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1 Dr. Carlton B. Goodlett Place, Room 244
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Application for Boards, Commissions, Committees, & Task Forces

Name of Board/Commission/Committee/Task Force: Sugary Drinks Distributor Tax Advisory Committee

Seat # (Required - see Vacancy Notice for qualifications): 1,2,3, 16

Full Name: Adina Safer

[redacted] Zip Code: 94118

[redacted] Occupation: Health Innovation and Health Equity Consultant

Work Phone: 4159999944 Employer: Self Employed

Business Address: 482 16TH AVE Zip Code: 94118

Business Email: adina.safer@gmail.com Home Email: [redacted]

Pursuant to Charter, Section 4.101(a)(2), Boards and Commissions established by the Charter must consist of residents of the City and County of San Francisco who are 18 years of age or older (unless otherwise stated in the code authority). For certain appointments, the Board of Supervisors may waive the residency requirement.

Resident of San Francisco: Yes ■ No ☐ If No, place of residence: _____

18 Years of Age or Older: Yes ☐ No ☐

Pursuant to Charter, Section 4.101(a)(1), please state how your qualifications represent the communities of interest, neighborhoods, and the diversity in ethnicity, race, age, sex, sexual orientation, gender identity, types of disabilities, and any other relevant demographic qualities of the City and County of San Francisco:

A lifelong San Franciscan with over 30 years of residence, I raised two children who attended San Francisco Public Schools. My career has been dedicated to the intersection of healthcare, public health, and innovation. I have a deep commitment to the health and mental well-being of young people, cultivated through my involvement with Hopelab and Headstream, philanthropic organizations dedicated to fostering mental health and well-being in youth. Recognizing the importance of equity and support for diverse populations, I currently serve on the board of San Francisco Health Plan. I am passionate about health and deeply committed to educating young people about health and fitness. I am a volunteer with Crisis Text Line and have sat on many boards focused on supporting public schools in San Francisco (see below). I am deeply passionate about this and want to give back at this time in my career.

(Applications must be submitted to BOS-Appointments@sfgov.org or to the mailing address listed above.)

Business and/or Professional Experience:

Adina brings over two decades of rich experience as a seasoned healthcare strategist, with significant achievements in business development, strategy, policy, and digital health. Her diverse background includes roles in consulting and investment banking, and she demonstrated her entrepreneurial spirit by founding an early internet health company later acquired by CVS. Notably, Adina spent a decade building the specialty pharmacy for CVS Health, contributing more than $75m in revenue to the organization.

In recent years, Adina has focused on ecosystem development in the startup world, utilizing her expertise in commercial and Medicare/Medicaid reimbursement to align stakeholders and achieve common objectives. She has worked with over a dozen startup companies in the digital health space in the last two years alone.

Her academic credentials, including a BA from Columbia University and an MBA/MPH from the University of California, Berkeley, provide a solid foundation for navigating the intricate landscape of the healthcare industry. She is a proud member of the Board of the San Francisco Health Plan, the MediCal plan for SF. This influential position has afforded her

Civic Activities:

Additional:
Service and Board Memberships

- San Francisco Health Plan Board of Directors
- Crisis Text Line counselor- 2020-Present
- Vesper Society- Health Care Board- 2015-Present
- Gateway Public Schools Board– 2013-2019
- San Francisco Education Fund Board 2009-2012
- Argonne Elementary School Board leadership-2006-2008

- Lecturer- (Haas School of Business & School of Public Health) Healthcare Finance & Strategy and Health Technology policy courses Spring 1998-2002 and Spring 2007, Fall 2008, Spring 2009 and Fall 2009
- Team Lead for Biologics Reimbursement Analysis- Berkeley Center for Health Technology currently under the direction of Professor James Robinson, Professor of Economics at UC Berkeley School of Public Health Featured National Speaker on Medicare Part D and High Cost Injectable drugs- invited to present at 5 national conferences on new Medicare

Have you attended any meetings of the body to which you are applying? Yes ■ No □

An appearance before the Rules Committee may be required at a scheduled public hearing, prior to the Board of Supervisors considering the recommended appointment. Applications should be received ten (10) days prior to the scheduled public hearing.

Date: 1/24/2024 Applicant's Signature (required): Adina Safer

(Manually sign or type your complete name. NOTE: By typing your complete name, you are hereby consenting to use of electronic signature.)

Please Note: Your application will be retained for one year. Once completed, this form, including all attachments, become public record.

FOR OFFICE USE ONLY:

Appointed to Seat #: _____ Term Expires: _____ Date Vacated: _____

1. Please describe the experience you have in public health programs related to diabetes, oral health, obesity, and sugary drink consumption.

My background in public health, particularly my Masters of Public Health from UC Berkeley, has provided me with a strong foundation in addressing critical health issues like diabetes, oral health, obesity, and sugary drink consumption. My experience spans several key areas:

- **Diabetes and Obesity:** While at CVS Health, I contributed to significant programs focused on these interconnected challenges. We created drug and patient support programs to serve affected patients.
- **Public Health Access in Diverse Communities:** My work has consistently focused on improving public health access for diverse populations. This experience has given me valuable insights into the social determinants of health that contribute to disparities in conditions like diabetes, obesity, and oral health outcomes. I was PTA president at Argonne Elementary School and was on the board of Gateway Charter schools here in SF so I understand the needs of SF's diverse community.
- **Digital Health and Health Disparities:** In my current role, I collaborate with numerous digital health companies working to address health disparities nationwide. This involves a deep understanding of how technology can be leveraged to improve access to care and promote healthier behaviors related to diet, exercise, and oral hygiene, ultimately impacting conditions like diabetes, obesity, and the consumption of sugary drinks.

2. Please describe the ways in which sugary drinks impact diverse communities across San Francisco.

Higher Consumption Rates:

- **Targeted Marketing:** Communities of color and low-income neighborhoods are often the target of aggressive marketing campaigns by the sugary drink industry. These campaigns often use culturally tailored messages and imagery to appeal to specific demographics, leading to increased consumption.
- **Accessibility and Affordability:** Sugary drinks are often more readily available and heavily promoted in these neighborhoods, while healthier options like water and fresh produce may be less accessible or more expensive.

Increased Health Risks:

- **Diabetes:** Higher consumption of sugary drinks is a major risk factor for type 2 diabetes, which disproportionately affects communities of color in San Francisco. This can lead to serious health complications and reduced quality of life.
- **Obesity:** Sugary drinks contribute significantly to weight gain and obesity, which are also more prevalent in diverse communities. Obesity is linked to a range of health problems, including heart disease, stroke, and certain types of cancer.

3. Social and Economic Impacts:

- **Health Disparities:** The disproportionate burden of health problems related to sugary drink consumption contributes to wider health disparities in San Francisco. This can affect educational attainment, economic opportunities, and overall well-being.
- **Financial Strain:** The health complications associated with sugary drink consumption can lead to increased healthcare costs for individuals and families, placing additional financial strain on already vulnerable communities.

4. Cultural and Environmental Factors:

- **Cultural Norms:** In some cultures, sugary drinks may be deeply ingrained in social gatherings and celebrations, making it challenging to shift consumption patterns.
- **Food Environment:** The prevalence of corner stores and fast-food restaurants selling sugary drinks in certain neighborhoods creates an environment that promotes unhealthy choices.

