tax revenue to support the health and wellness of SFUSD students.

Sincerely,

School Site: Roosevelt Middle School

Name	Role	Signature
Michael Stecher	Principal	
Patrick Ng	Teacher	
Rachel Clowes	Teacher – Librarian	
Erika Kniffel	Teacher	
Jon Ubents		
Whitney Marsh	Teacher	
Mike Atkins	Teacher	
	Counselor	
Leticia Arriel	Security	
	Security	

HEALTH EDUCATION

Teachers: Please sign. Please also have students sign!

February 27, 2018

Dear Sugary Drinks Distributor Tax Advisory Committee,

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We are voicing our opinion to show our solidarity in support of directing more funds to SFUSD from the Sugary Drinks Distributor Tax Advisory Committee. Please set aside 40% of the Soda Tax revenue to support the health and wellness of SFUSD students.

Sincerely,

School Site: Chinese Immersion School

Name	Role	Signature
Karen Chu	Teacher	
Madison Li	Student	Madison Li
Catherine Tang	Student	Cate
Piper Loo	Student	Piper
Michelle Kwong	Student	Michelle
Chloe Taylor	Student	Chloe
[illegible]	Teacher	
Carlon Chan	Student	Carlon Chan
Kari Cheung	Student	Kari Cheung
[illegible]	Student	[illegible]
Alex [illegible]	Student	Alex
Gavin	Student	Gavin
Alix Huang	Teacher	
[illegible]	Student	[illegible]
[illegible]	Student	[illegible]
[illegible]	Student	Herbie Cheng
[illegible]	Student	[illegible]
[illegible]	Student	[illegible]

HEALTH EDUCATION

SUPPORT

Natasha	Student	Natasha
Bradley	student	Bradley
Gil	student	Gil
Soleil	student	Soleil
Kyle	student	Kyle
Jee	student	Jee
Julian	student	Julian
Renee Tan	Student	Renee Tan
Evan Pham	student	Evan Pham
Lokyan Ng	Student	Lokyan Ng
Julianne Leong	Student	
Benson Lee	student	Benson Lee
Allison Lee	student	Allison Lee
Vincent Lee-Inhof	Student	Vincent Lee-Inhof
Reann Liu	Student	Reann Liu
Noah	Student	Noah
Brooke Patchen	Student	Brooke
Kaitlyn Su	Student	Kaitlyn Su
Michelle Ye	Student	Michelle Ye
Kira Lukemeigh	student	Kira Mukeigh
Jonas Lim	Student	Jonas Lim
Lauren Lee	student	Lauren Lee
Ella Klein	student	Ella Klein

HEALTH EDUCATION

SUPPORT

Avery Iewan	Student	Avery Kwan
Tedford Lewis	Student	Tedford Lewis
Kyle mcveigh	Student	Kyle mcveigh
Payton Ngan	Student	Payton Ngan
Keira Wong	Student	Keira Wong
Madeline Sue	Student	Madeline Sue
Betty Liked	Student	Betty Liked
Quinn Luk	Student	Quinn Luk
Brienna Tsui	Student	Brienna Tsui
Rosen P.L.	Student	Rosen P.L.
Jasmine Ng	Student	Jasmine Ng
Erin Lee	Student	Erin Lee
Charlotte Klein	Student	Charlotte Klein
Mona Huang	Student	Mona Huang
Militsa Linker	Student	Militsa Linker
Yurika Mui	Student	Yurika Mui
Sophia Nichol	Student	Sophia Nichol
Auden Szalva	Student	Auden Szalva
Jason Yu	Student	Jason Yu
Andrea Merino Mora	Student	[illegible]
Ivan Lin	Student	Ivan Lin
Chloe Lam	Student	Chloe Lam
Jerry Hou	Student	Jerry Hou

HEALTH EDUCATION

SUPPORT

Dennis Tan	K Student	Dennis Tan
Max Coursey		Max
Sharon Yu		Sharon
Katrina Li		K
Ethan Wong		Ethan
Rayne Wong		Rayne
Anson Li		A
Junius Dodge		Junius
Milo Schaal		Milo
Taylor Su		Taylor Su
Vienna Tzeng		Vienna Tzeng
Charlotte		Charlotte
Ethan Keast		Ethan
Gaillie Kam		Gaillie
William Huang		William
Amoreah Harrison		Amoreah
Sophia Sin Yeung	Teacher	
Meiyi Yu	Teacher	
Josh Schmidt	Teacher	
Xiumei Xie	custodian	Xiumei Xie

Khloe Tang	Student	Khloe Tang
Jillian Patchen		Jillian
Vicky Huang		Vicky Huang
Ryan Luo		Ryan Luo
Keaton Zhang		Keaton Zhang
Lyndsey Tan		Lyndsey Tan
Raina Liu		Raina Liu
Alana Lam		Alana Lam
Elena Carvajal		Elena
Elese Wu		Elese Wu
Dayton Lam		Dayton Lam
James Eckels		James
Luna Yee		Luna Yee
Faith Chan		Faith Chan
Henry Li		Henry Li
Bryn Iranon-Lieker		Bryn

HEALTH EDUCATION

SUPPORT

Austin.V.	student	Austin.V.
Katelyn H.	"	Katelyn H.
Flora.D	"	Flora.D
Carmen W.	"	carmenw.
Vesper. YG	"	Vesper.YG
Leor.	"	Leor.
Maybelle.W.	"	Maybelle.W.
Natalie.L.	"	Natalie.L.
CharlesLee	"	CharlesLee
Peter.C	"	Peter.C
Walter.Wt	"	walter.wt
Bailey.H.u	"	Bailey.Hu
Jayden.W	"	Jayden.W.
justin.L	"	Justin L
Bernice Lam	Student	Bernice Lam
Mikayla Chew	Student	Mikayla Chew
Alva Fahlgren	Student	Alva Fahlgren
Isabella Chan	Student	Isabella
Chingtam Fang	Student	Chingtam Fang
Pinky Dang	Student	Pinky Dang
Gianna Chan	Student	Gianna Chan
Vincent Guan	student	
Kaila Bohm	Student	
Flix Abbott	student	
	Student	
	Student	
Karen Tai	Staff	

HEALTH EDUCATION

SUPPORT

Name		Signature
	Student	
Omar Dajani	Student	Omar Dajani
Anya Li	Student	Anya Li
Sophia Chong	Student	Sophia Chong
Nehemiah Jones	Student	Nehemiah Jones
Elliot Zapol	Student	Elliot Zapol
Anson Wong	student	Anson Wong
Hannah Cong	student	Hannah Cong
Zoey Lee	Student	Zoey Lee
Angus	Student	Angus
Elliott Hartman	Student	Elliott Hartman
Clarisse Tam	Student	Clarisse Tam
Chloe	Student	Chloe
Cameron Bartkiw	student	Cameron
Isabella	Student	Isabella
Fiona Kuang	Student	Fiona Kuang
Hugo Mei	Student	Hugo Mei
Joshua wong	student	Joshua Wong
Maxwell	Student	
MARLEY	Student	
Kaitlin	Student	Kaitlin
Skylah	Student	Skylah
Gaelle	Student	Gaelle
Angie	Student	Angie
Lauren	student	Lauren
Nika	student	
Tyler	student	
Kaylie	student	Kaylie
Calder	Student	
Maria	Student	Maria
Morgan	student	Morgan
Peter Sayre	Student	Peter Sayre
Alexis	student	
Henry Gee	Teacher	

HEALTH EDUCATION

SUPPORT

Audrey	Student	Audrey Atkinson
Emma		Emma Kirkbride
Zachary	Student	Zachary Boyer
Amber	Student	Amber Li
Justin	Student	Justin Lin
Liam	Student	Liam Kline
Ruby	Student	Ruby Burt
Mika	student	Mika Mes
Jayden	student	Jayden Mor
Caroline	student	Caroline Pham
Ethan	Student	Ethan Tang
Emma	Student	Emma Wang
Kayli	student	Kayli Tu
Celia Yu	Staff	Celia Yu
Kennice Lam	Student	Kennice
Ethan Kusli	↓	Ethan
Kara Zhou		Kara Zhou
Emily Fu		Emily Fu
Henry Tang		Henry Tang
Amber Chen		Amber Chen
Anna Forlin		Anna Forlin
Chloe Wen		Chloe Wen
Drake Modelo Saddler		Drake Saddler
Flynn Shackett		Flynn F.S
Darren Liu		Darren
Marlo Burt		MARL Burt
Ella Seto		Ella Seto
Ethan Ou		Ethan Ou
Charlotte Wu	↓	Charlotte
Carmen Lam	TEACHER	Carmen Lam