3. Please describe your experience in reaching out to community-based organizations that serve communities most impacted by sugary drinks.

I do possess experience in engaging with community-based organizations serving communities focusing on diverse needs. It's given me a deep understanding of how to build effective partnerships and work collaboratively to achieve shared goals. Here are some key examples:

- **Early Childhood and Elementary Education (Argonne Elementary PTA):** As Head of the PTA at Argonne Elementary, I worked directly with the local community, including families and neighborhood organizations. This experience taught me the importance of understanding community needs and tailoring outreach efforts to resonate with specific audiences. While my focus wasn't solely on sugary drinks, this role laid the foundation for my understanding of how community partnerships can drive positive change in children's health and well-being, which includes healthy eating and beverage choices.

- **K-12 Education and Community Partnerships (Gateway Charter School Board):** Serving on the board of Gateway Charter School provided me with valuable experience collaborating with a range of local organizations. We relied on these partnerships for support in various areas, including after school programs, internships and college prep. This experience reinforced the importance of building strong relationships with community partners and leveraging their expertise to benefit the school community. Again, while not directly related to sugary drinks, this role honed my skills in community engagement and collaboration.
- **Citywide Education and Health Ecosystem (SF Education Fund Board):** My involvement with the SF Education Fund exposed me to a broader network of organizations across the education and health ecosystem. Working with these

organizations, I gained a deeper understanding of the interconnectedness of health and education and the importance of cross-sector collaboration to address complex challenges

- **National Healthcare and Medicaid (Medicaid Managed Care Organizations):** My work with Medicaid Managed Care Organizations (MCOs) across the country has provided me with experience at a national level. I've worked with MCOs on initiatives related to pediatric health and behavioral health. This experience has given me insights into how healthcare organizations can partner with community-based organizations to address health disparities, including those related to sugary drink consumption. I understand the importance of culturally competent outreach and the need to tailor programs to meet the specific needs of diverse communities.

4. Please describe your understanding of how businesses (soda industry, tobacco industry, etc.) impact chronic disease and community health.

My understanding of how businesses like the soda and tobacco industries impact chronic disease and community health is shaped by my business background (including an MBA from UC Berkeley), my public health training (MPH from UC Berkeley), and ongoing engagement on these topics within the growing digital health sector. These industries employ sophisticated marketing, often targeting vulnerable populations, and design products that can be addictive and harmful. This contributes significantly to chronic diseases like diabetes and heart disease, placing a heavy burden on individuals and communities. My public health training has deepened my understanding of the epidemiological data and the role of social determinants of health in these outcomes. I'm also an avid reader on this topic, and my uncle, Henry Saffer (Bio and Research), a published author on tobacco and alcohol marketing, has provided valuable insights. My business experience gives me a nuanced view of the challenges and opportunities for promoting corporate social responsibility within these industries. I'm committed to using my knowledge to advance evidence-based strategies that reduce chronic disease and improve health equity.

5. Please describe how your work or life experience will inform the work of the committee.

I bring over two decades of rich experience as a seasoned healthcare strategist, with significant achievements in business development, strategy, policy, and digital health. I have a diverse background including roles in consulting and investment banking, and my entrepreneurial spirit led me to founding an early internet health company later acquired by CVS. I also spent a decade building the specialty pharmacy for CVS Health, contributing more than $75m in revenue to the organization. In recent years, I have focused on ecosystem development in the startup world, utilizing my expertise in commercial and Medicare/Medicaid reimbursement to align stakeholders and achieve common objectives. I have worked with over a dozen startup companies in the digital health space in the last two years alone. In addition, my time as a board member of Vesper Society (program info) working directly with Healthright 360, Clinic by

the Bay and Asian Health services all with operations here in SF. I am deeply committed to continuing this kind of work.

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Application for Boards, Commissions, Committees, & Task Forces

Name of Board/Commission/Committee/Task Force: Sugary Drinks Distributor Tax Advisory Committee

Seat # (Required - see Vacancy Notice for qualifications): Seat #1 - 3 (any one of these if I am deemed qualified)

Full Name: Christina Sataraka-Faitala

[redacted] CA Zip Code: 94124

[redacted]ation: Program Coordinator

Work Phone: 415-718-1994 Employer: All My Usos

Business Address: 150 Executive Park Blvd Suite #3000 SF, CA Zip Code: 94134

Business Email: sataraka@allmyusos.org Home Email [redacted]

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Resident of San Francisco: Yes ■ No ☐ If No, place of residence: _____

18 Years of Age or Older: Yes ■ No ☐

Pursuant to Charter, Section 4.101(a)(1), please state how your qualifications represent the communities of interest, neighborhoods, and the diversity in ethnicity, race, age, sex, sexual orientation, gender identity, types of disabilities, and any other relevant demographic qualities of the City and County of San Francisco:

Growing up in San Francisco, especially in the Sunnydale and Bayview Hunters Point neighborhoods, has been both a blessing and a challenge over the past 30 years. Coming from a low-income family, I quickly became aware of the socioeconomic and health disparities surrounding me from a young age. There were times where my sisters and I wanted something, but my parents or grandparents could not afford it despite working multiple jobs. We also lived in a multi-generational home with different family members. During my junior year of high school, I got involved with community organizations like POWER, where I worked alongside amazing community organizers to secure Free MUNI for Youth in 2012. Even though I was 18 and ineligible for the Free MUNI for Youth campaign, my dedication to advocating for accessible transportation for young people in our city remained strong. Despite facing pushback from some community members, I understood that the struggles of low-income families are vastly different from those of more financially secured households. I was also involved with Coleman Advocates for Children and Youth, where I actively engaged in community meetings held at the San Francisco Unified School District or at Coleman. After graduating from Balboa High School and moving on to higher education, I sought ways to elevate the voices of marginalized communities. I truly believe that challenges and hardships people encounter do not discriminate by age, gender, race, or socioeconomic status; however, when systems perpetuate oppression, it becomes crucial to confront the very structures that claim to serve the people. I want to live in a world where the voices of the people are heard with love; but people often find this cliché because some may view love as an act of weakness. In my Smoan culture, we view it as strength. Love can allow people to move with the intention to do good work and service. I understand that we cannot make everyone happy, but this should not be the reason why people' s lives are trampled on because of one' s love for profit and business. Business and profit can be good because it provides security, but not at the expense of marginalized communities livelihood. My background as a low-income Smoan native of San Francisco, combined with my highest level of education, MSW (Master' s in Social Work), positions me to address the challenges faced by historically marginalized communities. As a first-generation student, I have navigated the complexities of higher education, and I feel a deep sense of responsibility not just to my family, but to the broader community. This journey is challenging, yet I am committed to fostering a future where our voices are genuinely represented in the discussions and decisions that impact us.

(Applications must be submitted to BOS-Appointments@sfgov.org or to the mailing address listed above.)

Business and/or Professional Experience:

I am currently serving as a Program Coordinator at All My Usos, where I collaborate with Community Health Workers to raise awareness about the health impacts of sugary drinks on Pacific Islanders and other BIPOC families. I also coordinate events and sessions that address mental health and grief in the Pacific Islander community, while also opening our doors to anyone in need of this service. Our partnership with Faatasi Youth Services and the Samoan Community Development Center has allowed us to organize events like Health and Unity Day, providing a platform for community members to connect with various organizations that focus on chronic health issues and the significance of physical activity. We just celebrated our 9th Annual Family Day BBQ where we had over 48 Community organizations table and provide free resources and knowledge on their services they provide. Our organization also collaborated with SF Hep-B, the Lion' s Club, and Walgreens to provide free health screenings, eye examinations, and flu shots.

Before my role at All My Usos and other community-based organizations, I spent nearly three years as a Shelter Services Case Manager with Samaritan House in San Mateo County. In this position, I supported adults facing homelessness due to a range of challenges, including severe mental health issues, substance abuse, financial difficulties, citizenship concerns, and the high cost of living in the Bay Area.

Civic Activities:

During my junior year of high school, I became actively involved in civic engagement, collaborating with community organizers to secure Free MUNI for Youth. I voiced my concerns at San Francisco education board meetings and attended City Hall Hearings, focused on the challenges faced by marginalized communities, and organized gatherings that raised awareness about policies affecting Black and Brown families. My education at Balboa High School helped me recognize the complex disparities that families of color encounter, while also empowering me to advocate for my community in different spaces based on issues that resonate deeply with both my family and the broader community.

I witnessed firsthand the impact of budget cuts on community organizations that provide essential resources and education on nutrition and health. When these services are reduced or taken away due to funding, entire communities suffer. I am committed to advocating for the inclusion of Pacific Islanders in important discussions, despite the lack of representation at decision-making tables. Standing in solidarity with other marginalized communities is also vital, as there is immense strength in unity among people fighting for justice and equity.

Have you attended any meetings of the body to which you are applying? Yes ■ No ☐

SDDT-related meetings

An appearance before the Rules Committee may be required at a scheduled public hearing, prior to the Board of Supervisors considering the recommended appointment. Applications should be received ten (10) days prior to the scheduled public hearing.

Date: 01/23/2025 Applicant's Signature (required): _____

(Manually sign or type your complete name. NOTE: By typing your complete name, you are hereby consenting to use of electronic signature.)

Please Note: Your application will be retained for one year. Once completed, this form, including all attachments, become public record.

FOR OFFICE USE ONLY:

Appointed to Seat #: _____ Term Expires: _____ Date Vacated: _____

Sugary Drinks Distributor Tax Advisory Committee (SDDTAC) Supplemental Questions

1. Please describe the experience you have in public health programs related to diabetes, oral health, obesity, and sugary drink consumption.

Since January 2024, I have participated in All My Usos and Faatasi Youth Services Peer Health Leaders trainings around nutrition education where the impacts of sugary drinks were discussed. I was able to increase my awareness around the chronic health diseases that exists within the Pacific Islander communities because of one leading factor, sugary drink consumptions. Throughout 2024, I engaged and attended to SDDT meetings where they provided in-depth knowledge on how chronic health diseases continue to rise within communities of color. I specifically noticed that this was impacting District 10 and 11 residents where majority of Black and Brown families live. I also attended meetings where Dental Robin Hood taught us about oral health prevention starting as early as early childhood. In all these spaces in which I occupied related to health programs in San Francisco, I gained insight on information that I lacked prior to starting at All My Usos in January 2024. Nutrition education is something I never expected I would be a part of, and yet I have grown so much in connecting our physical health to our mental and emotional health.

2. Please describe the ways in which sugary drinks impact diverse communities across San Francisco.

As mentioned above, I noticed a huge impact on District 10 and District 11's consumption of sugary drinks. I will draw from my own personal experience to answer this question. Sugary drinks are most always present at many Pacific Islander's functions such as birthday parties, graduations, weddings, funerals, family gatherings, or even a visit over to the family's house; and because of this, many Pacific Islanders that I know suffers from diabetes, high blood pressure, cardiovascular and gout. I didn't associate sugary drinks to gout because often times, individuals with gout were always told by doctors to stay away from red meat or anything with high levels of purine. Sugary drinks can also impact the overall quality of their oral health.

3. Please describe your experience in reaching out to community-based organizations that serve communities most impacted by sugary drinks.

My experience with All My Usos has highlighted the importance of community connection. We prioritize building meaningful relationships with families and individuals, as this is essential to our mission. By networking with local organizations, we can establish referral partnerships and collaborations that enhance our understanding of how to effectively serve our communities. This collaboration also allows us to learn about best practices for

delivering resources to those in need. To raise awareness about the negative effects of sugary drinks, we must first grasp the extent of its harm. From having this foundation established, we can partner with other community-based organizations to strategically spread crucial information to those most affected.

4. Please describe your understanding of how businesses (soda industry, tobacco industry, etc.) impact chronic disease and community health.

To be honest, the most that I know about how businesses impact chronic disease and community health is that they aren't to concern about the harm their products are producing in these neighborhoods. I knew early on that it has always been profit over the lives of people. If consumers are purchasing it, then there is a high need for it. When advertisements are created to connect with people on an emotional level, then pushing the narrative of the harm will only dismantle their business. Soda industries, tobacco industry, or even alcohol industries don't seem to care about the effects their products are creating because at the end of the day, the blame seems to be pushed on the consumers.

While consumers deserve complete autonomy in their purchasing decisions, this highlights the urgent need for enhanced nutrition education and awareness regarding the effects of businesses on community health and the rising prevalence of chronic diseases. Connecting with individuals in a culturally meaningful manner regarding the effects of sugary beverages can significantly influence the lives of those impacted by this issue.

5. Please describe how your work or life experience will inform the work of the committee.

I am dedicated to carry the weight that comes with uplifting the voice of the Pacific Islander community, but overall, the health of our communities in San Francisco impacted by sugary drinks. I cannot deny that I am a product of this impact. Sugary drink has always been associated with my life but since starting here at All My Usos, my intake of water has gone up significantly. Sugary drinks are not something I crave as much anymore; and I honestly believe it's because of the education I received while working with All My Usos, while also collaborating with Faatasi Youth Services, Samoan Community Development Center, and anyone who was granted funded through SDDT. I am committed to learning and growing with others who have a passion to put the lives of people impacted by sugary drinks over profit.

Christina Sataraka-Faitala

Name – Signature

01/23/2025

Date

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Application for Boards, Commissions, Committees, & Task Forces

Name of Board/Commission/Committee/Task Force: Sugary Drinks Distributor Tax Advisory Committee

Seat # (Required - see Vacancy Notice for qualifications): Health Equity Seat

Full Name: Dheyanira Calahorrano

[redacted] Zip Code: 94110

[redacted]ation: CHW

Work Phone: 415 424-6782 Employer: IntegrArte SF

Business Address: 515 Cortland Ave Zip Code: 94110

Business Email: dheyanira@integrartesf.org Home Email: [redacted]

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Resident of San Francisco: Yes ■ No ☐ If No, place of residence: _____

18 Years of Age or Older: Yes ■ No ☐

Pursuant to Charter, Section 4.101(a)(1), please state how your qualifications represent the communities of interest, neighborhoods, and the diversity in ethnicity, race, age, sex, sexual orientation, gender identity, types of disabilities, and any other relevant demographic qualities of the City and County of San Francisco:

As a Latin American immigrant, mother, and health coach rooted in the Mission neighborhood, I draw on seven years of experience at SF General Hospital—where I supported diverse patients—to address the health and social needs of Latino families. I've studied Child Development, taught bilingual, culturally responsive programs, and I'm involved in Leadership San Francisco 2025, an Urban Agriculture Fellowship, and the advisory board of the National Association of Community Health Workers.