HEALTH. EDUCATION

SUPPORT

[illegible]	Student	[illegible]
[illegible]	Student	Joseph Bradley
[illegible]	Student	[illegible]
Ryan Lee	Student	Ryan Lee
[illegible]	Student	[illegible]
Aaron	Student	Aaron
Roger	Student	Roger
[illegible]	Student	[illegible]
[illegible]	Student	[illegible]
[illegible]	Student	[illegible]
Dennis	Student	[illegible]
Julie	Student	Julie
Stella	Student	Stella
[illegible]	Student	[illegible]
Nitra Lee	Student	Nitra Lee
Sara Ko	Student	Sara
Brianna Yuen	Student	Brianna
Gigi	Student	Gigi
Kailee Vuong	Student	Kailee
Kaela Rosato	Student	Kaela
Sophia	Student	Sophia
Kylie Stil	student	Kylie
Haylee Kline	Student	Haylee
Tristan Kwan	Student	Tristan Kwan
Lucy Rios	student	Lucy ♡ Rios
Emily Solis	student	Emily Solis

HEALTH EDUCATION

SUPPORT

Hailey Yee	Student	Hailey
Audrie Lee	Student	Audrie
Bosson Mei	student	Bosson
Alexis Kwan	Student	Alexis
Beck Fladeland	Student	Beck
Dylan Hwey	Student	Dylan
Mei Hins	Student	Hins
Eva Tateishi	Student	Eva
Fiona Huang	Student	Fiona
Carmen chen	Student	Carmen
[redacted] Hong	Student	[redacted]
[redacted] Hisaki	Student	Jin
DeSantis	student	Mia
Tram	Student	Lucas
Tanaka-[redacted]	Student	Janelle
Leung	student	Madelyn
Jaime Hou	student	Jaime Hou
Jillian Lam	Student	Jillian Lam
Cameron Lee	Student	Cameron Lee
Benjamin Liang	Student	Benjamin Liang
Kevin Liang	Student	Kevin Liang
Joanna Lu	Student	Joanna Lu
Jayden Mac	Student	Jayden Mac
Hope Mowbray Lam	Student	Hope Mowbray Lam
Emma Posey	student	Emma Posey
Neva Strömberg	Student	[redacted]NOVA Strömberg
Veronica Yang	Student	Veronica Yang
River Yee	Student	River Yee
Anita Yu	Student	Anita Yu
Kaylachin	Student	Kaylachin

HEALTH EDUCATION

Teachers: Please sign. Please also have students sign 4 u

February 27, 2018

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Sincerely,

School Site: Chinese Immersion School @ DeAvila

Name	Role	Signature
Calvin Leung	Teacher	Calvin Leung
Vivienne Lee	Student	Vivienne Lee
Carson Wong	Student	Carson Wong
Tristan Mui Smith	student	Tristan Mui Smith
Venus Wong	Student	Venus Wong
Ella Schuparra	student	Ella Schuparra
Brooke	Student	
Serena	Student	
Josephine	Student	
Kaden	student	
Mason	Student	
Lia	Student	

HEALTH EDUCATION

Teachers: Please sign. Please also have students sign :)

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Sincerely,

School Site: Chinese Immersion School @ DeAvila

Name	Role	Signature
Sandy Ha	Teacher	
Walton Bang	Student	Walton Bang
Anson Chan	Student	Anson Chan
Christopher	Student	Christopher Bang
Zachary	Student	Zachary Yip
Kelly	student	Kelly

School Site: CIS @ DeAvila

Name	Role	Signature
May Hy	Teacher	
Bridger	student	Bridger
Olivia	student	Olivia
Allison Lin	student	Allison Lin
Parker	student	Parker
Jayden	student	Jayden

HEALTH EDUCATION

Teachers: Please sign. Please also have students sign :)

FOOD SUPPORT

February 27, 2018

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Sincerely,

School Site: CIS at DeAvila - Rm 101

Name	Role	Signature
Ms. Stella Lau	Teacher	
Charlotte Chan	Student	Charlotte Chan
Evelyn Dea	Student	Evelyn Dea
Mia Eastlack	Student	Mia Eastlack
Laurent Gavdi	Student	Laurent Gavelli
Aiden Harris	Student	Aiden Harris
Ms. A. Yu	teacher	
Dylan J	student	Dylan J
Corina L	"	Corina L
Addison N	"	Addison N.
Michael L.	"	Michael L.
Sabela M.	"	Sabela M.
Ms. Amy [illegible]	Teacher	
Jianna Robert	student	Jianna
Aisha [illegible]	Student	Aisha
Michelle Cheung	Student	Michelle
Myles Bartista	Student	Myles
Evelyn Lee	Student	Evelyn

HEALTH EDUCATION

Teachers: Please sign. Please also have students sign ☺

February 27, 2018

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Sincerely,

School Site: Chinese Immersion School @ De Avila

Name	Role	Signature
Dorea Yu	K Student	Dorea
Langton		Langton
Nathan Wong		Nathan
Lilian Abbott		Lilian
Chloe Lee		Chloe
Gavin Nao		Gavin
Carlee Wong		Amiah
Rylan Kline		RYLAN
Ian Chen		Ian
Jayden Ma		Jayden Ma
Carina Chan		carina
Stephen Lau	Teacher	
Cathleen Huang	Student	Cathleen Huang
Fiboli Tam		Fiboli Tam
Mason Liang		mason Liang
Stella Choi		Stella Choi
Anna Di Cristofaro		Anna

February 26, 2018

Sugary Drinks Distributor Tax Advisory Committee
1 Dr Carlton B Goodlett Place
San Francisco, CA 94102

Dear Sugary Drinks Distributor Tax Advisory Committee,

My name is Samantha and I am a Health Education student at San Francisco State University. I am writing to you to humbly request the funds generated by our city's consumption of sugar-sweetened beverages be donated to the San Francisco Unified School District. SFUSD would benefit tremendously from increased school funding, particularly for nutrition education programs.

Research has shown that sugar-sweetened beverages are linked to diabetes, poor oral health, obesity and lower academic performance. However, effective nutrition education can reduce the consumption of sugar-sweetened beverages helping to mitigate future health problems and improve academic success.

As not only a health educator but also the mother of a current and a future SFUSD student, I know that quality nutrition education is vital in our schools. I implore you, please consider allocating funds from the tax on sugar-sweetened beverages towards SFUSD so we can give our children the gift of a healthy and successful future.

Best regards,

Samantha Davis

1220 Russia Ave
San Francisco, CA 94112
(415) 350-4309
samwehrer@gmail.com

SFUSD

Hafiz, Saeeda <hafizs@sfusd.edu>

Sugary Drinks Distributor Tax Advisory Committee

Benefiel, Sarah <benefiels@sfusd.edu> Thu, Mar 1, 2018 at 5:12 PM
To: hafizs@sfusd.edu

My name is Sarah Benefiel, I am a 6th grade English teacher at Everett Middle School. I am writing in support of the proposal to set aside 40% of the Soda Tax revenue to support healthy initiatives in our schools. My students often do not eat lunch and drink unhealthy sugary beverages. I believe this is a direct way to benefit students and set them up for healthy lifestyles.

Thank you,
Sarah Benefiel

HEALTH EDUCATION

Student, Family & Community SUPPORT
San Francisco Unified School District

Name	Role	Signature
Sheree Catingub	Principal/Teacher	
Danny Adieoag	Clerk	
Kristina Kish	Teacher	
Jennifer Schultz	Teacher	
Mary Stern	lit support teacher	
Tess Robertson	3rd gr. Teacher	
Margaret Marcoccio	3rd grade teacher	
Erica Zuarna	K2 SDC teacher	

HEALTH EDUCATION

February 27, 2018

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Sincerely,

School Site:		
Name	Role	Signature
Canada Godoy	School Secretary	[signature]
Nadya Bratt	TRF/Resource	[signature]
Patricia Chan	School social worker	[signature]
Maria Chavez	Teacher	[signature]
Lilia Pulido	Teacher	[signature]
[illegible]	Teacher	[signature]
Ana Lumardi	Teacher	[signature]

HEALTH EDUCATION

Jason Schwartz	EL teacher	[signature]
Maggie Cox	Social worker	[signature]
Xavier [illegible]	1/2 teacher	[signature]
Carlos Vazquez	Principal	[signature]
Gianna DeCarl	Teacher Librarian	[signature]
Silvia Espinal	Para	[signature]
Veronica Castillo	Para	[signature]
[illegible]	Teacher	[signature]
Adelina Duncan	F teacher	[signature]
[illegible]	Teacher	[signature]
[illegible]	teacher	[signature]