In addition, I'm an elected member of the Latino Community Council, representing Latino students and families, and have served on ELAC, DELAC, SSC, and PTAs at my son's schools. These roles reflect my commitment to our community, especially as data shows 39–46% of Latino students in San Francisco are overweight or obese, and are at higher risk for diabetes type 2 . By promoting healthy habits, preventive education, and culturally relevant support, IntegrArte SF works to empower families and break cycles of health disparities.

(Applications must be submitted to BOS-Appointments@sfgov.org or to the mailing address listed above.)

Business and/or Professional Experience:

As the founder of IntegrArte SF, I combine my professional background as a health coach/ community health worker with a passion for culturally responsive education and community support. Having served for seven years as a health coach at SF General Hospital, I gained firsthand experience addressing the diverse health and social needs of families in the Mission and throughout San Francisco. This dual perspective informs IntegrArte SF's programs, ensuring they promote holistic well-being while honoring the cultural and linguistic heritage of our communities, while providing community health worker services to our members.

Civic Activities:

Beyond founding IntegrArte SF, I have actively participated in local civic initiatives to support the well-being of families in the Mission. This includes organizing bilingual literacy workshops and community events that bring together neighbors, schools, and health-focused organizations. My work often involves collaborating with local nonprofits, attending neighborhood meetings, and advocating for culturally inclusive policies and programs. Through these efforts, IntegrArte SF serves as both a cultural hub and a resource for families seeking holistic, community-based support in education, health, and mental wellness.

Have you attended any meetings of the body to which you are applying? Yes ☐ No ■

An appearance before the Rules Committee may be required at a scheduled public hearing, prior to the Board of Supervisors considering the recommended appointment. Applications should be received ten (10) days prior to the scheduled public hearing.

Date: 1-2-2025 Applicant's Signature (required): _____

(Manually sign or type your complete name. NOTE: By typing your complete name, you are hereby consenting to use of electronic signature.)

Please Note: Your application will be retained for one year. Once completed, this form, including all attachments, become public record.

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Appointed to Seat #: _____ Term Expires: _____ Date Vacated: _____

Please see additional document.

Sugary Drinks Distributor Tax Advisory Committee (SDDTAC)

Supplemental Questionnaire

1. Please describe the experience you have in public health programs related to diabetes, oral health, obesity, and sugary drink consumption.

See additional document

2. Please describe the ways in which sugary drinks impact diverse communities across San Francisco.

3. Please describe your experience in reaching out to community-based organizations that serve communities most impacted by sugary drinks.

4. Please describe your understanding of how businesses (soda industry, tobacco industry, etc.) impact chronic disease and community health.

5. Please describe how your work or life experience will inform the work of the committee.

Sugary Drinks Distributor Tax Advisory Committee (SDDTAC)
Supplemental Questionnaire

1. Please describe the experience you have in public health programs related to diabetes, oral health, obesity, and sugary drink consumption.

With over seven years of experience at SF General Hospital, I have been deeply involved in public health programs addressing diabetes, oral health, obesity, and sugary drink consumption. In my role as a bilingual health coach for the complex care management team, I provided tailored support and education to diverse patients, with a particular focus on Latino families in the Mission neighborhood. This work involved developing and implementing culturally responsive strategies to prevent and manage diabetes and obesity, promoting healthy eating habits, and reducing the consumption of sugary beverages. My background in Child Development and bilingual education enabled me to create effective communication channels that resonate with our community's unique needs. Additionally, my participation in Urban Agriculture Fellowships and my role on the advisory group of the National Association of Community Health Workers allowed me to design community-based initiatives that integrate healthy lifestyle practices with cultural traditions. These efforts have been instrumental in fostering holistic well-being and empowering families to make informed health choices, thereby addressing critical public health challenges within our community.

2. Please describe the ways in which sugary drinks impact diverse communities across San Francisco.

Sugary drinks have a profound impact on diverse communities across San Francisco, particularly within Latino populations. High consumption of these beverages is a major contributor to the alarming obesity rates among Latino children, which range from 30% to 45%. This elevated prevalence of obesity significantly increases the risk of developing type 2 diabetes, a condition that disproportionately affects Latino youth compared to their non-Latino peers.

Several factors exacerbate the impact of sugary drinks in these communities:

1. **Economic Hardships and Accessibility:** In many Latino neighborhoods, sugary drinks are more affordable and accessible than healthier alternatives. Economic constraints often limit families' ability to choose nutritious options, making sugary beverages a more viable choice.

2. **Aggressive Marketing:** Sugary drinks are frequently marketed in Latino communities, targeting children and families with advertisements that promote these

beverages as desirable and fun. This aggressive marketing influences consumption patterns, leading to higher intake among youth.

3. **Cultural Practices:** In some Latino households, sugary drinks are a staple in daily life and celebrations, reinforcing their regular consumption. Cultural norms around food and beverages can make it challenging to reduce intake without culturally sensitive interventions.

4. **Lack of Education:** Limited access to health education in Spanish can hinder awareness about the risks associated with excessive sugary drink consumption. Without proper information, families may not fully understand the long-term health implications.

The consequences of high sugary drink consumption extend beyond physical health. Obesity and diabetes can lead to decreased academic performance, as health-related issues may result in increased absenteeism and reduced cognitive function. Additionally, these health challenges contribute to mental health concerns such as anxiety and depression, further affecting the overall well-being of children and their families.

3. Please describe your experience in reaching out to community-based organizations that serve communities most impacted by sugary drinks.

As a community health worker and a bilingual education promoter, I have a strong track record of collaborating with community-based organizations that serve Latino families, many of them impacted by sugary drink consumption. Currently we are strengthening our partnership with local schools, family resource centers, senior centers, and health clinics to implement targeted educational workshops and health education initiatives. By integrating our bilingual literacy programs and community health worker services, we deliver culturally relevant education on the risks of sugary drinks and promote healthier alternatives.

Our collaborations include organizing joint events such as health fairs, nutrition workshops, and interactive activities conducted in Spanish, ensuring that our messages resonate with the community. We also train promotoras and community health workers to effectively communicate health information and support behavior change within their networks. Additionally, through our involvement in the Mushuk Nina Community Garden Network, we work with other organizations to increase access to nutritious foods and create supportive environments that discourage the consumption of sugary beverages.

These partnerships enable IntegrArte SF to leverage collective resources and expertise, addressing the public health challenges posed by sugary drinks. Our community-driven approach fosters a healthier, more resilient Latino population in San Francisco’s Mission District, empowering families to make informed health choices and improve their overall well-being.

4. Please describe your understanding of how businesses (soda industry, tobacco industry, etc) impact chronic disease and community health

Businesses like the soda and tobacco industries have a profound and harmful impact on chronic disease rates and community health, particularly within Latino communities in San Francisco. These industries often target marginalized groups with aggressive marketing strategies, making unhealthy products more accessible and appealing. This approach exacerbates health disparities by increasing the prevalence of conditions such as obesity, diabetes, and respiratory illnesses.