San Francisco
Sugary Drink Distributors Tax Advisory Committee
March 2018 Report

APPENDIX M: Ensuring Equity in Water Access for San Franciscans

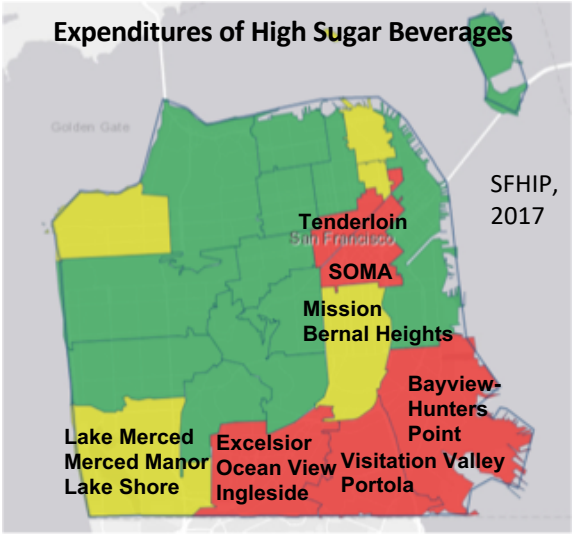
ENSURING EQUITY IN WATER ACCESS FOR SAN FRANCISCANS

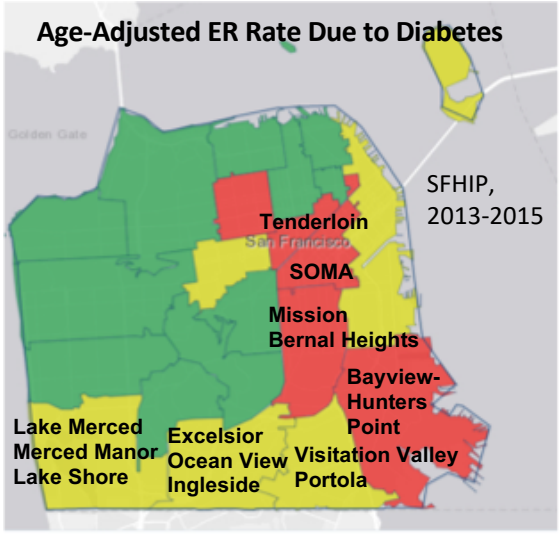
SF low-income neighborhoods have the highest rates of sugary drink intake & diabetes

Best 50%

50th to 75th Quartile

Worst 25th Quartile

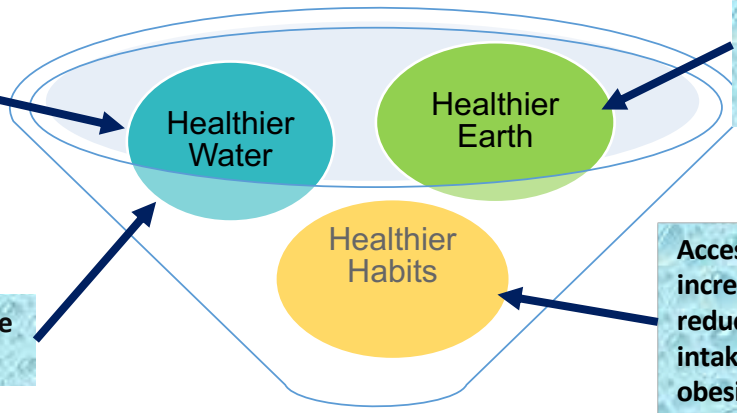




Improved access to tap water can help prevent obesity and related diseases

Tap water is tested more regularly and with higher safety standards than bottled water

Bottled beverages are harmful for the environment



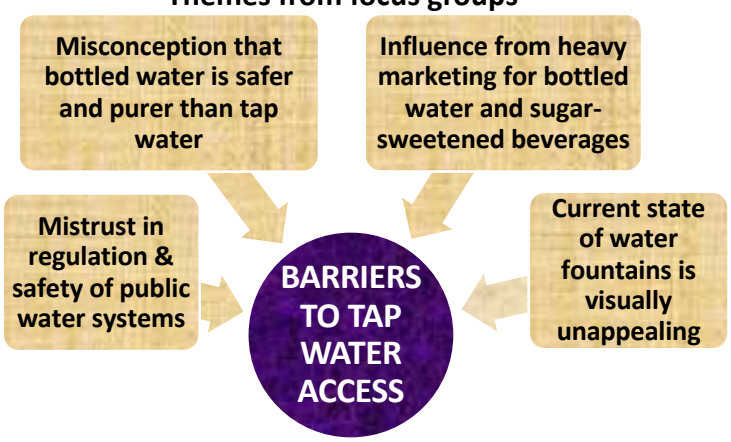
Plastic bottles may have harmful chemicals

Access to water can increase water intake, reduce sugary drink intake, and prevent obesity

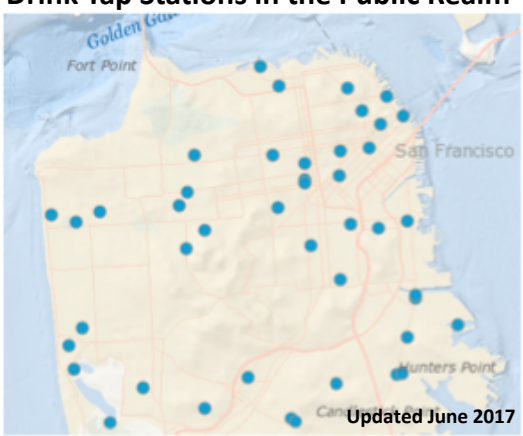
HEALTHIER YOU!

Focus groups with SF residents showed support for improved tap water in public spaces

Themes from focus groups



Drink Tap Stations in the Public Realm



Surveys with city residents and interviews with city officials identify key elements of water access/promotion:

- Installation of appealing water bottle refilling stations in convenient public locations
- Provision of pet bowls
- Promotion of public water consumption in multiple languages to reach immigrant communities
- Publicity of water access information on city maps
- Development of resident reporting system when stations need cleaning or repairs
- Testing of drinking water for contaminants

Average cost of public water filling station: $15000
Average cost of school water filling station: $13000

Document was prepared by UCSF staff, faculty, and medical students:
Annie Hoang, Natnaelle Admassu, Adrian Anzaldua, Adam Bazari, Snehal Ghatare, Roberto Vargas MPH, Anisha Patel MD

San Francisco
Sugary Drink Distributors Tax Advisory Committee
March 2018 Report

APPENDIX N: AJPH Water Editorials

Water Access in the United States: Health Disparities Abound and Solutions Are Urgently Needed

See also Brooks et al., p. 1387.

The tragedy in Flint, Michigan, riveted the public health community to the problem of water access, highlighting its pernicious influence on low-income, minority families.[1] In this issue of *AJPH*, Brooks et al. (p. 1387) put numbers on the scope of our nation's water access problem and highlight that this problem extends beyond Flint.

In their analysis, nearly one third of US adults were inadequately hydrated, with African Americans, Hispanics, and individuals at lower incomes at significantly higher risk for inadequate hydration than Whites and those with higher incomes.

In the United States, nearly one in two adults and one in four children do not drink tap water on a given day, with even more dismal statistics among minority and low-income populations.[2] Plain water contributes to only one third of daily fluid intake, and intake is lower among the poor and minorities (bit.ly/2rnWbtn). When low-income minority populations do choose plain water, they are more likely to drink bottled water,[2] a product that places an unequal cost burden on families.

We are only beginning to understand the inequities in water access and to embark on strategies to mitigate it. Given the scope of the problem documented by Brooks et al., we need to move toward evidence-based solutions on a national basis. We describe efforts around the country to address inequities in water access and what is currently known about their effectiveness.

MUNICIPAL WATER SAFETY AND PUBLIC TRUST

Minority and low-income populations are more likely to live in rural areas with water contaminants and in older housing prone to lead contamination.[3] Even when tap water is safe, many fear contamination and do not drink tap water because of numerous factors.

Reports relaying the results of municipal water testing are typically written in technical language that is beyond the public's literacy level. Distrust in tap water is heightened among immigrants from countries where tap water is unsafe to drink. Even if safe, water that tastes bad, is discolored, or dispensed from an old, dirty tap may trigger distrust. In many communities, it may be easier to purchase bottled water than to find a clean, functioning drinking fountain.

Tap water suppliers are leading the charge to clean up municipal water and promote their products. Approaches include education through community campaigns, local tap water tasting events, and reusable water bottle distribution. Louisville Water, which provides drinking water to Louisville, Kentucky, and surrounding areas, has trademarked its tap water—"Louisville pure tap"—to promote a more appealing, safe image (Figure 1). New York City promotes its award-winning water through billboards and portable tap fountains at city events.

For many low-income communities, concerns about water safety are all-too realistic. In some, funders and community organizations have innovated short-term strategies until more sustainable solutions for cleaning up the water are available. California-based Agua4All installs filtered water bottle filling stations in libraries, schools, and parks where potable drinking water is otherwise not readily available. To promote public trust, Agua4All posts a recognizable water droplet icon on stations to signify their safety (Figure 1). In Boston, Massachusetts, and Baltimore, Maryland, some public schools are providing bottled water until lead in water is remediated.

Although isolated efforts around the country to address these problems are a step in the right direction, scaled-up, sustainable strategies that promote clean water and instill public confidence are needed.

WATER IN SCHOOLS AND COMMUNITY SETTINGS

Efforts to reduce consumption of sugar-sweetened beverages (SSBs; sodas, sports drinks, and other beverages with added sugar) have historically focused on restricting SSB access in schools and other community settings. In 2010, the federal Healthy Hunger-Free Kids Act requirement that water be provided with school meals incentivized schools to promote access to healthy beverage alternatives, such as fresh drinking water. Even so, upward of 50% of US schools still do not provide free water in school cafeterias.[4] Many that do provide a single fountain for hundreds of students.

ABOUT THE AUTHORS

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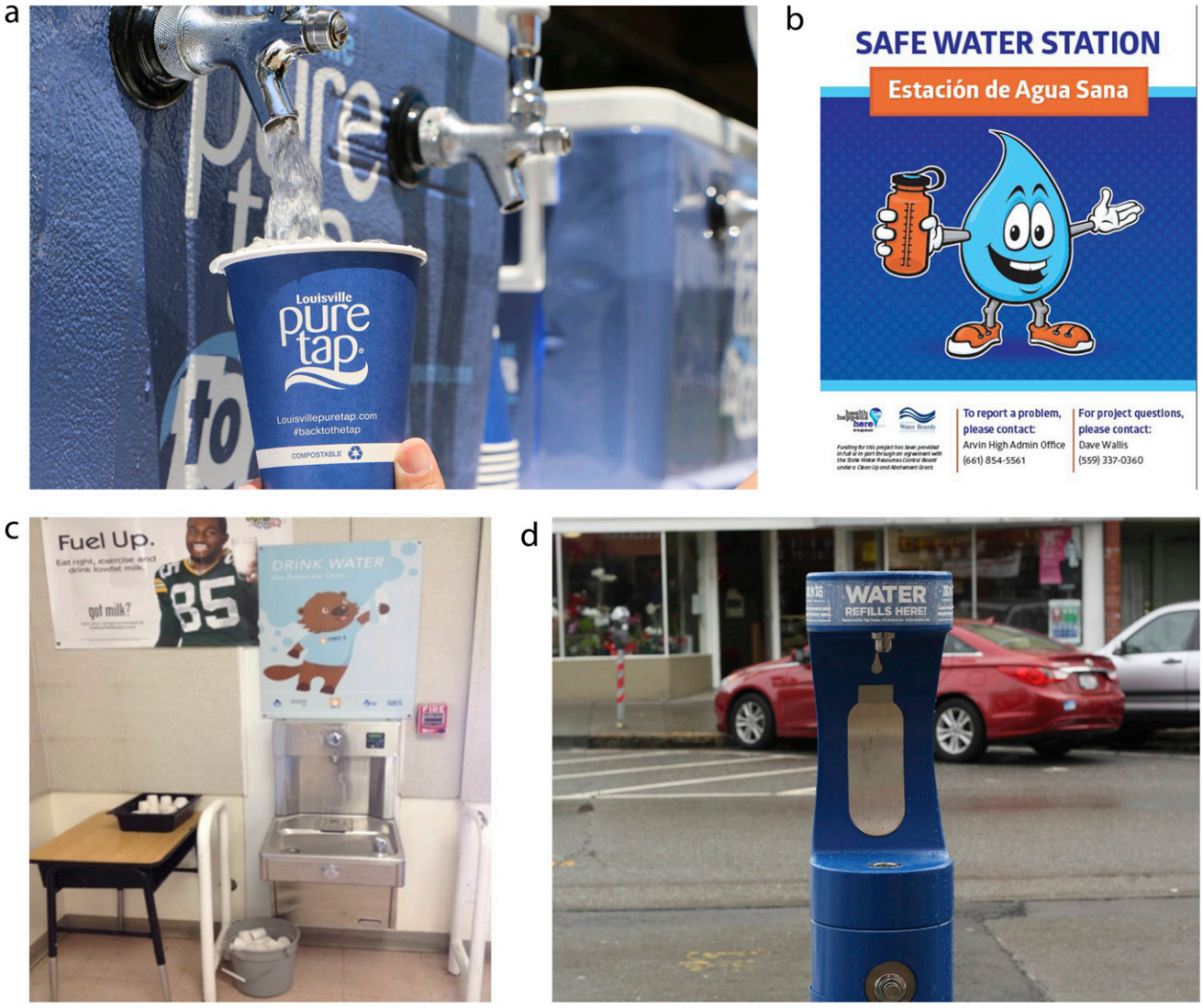

Note. Part a: Louisville pure tap Fill & Chill coolers are available with biocompostable cups for local events. Part b: an element of the Agua4All program, weather-resistant metal signs featuring "Wally the Water Droplet" are posted next to filtered reusable water bottle filling stations to signify safe drinking water in California communities where tap water is not potable. Part c: a water station with reusable water bottle filling capability in an elementary school cafeteria. A promotional poster and small cups also help to encourage water consumption among students. Part d: one of 100 reusable water bottle filling stations that are being installed in parks and public spaces by the City of San Francisco, California.

FIGURE 1—Efforts to Promote Safe, Appealing Water in Schools and Community Settings

In studies in which we directly observed students in schools, rates of water fountain use ranged from 2% to 11%.[5] These low rates stem not only from concerns about tap water safety, but also from the lack of appeal of fountains that are older, in disrepair, that dispense warm water, have minimal flow, and are obstructed by cafeteria mops or cleaning equipment.

Recognizing the limitations of traditional drinking fountains, schools are increasingly providing water through stations with bottle filling capability or via dispensers with cups that allow students to drink more than a few sips of water (Figure 1). Evaluations of such efforts suggest that offering more appealing water can increase students' consumption of water, decrease their intake of SSBs, and help them maintain a healthier weight.[6] Although similar efforts in non-school settings are still in their infancy, evaluations show their promise in modifying beverage intake patterns. The City of San Francisco, California, is installing 100 water stations in public locations, such as parks, with many targeting the city's low-income communities (Figure 1).

SUGARY DRINK TAXES: CARROT AND STICK

Taxing SSBs has emerged as an evidence-based approach to curb consumption of sugary drinks and promote cardiometabolic health.[7] Eight US localities have SSB tax policies and another six are actively debating such measures. Opponents of SSB taxes argue that such levies

are regressive, causing undue financial burden for lower-income populations. If taxes were coupled with programs that provide safe, appealing tap water sources as a free substitute for SSBs, tap water could serve as a "carrot" to complement the "stick" of SSB taxation. By devoting a portion of the tax revenue to increasing access to free, safe, and appealing tap water in low-income communities, governments could not only mitigate any regressive effects of SSB taxation but also relieve the cost burden of purchasing bottled water as a substitute for SSBs.

Pairing SSB taxation with improved water access has been proposed but, as yet, not fully implemented. A popular proposal in Mexico that has yet to be finalized would use revenue from that country's SSB tax to fund purified water fountains in schools. Public health advocates in Philadelphia, Pennsylvania, and Berkeley, California, have also called for city SSB taxes to be earmarked for water access improvements. As more and more governments consider SSB taxation, the promotion of free, safe, appealing tap water access in low-income communities remains a promising, though still novel, approach to narrowing the gap in SSB-related health disparities and optimizing public health.

PRIORITIZING WATER ACCESS INEQUITY SOLUTIONS

The analysis by Brooks et al. demonstrates that the problem of water access and its associated socioeconomic inequities is national in scope. Isolated community efforts across the nation show some promising solutions, but there is much to be done. Efforts to test municipal water and clean up contaminants are not enough. The early experience of programs, primarily in schools, shows that water supply clean-up efforts must be coupled with ready access to appealing water sources and promotional campaigns to successfully increase water intake, reduce SSB consumption, and stabilize weight gain. A promising—but so far, untried—strategy would be to earmark a portion of SSB tax revenues for programs that promote the availability of appealing, free sources of tap water in low-income communities. Such programs would address criticisms about the regressive nature of SSB taxes while promoting a freely available, healthy substitute for SSBs in our nation's most vulnerable communities. AJPH

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Laura A. Schmidt, PhD

CONTRIBUTORS

A. I. Patel conceptualized the content and drafted the article. L. A. Schmidt contributed to the content and helped edit the article.

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Addressing Colorectal Cancer Disparities Among African American Men Beyond Traditional Practice-Based Settings

See also Cole et al., p. 1433.

Colorectal cancer continues to be the third leading cause of cancer-related death among men and women in the United States. Over the past three decades, mortality related to colorectal cancer has decreased steadily as a result of increased screening rates and improvements in treatment. However, the rate of decline has not been equal across racial and ethnic groups. In 1980, mortality rates among non-Hispanic Whites and African Americans were equivalent. Since that time, there has been a progressively growing gap in mortality, and now the rate among African Americans (29.4 per 100 000 population) is more than 50% higher than that observed among non-Hispanic Whites (19.2 per 100 000 population) and is the highest of any racial/ethnic group.[1]

These disparities are thought to stem primarily from lagging rates of screening among African Americans. As a result, the US Multi-Society Task Force on Colorectal Cancer has suggested initiating average-risk screening among African Americans beginning at the age of 45 years.