For example, the soda industry heavily markets sugary beverages in Latino neighborhoods, contributing to high rates of obesity and type 2 diabetes among Latino children and adults. Similarly, the tobacco industry's targeted advertising leads to higher incidences of smoking-related diseases, including cancer and heart disease. These practices not only undermine public health but also perpetuate cycles of illness and economic hardship within affected families.

I understand the significant ways these industries influence chronic disease and community health. Through our educational programs, we address the root causes of these health issues by providing culturally relevant education on nutrition, the dangers of sugary drinks, and the risks associated with tobacco use. Our bilingual literacy programs and community health worker services empower Latino families with the knowledge and resources needed to make healthier choices.

Additionally, our Healing Gardens Network and cultural workshops offer alternative avenues for stress relief and social engagement, reducing reliance on unhealthy coping mechanisms promoted by these industries. By integrating ancestral wisdom and peer support, we create a supportive environment where families can develop healthier habits and build resilience together.

We collaborate with local schools, health clinics, and community organizations to amplify our impact, ensuring that our efforts reach those most affected by these chronic health issues. Through advocacy and community engagement, I hope we can help promote policies that provide more equitable access to health resources.

In summary, the soda and tobacco industries significantly contribute to chronic diseases and undermine community health among Latino populations in San Francisco.

5. Please describe how your work or life experience will inform the work of the committee

My extensive work and life experience uniquely position me to contribute meaningfully to the committee. As a Latin American immigrant, mother, and health coach deeply rooted in San Francisco's Mission District, I have firsthand understanding of the challenges faced by Latino families, including high rates of obesity, diabetes, and mental health issues exacerbated by post-pandemic pressures and economic hardships. Over seven years at SF General Hospital, I supported diverse patients, gaining valuable insights into the social and health needs of our community.

Through IntegrArte SF and the Mushuk Nina Network of Learning & Healing, I have developed and implemented culturally responsive programs that promote bilingual education, health education, and holistic well-being. My involvement in Urban Agriculture Fellowships and the National Association of Community Health Workers' advisory group has equipped me with the skills to address intersectional issues of health and social equity effectively. Additionally, my role as an elected member of the Latino Community Council and active participation in various parent advisory groups demonstrate my commitment to advocacy and community collaboration.

These experiences have honed my ability to create inclusive, supportive environments that empower families to reclaim their cultural heritage and improve their health outcomes. I bring a comprehensive understanding of the importance of integrating cultural practices with modern health strategies, ensuring that initiatives are both effective and respectful of the community's values. My dedication to fostering strong, resilient communities through education, health, and cultural integration will inform and enhance the committee's efforts to address the diverse needs of San Francisco's populations.

BOARD of SUPERVISORS

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Application for Boards, Commissions, Committees, & Task Forces

Name of Board/Commission/Committee/Task Force: Sugary Drinks Distributor Tax Advisory Committee

Seat # (Required - see Vacancy Notice for qualifications): 1 through 3

Full Name: Dr. John Maa

[redacted] Zip Code: 94109

[redacted] Occupation: Surgeon

Work Phone: 415-602-6148 Employer: Self-employed

Business Address: 165 Rowland Way, Suite 312, Novato CA Zip Code: 94945

Business Email: john.maa@mymarinhealth.org Home Email [redacted]

Pursuant to Charter, Section 4.101(a)(2), Boards and Commissions established by the Charter must consist of residents of the City and County of San Francisco who are 18 years of age or older (unless otherwise stated in the code authority). For certain appointments, the Board of Supervisors may waive the residency requirement.

Resident of San Francisco: Yes ■ No ☐ If No, place of residence: _____

18 Years of Age or Older: Yes ■ No ☐

Pursuant to Charter, Section 4.101(a)(1), please state how your qualifications represent the communities of interest, neighborhoods, and the diversity in ethnicity, race, age, sex, sexual orientation, gender identity, types of disabilities, and any other relevant demographic qualities of the City and County of San Francisco:

As a first generation Chinese American, I have resided in SF for 28 years. In 2005, I implemented the first surgicalist program at UCSF to stregthen emergency care access for San Franciscans across all demographic groups, and the model was adopted across America. In 2009, I was named a "Top 20 People Making a Difference in Health in America" by HealthLeaders Magazine in recognition. My career expanded to reduce the impact of sugary drinks, firearms and tobacco products (Prop E 2018, Prop C 2019) on the diverse populations in SF. I am a US Military Veteran of Operation Desert Storm, and served as 2018 President of the San Francisco Marin Medical Society (SFMMS), and as 2013 President of the Northern California Chapter of the American College of Surgeons (ACS). I previously served on the 2019-2021 SDDTAC in the Health Equity Seat 2, and as a liaison to the API Health Parity Council. I am currently the Chair of the California AHA Advocacy Committee, which has been the national leader in championing strategies to reduce the impact of sugary drinks across all populations, especially minority communities that have been the focus of soda advertising, and I also Co-Chair the ACS California Joint Advocacy Committee.

(Applications must be submitted to BOS-Appointments@sfgov.org or to the mailing address listed above.)

Business and/or Professional Experience:

During my UCSF health policy fellowship, I also focused on tobacco control and reducing the impact of smoking on surgical outcomes. I was first appointed by Governor Gavin Newsom to the California Tobacco Education and Research Oversight Committee (TEROC) in 2022. I served as the Chair of the UC Office of the President Tobacco Related Disease Research Program (TRDRP) from 2013-2016 to represent the American Heart Association (AHA), and currently am appointed ex-oficio to TRDRP as the TEROC representative. I was recently elected ACS Governor and serve as the American Medical Association (AMA) delegate for SF, and was elected the California Medical Association CALPAC Secretary-Treasurer. I have worked on soda taxes since 2012, when I first met Richmond soda tax champion Dr. Jeff Ritterman. I was the finance lead for the Prop E 2014 soda tax, and was featured in the television commercials for Prop V in 2016. I wrote the article "Taxing Soda" published by the Johns Hopkins University Press in 2018, and most recently was featured in the successful Prop Z soda tax campaign passed by Santa Cruz voters 52 to 48 in November 2024.

Civic Activities:

I was also appointed by Treasurer Fiona Ma to the Citizens Financial Accountability Oversight Committee to oversee Prop 71 and the California Institute for Regenerative Medicine, and by Speaker Anthony Rendon to the Children's Data Protection Committee. I have served on the AHA Bay Area Board of Directors for nearly 25 years and was the 2004 President of the AHA San Mateo Board. I was the 2016 Physician Volunteer of the Year for the AHA Western States Affilitate and the SFMMS Committee Member of the Year in 2024. I currently serve on the AHA Western States Affiliate Board of Directors and Chair the AHA California Advocacy Committee, having previously served on the AHA National Advocacy Committee. I serve on the Smithsonian Institute Traveling Exhibition Board of Directors, and am assisting with the national celebrations of America's 250th birthday in 2026. I served on the Board of Trustees of the Asian Art Museum to promote a deeper understanding of the AAPI community. I was actively involved in the 2018 Prop E flavored tobacco products ban and the 2019 No on Prop C ballot measure to enforce FDA regulation of electronic cigarettes. I chaired my Harvard Medical School 25th and 30th Reunion Class gift campaigns, raising nearly $325,000 in 2024.