African American men experience a disproportionate burden of death related to cancer. Among men and women across all races and ethnicities, African American men have the highest mortality related to colorectal, lung, prostate,

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San Francisco
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March 2018 Report

APPENDIX O: San Francisco Health Improvement Partnership Sugary Drinks Policy Community Perspectives

Clinical and Translational Science Institute (CTSI)
University of California, San Francisco (UCSF)

SAN FRANCISCO HEALTH IMPROVEMENT PARTNERSHIP

SUGARY DRINKS POLICY COMMUNITY PERSPECTIVES

What do community folks think about policies recommended by scientists to deal with this problem?

FINDINGS FROM OUR FOCUS GROUP

These are preliminary findings from 9 focus groups across San Francisco in communities most impacted by obesity-related disease.

"...Same thing on Third street; its like its a lot easier to find a corner store than it is to find fresh fruits and groceries."
— Tenderloin Resident

Government

"The government is with the soda corporations. It has to come from the people. The people have to take action."

TRUST was sorely lacking-- especially African Americans, followed by Latinos—in government to implement policy, and to spend potential Soda Tax revenue in ways they say they will. They do trust government more than corporations, but also think the two are collaborating.

ROLE of government should be to ensure labeling for awareness of what's in a product and its health impacts. They think the government should recommend a daily allowance of sugar, tell everyone what it is, and why, and not allow subsidized foods to exceed those limits.

CHOICE is important to participants, and they want theirs preserved. They are willing to limit choice for kids, however, including setting an age limit for purchase.

Education

SUPPORT for it is strong across groups, whether supportive of policy approaches or not. Including labeling—consumers want to know how much sugar is in it and what that means for health.

CAMPAIGNS should be public (including use of media), and school and family based. Industry tactics to target communities of color and young people invoked a sense of "disrespect"—particularly from African Americans and Latinos (American-born Latinos more than immigrant). Some thought this would be most important for education efforts, maybe more than health information.

"IS KEY CHANGE TO CHANGE", and policy isn't as effective according to participants. [Researcher Perspective: Evidence shows that policy is more powerful and sustainable for behavior change.]

Protect Our Children

"They should regulate [SSBs] like they do alcohol, if you're under a certain age, you can't get this."

STRONG SUPPORT of policy that was protective of children, even among respondents not generally supportive of policy interventions that affected adults.

MARKETING AND ACCESS should be kept from children, most agreed. There was support for banning ads and sales near schools and playgrounds, even medium to high support for banning fast food locations from near schools and playgrounds. Many supported age restrictions for purchase—to between 8 and 12 years old.

PRODUCT PLACEMENT support is mixed; many doubt its impact, while some think it makes a difference.

Cost / Affordability

"It's just placing a tax on the poor... because the only people purchasing these drinks are the poor."

LOW COST of sugary drinks makes them attractive. Most don't want cost to go up, even if they agree it is unhealthy; even if they agree people should consume less.

SUPPORT FOR A TAX increased when participants were presented with what revenue would pay for.

TAX OR REGULATE PRODUCERS rather than retailers or consumers, is what most participants preferred.

MAKE HEALTHY DRINKS MORE AFFORDABLE AND WATER MORE ACCESSIBLE. While water is the cheapest, healthiest drink, most talked about healthy alternatives being too expensive.

Water

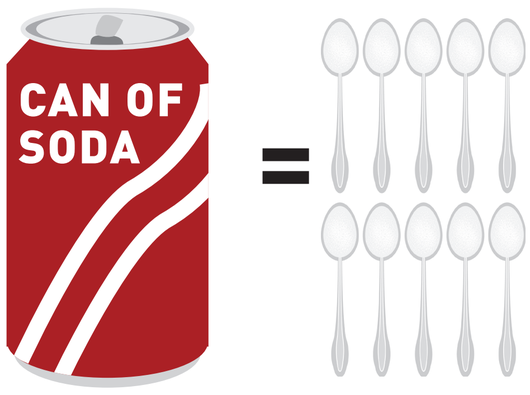
WATER STATIONS were supported strongly to increase access to clean drinking water. Generally, bottle-filling stations, are seen as more sanitary than fountains, and should be:

- located in busy areas (near transit hubs or important centers)– in libraries, parks, and community centers.
- be kept safe, clean, accessible, protected from vandalism.
- should include education or be supplemented by education.
- Ideally would include both a fountain and a bottle-filler to increase access and utility.

WHY IS THIS A PROBLEM?

The American Heart Association recommends no more than these limits per day of added sugar:

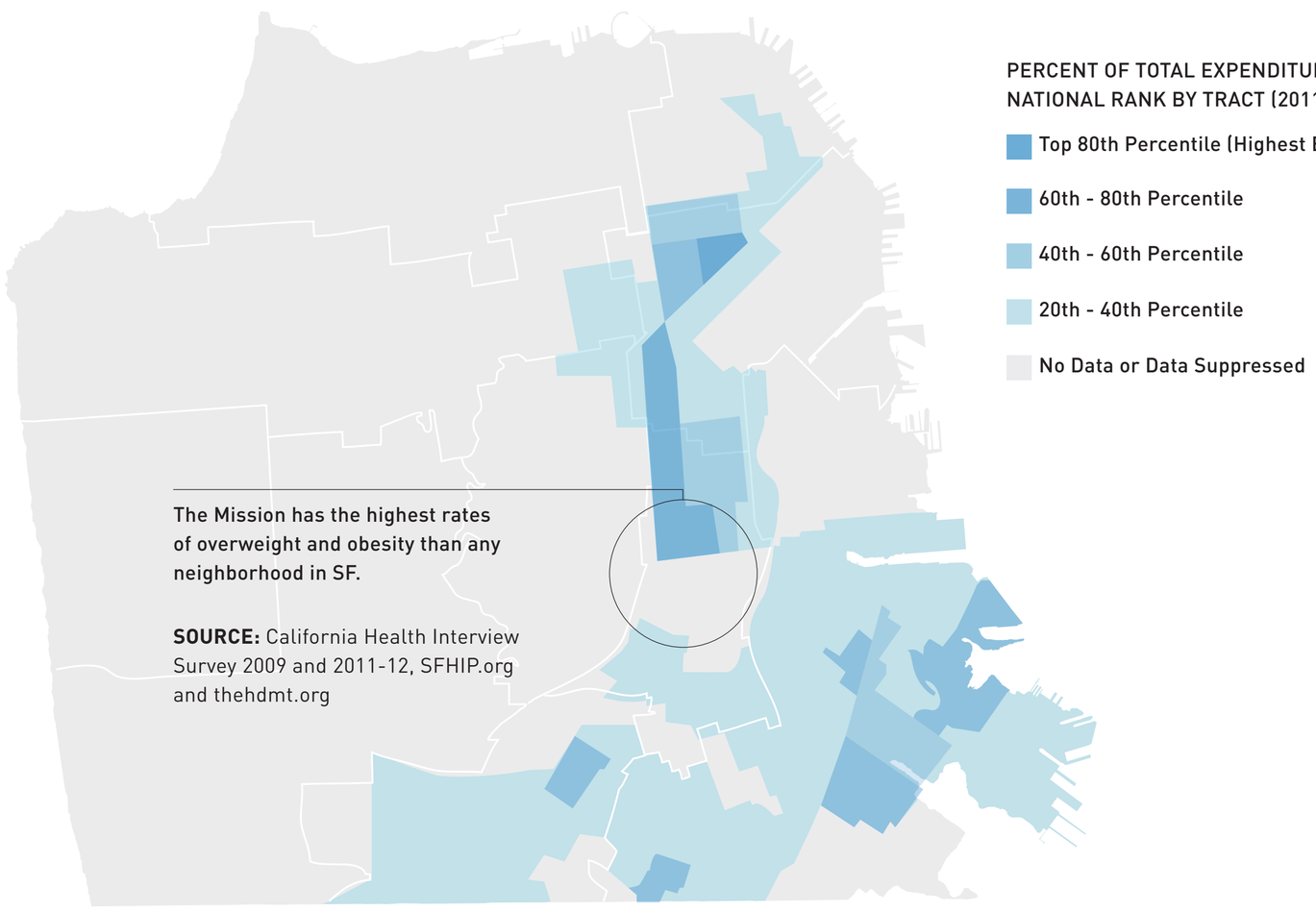
- Children **3** Teaspoons
- Women **6** Teaspoons
- Men **9** Teaspoons



American Heart Association
Learn and Live®

10 TEASPOONS OF SUGAR

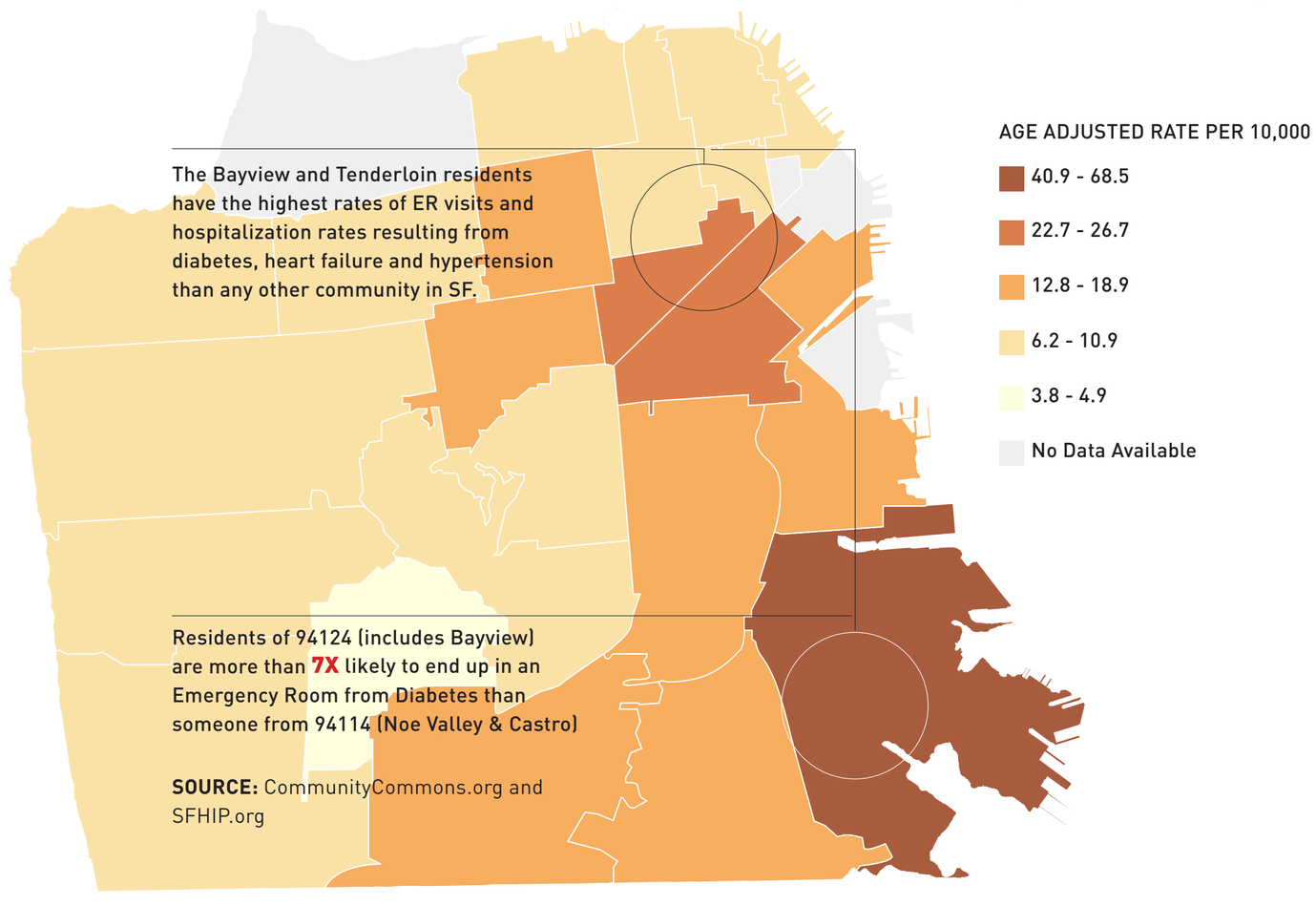
SUGARY DRINK EXPENDITURES



The Mission has the highest rates of overweight and obesity than any neighborhood in SF.

SOURCE: California Health Interview Survey 2009 and 2011-12, SFHIP.org and thehdmt.org

DIABETES HOSPITALIZATION RATE, PER 10,000



The Bayview and Tenderloin residents have the highest rates of ER visits and hospitalization rates resulting from diabetes, heart failure and hypertension than any other community in SF.

Residents of 94124 (includes Bayview) are more than 7X likely to end up in an Emergency Room from Diabetes than someone from 94114 (Noe Valley & Castro)

SOURCE: CommunityCommons.org and SFHIP.org

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APPENDIX P: SSB strategies and evidence v2.21.2018

Strategies	Institute of Medicine (IOM)	Changelabsolutions.org	World Health Organization (WHO)	CDC	SF Community	SF Implementation	Other Evidence	Shape Up Coalition	CavityFree SF	Policy, Structural, Evironmental (PSE) change	*Vote to keep or remove:*	
Education											Keep/Remove?	Pls explain (evidence, cost effectiveness, etc.)
Public Education												
Launch public awareness campaign (multi-media; multi-lingual; multi-platform; in and out of schools)	x	x	x	x	x	1,2		x	x			
Raise awareness regarding marketing strategies that target vulnerable populations and communities of color					x	1,3		x				
Develop counter-advertising media approaches against unhealthy products to reach youth (i.e., anti-tobacco campaigns)	x					1,3		x				
Hire, train, promote Lay Health Workers/ Promotoras /Community Health Workers to educate and engage impacted communities about food justice (access, food insecurity, healthy retail, etc); sugary drinks/water; physical activity benefits (mental and physical);					x	4,5,6		x	x			
Capacity Building/ Educating Providers												
Raise awareness regarding marketing strategies that target vulnerable populations and communities of color					x			x				
Expand knowledge and skills of medical care providers regarding screening and counseling of SSB consumption				x		7			x			
Medical schools provide nutrition education to improve counseling skills of medical students as a part of their curricula.				x		7?			x	x		
Increase Access to Healthy Alternatives												
Water												
making water readily available and promoting its consumption increases water intake	x	x	x	x	x	8		x	x	x		
water consumption increases more with the introduction of alternative water delivery systems such as filtered water dispensers or water cooler stations, than with added traditional water fountains						8	B		x	x		
Install water-filling stations throughout high-traffic areas		x			x	8		x	x	x		
Provide mobile potable water options for public events						9		x		x		
Fund lead testing in low income homes (that don't qualify for WIC) to assure water safety						9		x				

Regular lead/safety testing and promotion of said testing of public water stations/fountains. (if made policy, then it is PSE)								x		
provide multi-lingual water station information about the safety and health benefits of SF water								x	x	x
Childhood (< age 5) obesity prevention interventions (water consumption)							Q			
Increase access to public restrooms to encourage consumption of public water							M	x		x
Grab a Cup, Fill It Up" campaign, a cafeteria-based intervention featuring signage promoting water and installation of disposable cups near water fountains. The percentage of students drinking water more than doubled in intervention schools, and students drank significantly more water and had fewer sugary drinks with their lunch as a result of the intervention.							C			x
Complete a needs assessment to identify where access to potable drinking water is limited. Provide public map				x				x		
Public and private partnerships to improve infrastructure to increase access to potable drinking water				x				x		x
Collaborate with state, local, and city government officials to establish, promote, and enforce policies to ensure ready access to potable drinking water.				x				x		x
Food Access										
Create incentive programs to enable current small food store owners to carry healthier options (e.g.. Provide refrigerators; currently provided by soda distributors)	x					10,11, 12		x		x
Healthy Retail: Fund neighborhood based, community engagement work for Healthy Retail SF						13		x		x
Healthy Retail: expand Healthy Corner Store incentives for markets								x		x
Healthy Retail: Support the establishment of local grocers/farmers markets in areas that are food insecure								x		x
Food Subsidy: Increase access/funding for food voucher programs (EAT SF, Market Match, etc)								x		
Food Subsidy: Increase SNAP/WIC participation								x		
Improve school lunches to increase participation								x		x
Food suppliers re-formulate what they serve (evidence is for salt interventions)							L			
Create incentive and recognition programs to encourage grocery and convenience stores to reduce POS marketing (i.e., "candy-free" checkout aisle)	x				x					x
Clinical interventions										