Have you attended any meetings of the body to which you are applying? Yes ■ No ☐

An appearance before the Rules Committee may be required at a scheduled public hearing, prior to the Board of Supervisors considering the recommended appointment. Applications should be received ten (10) days prior to the scheduled public hearing.

Date: Jan 23, 2025 Applicant's Signature (required): 

(Manually sign or type your complete name. NOTE: By typing your complete name, you are hereby consenting to use of electronic signature.)

Please Note: Your application will be retained for one year. Once completed, this form, including all attachments, become public record.

FOR OFFICE USE ONLY:

Appointed to Seat #: _____ Term Expires: _____ Date Vacated: _____

Sugary Drinks Distributor Tax Advisory Committee (SDDTAC)

Supplemental Questionnaire

1. Please describe the experience you have in public health programs related to diabetes, oral health, obesity, and sugary drink consumption. I noted the dramatic rise in obesity rates as a surgeon in the 1990s leading to the growth of bariatric surgery. As San Mateo AHA President I presented the national evidence which led to the AHA Alliance for a Healthier Generation with Bill Clinton to address childhood obesity and curb sugary drink consumption. Diabetes and obesity burden our healthcare system and surgical outcomes, which led me to support the 2014 SF soda tax and write the article "Taxing Soda" in the "Perspectives in Biology and Medicine" from Johns Hopkins Press.

2. Please describe the ways in which sugary drinks impact diverse communities across San Francisco. One out of two African American and Hispanic youth in SF are at risk for Type 2 "adult onset" diabetes with nearly two-thirds of African-American and Latino adults either overweight or obese. Sugary drinks are the leading source of extra calories in the American diet that are fueling this dual epidemic that strains SF's precious healthcare resources. Nationally, young white men are the largest consumers of sugary drinks, less affluent SF neighborhoods tend to have higher rates of SSB consumption, food deserts, and related health problems.

3. Please describe your experience in reaching out to community-based organizations that serve communities most impacted by sugary drinks. As a 2019-2021 Member of the SDDTAC, I served on the Community Input Subcommittee and worked with Carecen, the Tenderloin community and the AAPI Health Parity Council to disburse funds to impacted populations. As a member of the AHA Board and SFMMS, I have assisted with several community-based programs to improve population health by educating the health risks of sugary drinks, delivery presentations about grant funding opportunities to promote oral hygeine and water filling stations, healthy retail and purchasing.

4. Please describe your understanding of how businesses (soda industry, tobacco industry, etc.) impact chronic disease and community health. Industries that market highly addictive products like tobacco and sugary drinks burden our healthcare system with preventable diseases like cancer, heart disease, type 2 diabetes and obesity. Their marketing like the Coca-Cola bottle at Oracle Park, and the modern version of Santa Claus, fail to inform consumers of the hidden health risks. Their advertising disproportionately targets communities of color who struggle with lifelong chronic diseases that strain their financial health.

5. Please describe how your work or life experience will inform the work of the committee. As a surgeon advocate who served as SFMMS President in 2018 and has worked with the AHA since 2003 - I have a unique public policy and clinical perspective of the twin epidemic of obesity and type 2 diabetes that has been fueled by sugary drinks. Over 20 nations began taxing soda after the Bay Area successes in 2016, and there is strong population health data to catalyze further progress in America. I am an appointee in the Newsom Administration and serve in the leadership of the California Medical Association, and a goal is to disseminate the successes of the Prop N soda tax and SDDTAC across California & nationally.

CAPITOL OFFICE
1021 O STREET, SUITE 8620
SACRAMENTO, CA 95814
TEL (916) 651-4011
FAX (916) 651-4911

DISTRICT OFFICE
455 GOLDEN GATE AVENUE
SUITE 14800
SAN FRANCISCO, CA 94102
TEL (415) 557-1300
FAX (415) 557-1252

SENATOR.WIENER@SENATE.CA.GOV

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JOINT LEGISLATIVE BUDGET
CHAIR
LEGISLATIVE ETHICS
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HEALTH
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PUBLIC SAFETY
JOINT RULES

January 23, 2025

Honorable Rafael Mandelman
President, San Francisco Board of Supervisors
1 Dr Carlton B. Goodlett Place
City Hall, Room 244
San Francisco, CA 94102

Dear President Mandelman:

I writing in support of Dr. John Maa's application to fill a health equity seat (seats 1-3) on the Sugary Drinks Distributor Tax Advisory Committee (SDDTAC).

Dr. Maa is a general surgeon and 28-year resident of San Francisco, and served as 2018 President of the San Francisco Marin Medical Society. He was previously appointed by Mayor London Breed to the SDDTAC from 2019 to 2021 in the AAPI Health Equity Seat 2 as a liaison to the API Health Parity Council.

Dr. Maa's professional efforts in public health have focused on tobacco control and educating the public about the health hazards of sugar sweetened beverages. He has been engaged in research, community outreach and advocacy efforts since the first SF Soda Tax Prop E in 2014. He helped illuminate the debate with a surgeon's perspective on the role of sugary drinks to the rising rates of obesity and type 2 diabetes in America which contribute to the rising rates of bariatric surgery. He has worked with both the California Medical Association and the American Heart Association since 2003 to address the accumulating evidence that led to the nationwide Alliance for a Healthier Generation to address the rates of childhood obesity in America.

Dr. Maa continues his advocacy work, most recently in helping to successfully pass Prop Z, the Santa Cruz soda tax in 2024. He has chronicled his findings in a Johns Hopkins University Press article - *Perspectives in Biology and Medicine "Taxing Soda"*.

Dr. Maa would make an excellent addition to the SDDTAC and has my full support. Thank you for your consideration of his application.

Sincerely,

Scott Wiener

Scott Wiener
11th Senatorial District

CC: Members, San Francisco Board of Supervisors

SAN FRANCISCO MARIN MEDICAL SOCIETY

January 22, 2025

Christina Goette
Melinda Martin
Department of Public Health
San Francisco, CA

Dear Ms. Goette and Ms. Martin:

As Executive Director of the San Francisco Marin Medical Society (SFMMS), I am pleased to support John Maa, MD for Seat #1, 2, or 3 on the Sugary Drinks Distributor Tax Advisory Committee (SDDTAC). SFMMS represents more than 3500 physicians of every medical specialty and mode of practice in San Francisco and Marin Counties. Our organization and members have been dedicated to improving health for more than 150 years. The Bay Area movement to increase taxes on sugary sweetened beverages began more than 15 years ago with an SFMMS 2009 resolution in support of the targeted tax increase.

Dr. Maa is a general surgeon and 28-year resident of San Francisco. He previously served as 2018 President of the San Francisco Marin Medical Society and is the current American Medical Association Delegate for San Francisco and Marin. He was previously appointed by Mayor London Breed to the SDDTAC from 2019 to 2021 in the AAPI Health Equity Seat 2 as a liaison to the API Health Parity Council, where he helped shape the budget recommendations to disburse funds generated by the soda tax.

Dr. Maa is a committed public health champion dedicated to reducing the use of tobacco and consumption of sugar sweetened beverages. He has engaged in community outreach and advocacy efforts since the Prop E San Francisco Soda Tax in 2014. Dr. Maa brought his knowledge and experiences as a surgeon battling the rising rates of bariatric surgery in America, and the consequences of sugary drinks on obesity and type 2 diabetes. He has worked with both the California Medical Association and the American Heart Association since 2003 to inform public policy actions in San Francisco and California to educate the public about sugar sweetened beverages.