IT systems support and training to address barriers to FV application in the primary care medical setting							D,E		x	x
Primary care provider screening for early oral effects of SSB consumption (white spot lesion, early cavities) and preventive factors (tap water consumption & appropriate fluoride tooth paste use)							D,E		x	
Application of fluoride varnish on children 0-5							D,E		x	
Counseling on fluoride coverage (tap water and appropriate fluoride toothpaste) in additional to counseling already provided on SBB & food choices							D,E		x	
Routine referral to dental home for preventive care							D,E		x	
Support efforts to ensure reimbursement for practitioner time spent providing nutrition counseling.				x						x
Support the implementation of the recommendation from the Expert Committee on Assessment, Preventions, and Treatment of Child and Adolescent Overweight to ensure screening and counseling for high SSB consumption as part of all well child visits.				x						x
Support preventive lifestyle services within the health care system, such as coverage for weight management; nutrition education; and diabetes, blood pressure, and cholesterol screening and management.				x		14				x
Support “baby friendly” hospital programs that encourage breast feeding and provide peer-to-peer breastfeeding support programs.				x		15				x
Reduce fetal risk of metabolic dysregulation by increasing eligibility of services beyond women who have pre or diagnosed gestational diabetes							O			x
Intensive lifestyle interventions for patients with type 2 diabetes to improve glycemic control and reduce risk factors for cardiovascular disease. (CPSTF Finding and Rationale Statement)						16,17	F			
Oral Health										
Fluoridated water: Peer to peer training and education				x	x	8	E	x	x	
Fluoridated water: Mass media marketing to increase public awareness				x	x	8	E	x	x	
Fluoridated water: Culturally appropriate messaging including safety of SF tap water				x	x	8	E	x	x	
Expand dental sealant program in schools				x		18	E,G		x	
Fluoride Varnish program in pre-school settings							D,E		x	
Restrict sugary food and drink avialbility in schools to improve oral health							R			x
IT systems support and training to address barriers to application in the primary care medical setting							D,E		x	x
Physical Activity										
Fund SFUSD to meet state PE mandates by hiring PE teachers especially in schools with high proportion of students most impacted by CD and SSBs								x		
Fund community physical activity programs to provide equitable, free and very low-cost physical activities in San Francisco that are offered at times that are convenient for families								x		
Identify ways to address cost barriers for ‘club’/private sports (that require fees to participate) that aren’t otherwise available to low income families.								x		
Other										
Urban Agriculture: Support efforts to expand equitable access to community gardens and farms so that all SF residents live within “x” distance of a community garden						9,19, 20		x		x

Fund local community conveners to build capacity of community members to conduct research, implementation, etc. of HEALand COH activities.						20,21, 22,23		x		
Fund infrastructure/backbone support for collective impact efforts to impact HEAL work at neighborhood and citywide level						20,21, 22,23	H	x		
Policy										
Collaborate with state and local policymakers to develop or adopt policies that limit advertising of SSBs in public service venues.										x
Establish and implement nutrition education and standards in schools, child care facilities, worksites and hospitals.						24,25, 26	P			x
Limit pouring rights contracts										x
Warning Labels							I			x
Collaborate with state and local policymakers to eliminate advertising of SSBs aimed at children.										x
Portion size - On a given day, the portion-size cap would affect 7.2% of children and 7.6% of adults. If 80% of affected consumers choose a 16-oz beverage, the policy would result in a change of - 57.6 kcal for affected consumers aged 2 - 19 years and - 62.6 kcal for affected consumers≥ 20 years							J			x
Systematic Review and Meta-analysis of the Impact of Restaurant Menu Calorie Labeling.							K			x
Collaborate with food manufacturers, retailers, restaurants and others to adopt guidelines for responsible food marketing to children.				x	x					x
Label SSBs with health risks (i.e., surgeon general warning on tobacco products)					x					x
Eliminate advertisements near schools					x					x
Implement a tax on SSBs (DONE)	x	x								x

SF Implementatoin	Other Evidence
1. OpenTruth	A. (Giles 2012, Loughridge 2005, Patel 2011, Muckelbauer 2009, Elbel 2015)
2. Other SFDPH and SFUSD	B. Patel 2012 (https://www.cdc.gov/pcd/issues/2012/11_0315.htm, https://www.thecommunityguide.org/findings/obesity-increasing-water-access-schools, https://www.nap.edu/read/24910/chapter/1)
3. TheBiggerPicture.org	C. Harvard SPH (https://www.hsph.harvard.edu/prc/2015/07/17/grab-a-cup-fill-it-up/)
4. CARECENSF	D. USPSTF
5.NICOS	E. Cochrane Review
6.Rafiki Coalition	F. The Community Guide (https://www.thecommunityguide.org/findings/diabetes-intensive-lifestyle-interventions-patients-type-2-diabetes)
7. UCSF	G. American Dental Association
8. SFHIP pilot	H. Stanford Social Innovation
9. SFPUC	I. NCBI (https://www.ncbi.nlm.nih.gov/pubmed/26768346)
10. Healthy Retail SF	J. Rudd Center (http://www.uconnruddcenter.org/resources/upload/docs/what/policy/SSBtaxes/SSBStudies_InterventionsReduceConsumption.pdf)

11. Bayview HEAL Zone	K. CHOICES (http://choicesproject.org/research/community-and-government/)
12. TLHCSC	L. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0177535 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4877955/ http://onlinelibrary.wiley.com/doi/10.1111/jch.12971/full
13. Previously Kaiser HEAL Zone	M. http://journals.openedition.org/factsreports/1627 http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0046548 https://www.poverty-action.org/sites/default/files/publications/chlorinedispensers.pdf
14. ACA	N. http://www.esrc.ac.uk/news-events-and-publications/impact-case-studies/website-of-public-toilets-improves-quality-of-life/ https://greatbritishpublictoiletmap.rca.ac.uk/
15. SF Hospitals Baby Friendly	O. Diabetes Diagnosis Consistently Increases The Relative Odds of Meeting Pregnancy Weight Gain Recommendations For Overweight/Obese Women In San Francisco -Jodi Stookey,San Francisco, Department of Public Health, Maternal, Child & Adolescent Health, Epidemiology.
16. WATCH clinic	P. https://www.ncbi.nlm.nih.gov/pubmed/24580983 Similar RCT done in San Francisco: http://rdcu.be/EtwY
17. Diabetes prevention program/YMCA	Q. https://www.karger.com/Article/Pdf/463074 http://www.mdpi.com/2072-6643/8/1/19
18. CavityFreeSF Pilot	R. https://www.ncbi.nlm.nih.gov/pubmed/28073166
19. PODER	
20. Healthy Southeast	
21. THCSC	

22. Shape Up SF	
23. Cavity Free SF	
24. standards adopted for SFUSD	
25. Healthy Apple for child care	
26. city wellness policies being implemented	

Theme
The Health Impact pyramid (ranking types of PH interventions by level of impact).
CDC and WHO guidelines to any PH intervention (resources, expectations, assessments)
Dissacoiating obesity from diabetes

Evidence
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/
https://www.cdc.gov/stltpublichealth/publichealthservices/essentialhealthservices.html
https://www.ncbi.nlm.nih.gov/pubmed/25059108 http://www.canadianjournalofdiabetes.com/article/S1499-2671(15)30072-1/abstract

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APPENDIX Q: Shape Up San Francisco Coalition Letter to the Committee

Our mission is to convene partners for greater collective impact in order to create equitable and sustainable environments, systems and policies that promote healthy eating and active living across the lifespan in San Francisco.

SUSF Coalition Co-Chairs
Roberto A. Vargas
Navigator
UCSF Community Engagement & Health Policy

Sarah Fine
Campaign Director, The Bigger Picture
Manager, Health Communications Program
UCSF Center for Vulnerable Populations

SUSF Ambassador & Development Chair
Beatrice Cardenas-Duncan
Policy Advocate
American Cancer Society
American Heart Association

www.shapeupsfcoalition.org

February 27, 2018

To: Sugary Drinks Distributor Tax Advisory Committee (SDDTAC)

Shape Up SF Coalition was founded in 2006 and since its inception, has adopted far-reaching environmental strategies in partnership with local neighborhoods and communities to create a city where healthy opportunities and choices became the norm. The Shape Up San Francisco Coalition's mission is to convene partners for greater collective impact in order to create equitable and sustainable environments, systems and policies that promote healthy eating and active living across the lifespan in San Francisco. The Shape Up SF Coalition has been working on decreasing consumption of sugary drinks for over a decade and is excited about the potential for the soda tax revenue to decrease consumption of sugary drinks and prevent chronic disease among populations with higher consumption of sugary drinks and higher prevalence of chronic diseases.

Given the Coalition's extensive work and track record on sugary drinks and chronic disease prevention, the Coalition submits the following recommendations for the allocation of soda tax revenue for your consideration.

Funding Distribution

1. A maximum of 10% of total soda tax revenue should be directed to administration and infrastructure of soda tax revenue including staffing, evaluation, and grant oversight.
2. It is essential that this voter-approved funding is reinvested back into the communities that are most impacted. 90% of total soda tax revenue should be spent on new programs or initiatives. Programs that are currently funded by the general fund should continue to receive their existing levels of funding; and any additional soda tax revenue for existing general fund programs would serve to expand the program. Of the 90%:
    a. 10% should be allocated to maintenance, promotion and safety testing of public water stations and fountains and to expand the infrastructure of the Healthy Retail SF program.
    b. 30% should be allocated to SFUSD to support efforts to meet state PE mandates by hiring PE teachers, especially in schools with high proportion of students most impacted by chronic diseases and higher consumption of SSB; installation, testing and promotion of publically accessible water fountains and hydration stations in schools; Nutrition education and student engagement programming.
    c. 50% should be allocated to fund community-based organizations in the following priority areas, (each priority should receive no less than 5% of the funding):
        i. Addressing health inequities among community residents, impacted by chronic diseases and targeted by the SSB industry to implement HEAL-related work
        ii. Implementing culturally-informed and consistent awareness and education campaigns for HEAL (Healthy Eating Active Living) messaging
        iii. Funding neighborhood-based community-engagement work to sustain and support Healthy Retail SF work
        iv. Expanding access to quality, free food vouchers/matching programs for fresh produce

v. Community physical activity programs, including active transportation (ex. open streets programs, bicycle and pedestrian education programs to encourage active transportation) to provide equitable, free and very low-cost physical activities in SF that are offered at times that are convenient for families.
vi. Water safety testing in low income homes (that don't qualify for WIC) to assure water safety.
vii. Support efforts to expand equitable access to community gardens and urban agriculture so all SF residents live within walking distance of a community garden.

Addressing health equity is at the heart of the Coalition's work. To that end the Coalition strongly urges that community members most impacted by sugary drink consumption not only benefit from resulting programing but also are trained and hired to implement HEAL programming. It is imperative to address poverty and social exclusion as a root cause of health inequity while also working to address social determinants of health, including reducing barriers to housing, healthy food and beverages, education, safe neighborhoods and environments, employment, healthcare, among others.

Thank you for your consideration. An earlier iteration of these recommendations (without allocation recommendations) were shared with the Mayor's Office in January 2018. We look forward to working with you to make the healthy choice the easy choice for *all* San Franciscans.

Sarah Fine, MPH
Shape Up SF Coalition Co-Chair
Campaign Director, The Bigger Picture
Manager, Health Communications Program
UCSF Center for Vulnerable Populations

San Francisco
Sugary Drink Distributors Tax Advisory Committee
March 2018 Report

APPENDIX R: Evidence-based Preventive Interventions for the Primary Adverse Oral Health Outcome of SSB Consumption: Dental Caries/Cavities

Evidence-based Preventive Interventions for the Primary Adverse Oral Health Outcome of SSB Consumption: *Dental Caries/Cavities*

- Sugar causes dental cavities
- SSB is the largest source of added sugar in the diet
- More people have dental cavities than have diabetes or are obese

STRONGEST EVIDENCE BASED INTERVENTIONS:

- ❑ Community Water Fluoridation *(evidence: CDC, Cochrane review)*. Encouraging the consumption of San Francisco tap water, highlighting the additional effect of increased protection against dental cavities and safety of SF tap water.
    - Peer to peer training and education
    - Mass media marketing to increase public awareness
    - Culturally appropriate messaging including safety of SF tap water

- ❑ School-based/school-linked sealant program *(evidence: CDC, American Dental Association, Cochrane review).* The tooth surfaces most likely to get a cavity are the tops of the first permanent molars. Dental sealants target these tooth surfaces. However, only 31% of children ages 6-8 have a sealant on at least one permanent molar, compared to other preventive interventions, such as immunizations- 72% of children 19-35 months *(CDC data).*
    - Expansion of current programs into elementary schools (staffing RDH, RDA)
    - Expansion of current programs into middle schools (staffing)

- ❑ Application of fluoride varnish (FV) on children 0-5 *(evidence: USPSTF, Cochrane review)*
    - Expansion of pre-school-based FV programs (staffing)
    - EHR systems support and training to address barriers to ordering and documenting FV application in the primary care medical setting (EHR revisions, training)

EMERGING INTERVENTIONS:

- ❑ EHR systems revision for integration of oral health with primary care practice.
  - Primary care provider screening for early oral effects of SSB consumption (white spot lesion, early cavities) and preventive factors (tap water consumption & appropriate fluoride tooth paste use)
  - Application of fluoride varnish on children 0-5 *(see above)*
  - Counseling on fluoride coverage (tap water and appropriate fluoride toothpaste) in additional to counseling on SBB & food choices
  - Routine referral to dental home for preventive care

- ❑ Support all collaborative efforts to increase access to potable water, decrease SSB consumption, provide alternatives to SSB, using community-based agencies including the three oral health task forces

- ❑ Pilot oral health professionals conducting screenings/assessments for other SSB adverse outcome conditions: saliva testing for carbohydrate levels, pin-prick diabetes screening, BMI (training, EHR revisions)

Additional Data Needed to Assess Oral Health Effects of Recommended Interventions

- ❑ Expanding SFUSD dental surveillance programs to align with California state oral health strategic plan (staffing: RDH, RDA)
  - 3rd grade
  - 10th grade

- ❑ ED utilization data for non-traumatic dental visits in children and adults (staff for data collection and analysis)

- ❑ Electronic Health Record technical support for revision of visit templates to prompt and document FV placement, oral health assessment, anticipatory guidance and dental referral for data analysis

- ❑ MIHA data- oversample for SF

- ❑ CHIS data– oversample dental questions for SF

- ❑ Improve existing K screening surveillance program with stronger training and calibration

- ❑ Add questions to annual Smile Survey (1000 caregivers of SFUSD K's (25%) about SSB consumption to correlate caries status and dental utilization with SSB consumption (staff for data analysis)

- ❑ Develop a secure health program online consent website to include SFUSD, Head Start and state-subsidized pre-schools to facilitate parents/caregivers enrolling in school-based health programs

San Francisco
Sugary Drink Distributors Tax Advisory Committee
March 2018 Report

APPENDIX S: CavityFree SF Oral Health Proposal

CavityFree SF

OUR VISION
All Children in SF are Caries Free

March 7, 2018

Dear Sugary Drinks Distribution Tax Advisory Committee:

Many thanks for recognizing the value of investing in Oral Health in San Francisco. On behalf of the CavityFree SF Implementation Coordinating Committee, we offer the follow detailed proposal for the 10% of Sugary Drinks Distribution tax revenue designated for oral health to address:

The #1 Adverse Oral Health Outcome of Sugary Drinks Consumption Resulting in the Worst Preventable Health Inequity in San Francisco:
Dental Cavities

- Sugar causes dental cavities
- Sugary drinks are the largest source of added sugar in the diet
- More people have dental cavities than have diabetes or are obese

Proposed allocations of funding presented as both actual amount and percentage of funds based on estimate of $1,000,000:

- ❑ **$450,000 (45%) Three Oral Health Community Task Forces:** Continuation of initial one-year, start-up funding. Currently granted through SFDPH-managed rfp process, the goal of the task forces is to enable communities to strategize and promote the importance of oral health in a way that is most acceptable, appropriate, and effective for the communities experiencing the greatest disease burden by promoting oral health prevention, and addressing health needs and barriers to receiving oral health care by building community capacity.
  - Community focus group interview process including community development and implementation of items/topics relating to oral health values and norms
  - Peer to peer training and education of self-collected community needs information as per focus group results
  - Marketing developed by community to increase public awareness of negative oral health effects of sugary drink intake, alternative beverages and programs funded by "Sugary Drink Tax Funds"
  - Culturally appropriate messaging about community indicated oral health topics of interest
  - Community Oral Health monthly meetings with community members (SFUSD school staff, Head Start staff, local community health center leadership, community groups, faith organizations, parents and others) to identify local community oral health needs, gaps, resources and prioritize local efforts to improve children's oral health in their communities.
  - Local engagement and recruitment of community dental providers to link with local childcare sites, schools and medical clinics.
  - Alignment and communication with CavityFree SF and other citywide health efforts.

CavityFree SF

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- ❑ **$350,000 (35%) School-based/school-linked Preventive Sealant Program:** Dental sealants are an evidence-based intervention that prevents dental cavities. On average, one of three SFUSD students have a cavity by Kindergarten; however, the current SFDPH-SFUSD sealant program only reaches 12 out of 72 (one in six) of the highest risk elementary schools where cavity rates can be as high as 46% (2016-17 data).
  - Proposed funding to support SFDPH staff and equipment will double the reach of the sealant program to 24 schools or 1/3 of SFUSD elementary schools, allowing coverage of the 1/3 highest-risk schools (based on high free-lunch participation and/or high caries rates in kindergarteners).

- ❑ **$200,000 (20%) SFUSD Dedicated Oral Health Staff:** Currently, SFUSD has capacity to assign oral health management as a small percentage of one school district nurse's time. Funding for dedicated oral health staff will increase capacity to address student's direct oral health needs and build on the collaboration and strategies developed through the CavityFree SF strategic plan.
  - Collaborate with oral health community task forces to develop educational content, gather student input on oral health and support student-led oral health efforts
  - Participate in development and implementation of efforts to address identified disparities in consent form return rates for the school-based sealant program
  - Participate fully in CavityFreeSF workgroups and meetings to facilitate collaboration and input of SFUSD perspective into overall CavityFreeSF Strategic Plan goals and serve as liaison in cross sector oral health collaboratives
  - Increase care coordination of SFUSD students identified with dental cavities, including same day communication with parents/guardians, dental home providers and primary care medical home providers
  - Assist in coordinating school based oral health surveillance, survey and assessment activities
  - Develop school based outreach programs and activities to advance oral health and tap water consumption
  - Develop oral health curriculum and training programs for SFUSD educators, students and parents
  - Promote and provide information and technical assistance to SFUSD schools on school based dental screening, sealant and fluoride varnish programs