Dr. Maa was featured in the 2016 Prop V campaign, and most recently in the successful 2024 Prop Z Santa Cruz soda tax. He summarized his findings in a Johns Hopkins University Press article, "Taxing Soda."

SFMMS believes he would provide an important perspective to the SDDTAC and urge your support for his application.

Sincerely,

Conrad Amenta
CEO, San Francisco Marin Medical Society

312 Sutter Street, Suite 608, San Francisco, CA 94108 • www.sfmms.org • P 415.561.0850 • F 415.561.0833

TAXING SODA

strategies for dealing with the obesity and diabetes epidemic

JOHN MAA

ABSTRACT Over the past several decades, the United States has been experiencing a twin epidemic of obesity and type 2 diabetes. Recently, advocacy efforts to tax sugary drinks, place warning labels on soda, improve nutritional labeling, and reduce sugar overconsumption have swept across the nation to address public health concerns from sugary drinks that strain our nation's health-care resources. In this article, the historical and scientific framework of this public health policy and valuable lessons learned from implementation efforts thus far will be examined to shape the next steps forward for the movement. Additional goals of this article are to share a surgeon's perspective about trends in bariatric surgery and the link between obesity and type 2 diabetes as a result of peripheral insulin resistance.

OBESITY IS ONE OF THE most common health problems facing children and society today. Since 1960, the obesity rate among adults has risen to 34% in the United States, and morbid obesity is up six-fold (Glickman et al. 2012). In

Division of General and Trauma Surgery, Marin General Hospital, Greenbrae, CA.
Correspondence: 5 Bon Air Road, #101, Larkspur, CA 94939.
E-mail: maaj@maringeneral.org.

Decades from now, the benefits from the passage of Prop V will likely have an enduring impact in San Francisco, across the nation, and around the globe. The world may likely not recall the names of those individuals who decades earlier battled the soda industry over this life-saving measure in 2016, but the intent of this article is to chronicle those individuals who played an important role in this victory. The author would like to dedicate this article in deep appreciation and gratitude to Mayor Michael Bloomberg, for making the difference and being the margin of victory in Berkeley, Philadelphia, San Francisco, and Oakland in particular.

Perspectives in Biology and Medicine, volume 59, number 4 (autumn 2016): 448–464.

1980, only 14% of adult Americans were obese, but this figure had skyrocketed to 31% by 2000 (nearly 85 million Americans). Two out of three Americans today are overweight or obese, and one in 20 suffers from extreme obesity. In 2012, Reuters reported that obesity in America added $190 billion to annual national health-care costs, passing smoking for the first time (Begley 2012).

Following closely on the heels of this epidemic is an explosion in the number of cases of diabetes, particularly among children, which has been steadily increasing since a spike in 2003. According to the Centers for Disease Control, the rate of diabetes soared from 5.8 million in 1980, to 17.9 million in 2009, and reached 29.1 million in 2014 (1 of 11 people in the United States) (Reusch and Manson 2017). This represents 9.3% of the population (21 million diabetics are diagnosed, while another 8.1 million are undiagnosed). Diabetes added another $245 billion to national costs in 2012, including both medical costs and lost wages, and one out of 10 health-care dollars is attributed to the care of patients with diabetes (Hill, Nielsen, and Fox 2013; Menke et al. 2015). Particularly concerning is the explosion of type 2 "adult onset" diabetes that is now being increasingly diagnosed in adolescents and teenagers (Dabalea et al. 2017). Many researchers attribute this second wave as resulting from the epidemic of childhood obesity. Together, obesity and diabetes increase the risk of cardiovascular disease (both heart disease and stroke), renal failure, peripheral vascular disease, depression, dementia, retinal disease, and the risk of amputation (Laiteerapong and Cifu 2016). Type 2 diabetes and obesity are both a cyclical process; they result from and contribute to poorer health-care outcomes (Hill, Nielsen, and Fox 2013). Strategies to reduce the trillions spent each year on health care must find ways to curb the dual tidal waves of obesity and diabetes and the resulting economic burden.

THE RISE OF BARIATRIC SURGERY

As a medical student in the early 1990s, I never scrubbed for an operation of a patient requiring obesity surgery. This was likely the result of a very valuable lesson learned by the profession of general surgery decades prior. Between the 1960s and the 1980s, the jejunoileal bypass (which bypassed all but 30 cm of the intestinal tract) had been championed as the solution to morbid obesity. The procedure was abandoned as dangerous years later, when it was recognized that some patients developed serious complications of malnutrition, leading to liver failure requiring transplantation (Singh et al. 2009). In the absence of any effective therapy for obesity, some advocated wiring the jaws of obese patients shut, but for the most part, surgical intervention for morbid obesity was regarded as unfruitful.

During the first three years of my general surgery residency, I cared for only a handful of patients with morbid obesity, mostly those who had suffered serious complications from the jejunoileal bypass. But something changed during the years I spent in the research laboratory in the middle of my residency. The first

bariatric programs were being introduced in academic medical centers in the mid-1990s, and by the time I returned to finish my training in 2000 after three years in the laboratory, the Roux-en-y gastric bypass (commonly known as stomach stapling) had become one of the most popular treatments for morbid obesity. The procedure had been championed by organizations such as the American Society for Metabolic and Bariatric Surgery (ASMBS), founded in 1983.

Between 1998 and 2004, the national annual rate of "stomach stapling" for obesity would soar by 800% (Lim, Blackburn, and Jones 2010). The field of "bariatric surgery" soon became a very active and lucrative service line within hospitals, and membership in the ASMBS soared to 4,000 surgeons. Caring for morbidly obese patients in America's hospitals required modifications, including larger-sized hospital gurneys and beds, waiting room chairs, CT scanners, operating tables, and other special equipment to accommodate patients over 350 pounds. The gastric bypass became one of the most common operations I performed in the last two years of my surgical residency. According to the Agency for Healthcare Research and Quality, the number of bariatric operations nationally rose nine-fold, from 13,386 in 1998 to 121,055 in 2004 (Nguyen et al. 2011). In 2008, nearly 220,000 patients in America underwent surgery for weight control (at which time the rates plateaued) (Livingston 2010), and the ASMBS estimates that between 2010 and 2015, nearly 1 million Americans underwent one of the various types of bariatric procedures, of which stomach stapling is the most commonly performed procedure.

Ethical controversies and debate arose when the first bariatric procedures were performed on adolescents. Some argued that it was unethical to alter the internal anatomy of teenagers who were suffering from a simple condition that might respond to exercise and diet change. In 2004, Lucille Packard Children's Hospital performed the first adolescent bariatric procedure in California on a teenager, though choosing the laparoscopic band procedure rather than the more radical anatomy-altering gastric bypass. Between 2005 and 2007, 590 adolescents underwent bariatric surgery in California, and by 2009 an estimated 1,000 adolescents in America underwent bariatric surgery annually (Klebanoff et al. 2017). The new thresholds in bariatric surgery from preschoolers in Saudi Arabia have been even more concerning. In 2010, a two-and-a-half-year-old child underwent a sleeve gastrectomy for obesity, following on the heels of a five-year-old who had undergone a similar procedure (Al Mohaidly, Suliman, and Malawi 2013).

But there is a downside of the rise of bariatric surgery too, beyond the anticipated long-term nutrition and micronutrient deficiency (Brito, Montori, and Davis 2017). Complications and catastrophic outcomes from bariatric surgery have become a prime source of medical liability litigation, and there is a lack of surgeons with expertise in bariatric surgery to solve the obesity crisis at a population level (Blackstone 2015). The extra procedures and caring for the complications of bariatric surgery add enormous costs to the health-care delivery system and strain

operating room resources and schedules across America. Later modifications of the gastric bypass that are technically easier to perform (the sleeve gastrectomy), as well as the laparoscopic banding procedure, have proved to be less effective in achieving long-term sustained weight loss or a decrease in cure rates of diabetes after longer-term follow-up, and they have fallen into disfavor (Golomb et al. 2015). For patients who underwent these less invasive procedures, surgery has proved to be a temporary solution.

Hollywood celebrities who have had their stomachs stapled may have contributed to making Americans less concerned about the health risks of being obese and leading them to regard bariatric surgery as a permanent solution. Hearing only the success stories after bariatric surgery (and not the treatment failures with weight regain) may have encouraged Americans to mistakenly believe that being obese is not a problem—and that surgeons have perfected a simple "solution." Celebrity stories are amplified in the media, and perhaps serve as an impetus for others to choose surgery over natural approaches for weight control. The more cautious approach to weight loss, through improved nutrition and increased activity, was reflected in a recent *New York Times* article titled "Think About Options Before Spending $26,000 on Bariatric Surgery" (Castellano 2016).

WHAT IS DRIVING THE EPIDEMIC?

More Americans, including children, either have diabetes or are in the early stages of diabetes than at any time in our history. The increase has come primarily from the increased consumption of sugary beverages. Yet if one reads the arguments of the soda industry and other opponents of warning labels on sugary beverages and soda taxes, the source of this dual epidemic of obesity and diabetes is a mystery. Culprits, they claim, include a lack of exercise, poor parenting, a possible virus, a lack of walkable neighborhoods, processed foods, and lower smoking rates (smoking suppresses appetite), among others (Nestle 2015).

The medical community, including respected organizations like the American Heart Association (AHA) and American Diabetes Association (ADA), has attempted to raise awareness of the problem and promote civic action to build support for education campaigns and taxes on sugary drinks. The soda industry response has catalyzed the soda tax campaigns nationally and worldwide. To try to weaken the further connection to diabetes, industry proponents often argue anecdotally about a thin diabetic that they know personally who consumes soda regularly. What the industry experts are doing here is citing the minority of cases and ignoring the overwhelming majority of obese type 2 diabetics. Part of the confusion also stems from the existence of two distinct types of diabetes. Type 1 juvenile diabetics are often thin due to the inability to store carbohydrates, and this genetic condition typically does not result from soda consumption. Type 2 diabetes accounts for an estimated 90 to 95% of all diabetes cases in the United States, and almost 90% of

people with type 2 diabetes are either obese or overweight. Thus over 80% of all diabetics in America are obese or overweight diabetics (CDC 2011). Soda remains a major source of excess dietary sugar and calories in U.S. diets.

THE MISSING LINK: INSULIN RESISTANCE

As a medical student, one of the more intriguing lessons I learned in physiology classes was the principle of insulin resistance—the inability of peripheral fatty tissues and cells to properly respond to the hormone insulin. Insulin is the hormone of anabolism, telling the body that there are plenty of nutrients around, and to store them. In type 1 juvenile diabetes, the body does not make enough insulin in the pancreas, resulting in elevated blood sugars. These cases represent a small fraction of total diabetes cases (5%), and what is confusing is that type 1 diabetics are often thin, as a dramatic loss of weight is a key symptom of type 1 diabetes. In type 2 diabetes, the body makes normal amounts of insulin, but the peripheral fatty tissues—in other words, obesity—cannot respond properly to the hormonal signals. Type 2 diabetes can be prevented and also cured by losing weight, healthy eating, and being more active.

The current projected risk is that one of every three Americans will develop type 2 diabetes in their lifetime, and the greater concern is that the risk of diabetes rises exponentially as one's BMI increases in a nonlinear fashion. Being overweight increases the risk of developing diabetes five-fold, but being seriously obese increases the risk over 40-fold (Chan et al. 1994). Even more concerning is that while type 2 diabetes is commonly described as "adult onset," it is increasingly being diagnosed in adolescents and teenagers. People who develop type 2 diabetes often have undiagnosed insulin resistance first, before progressing to full-blown diabetes. This is a common precursor in the condition known as prediabetes, which afflicts an estimated 86 million Americans (CDC 2014). The fascinating silver lining is that this condition is reversible. If the excess weight is lost, then the diabetes often resolves. Not many conditions in medicine are so easily curable through a balance of exercise and dietary change.

The other challenge is that this constellation of obesity and diabetes can be wrapped up with other co-morbidities in a condition known as the metabolic syndrome, which includes a whole package of troubling health problems once the BMI crosses 35, including sleep apnea, hypertension, depression, decreased fertility, heartburn, arthritis, and urinary stress incontinence. A BMI between 25 and 30 is defined as overweight, over 30 is obese, and morbid obesity is reached either at a BMI over 35, or if one is over 100 pounds over ideal weight. Recognizing the effectiveness of surgery in treating co-morbidities, the National Institutes of Health recommends that those with coexisting diabetes undergo surgery at a lower BMI threshold of 30, instead of 35 (Arterburn and McCullock 2016). Most insurers will authorize bariatric surgery if the BMI is over 30 and there is coexisting di-

abetes. In 2006, nearly one-third of all patients in the United States undergoing bariatric surgery had coexisting obesity and diabetes (Nguyen et al. 2011). Up to 80% of bariatric patients are able to stop taking diabetes medications two years after surgery as they shed their extra weight—further proof of the relationship between obesity and diabetes (Johnson et al. 2013). The temporary diabetes induced by the weight gain of pregnancy (gestational diabetes) is also further proof of the role of insulin resistance.

As a surgeon, I saw in an interesting manifestation of this silver lining. One of the common procedures a general surgeon performs is to repair incisional hernias, which often result from diabetes, obesity, and smoking. We would routinely counsel patients to lose 10% of their body weight preoperatively. Many frustrated patients would say that losing even five pounds was hard, but others succeeded in losing 50 or 75 pounds or even more. They would often share that while losing the first pounds was the hardest, afterwards the weight loss would accelerate. It became easier to exercise as they carried less body extra weight, they spent less time snacking on processed foods, and their spirits lifted as their body image improved. I also believe they were losing the peripheral fat with insulin resistance first, especially those with an "apple" body type, where they carry more weight around their waist, than those with a "pear" body type, who carry more weight in their hips and thighs.

The triple hazard of soda derives first from undesired weight gain, which results in peripheral insulin resistance and in turn leads to diabetes as a third adverse health impact. Insulin resistance is the missing link. What the soda industry counterarguments are ignoring is the critical link—the fact that the chronic consumption of beverages containing 10 teaspoons of added sugar will contribute to obesity and peripheral fatty tissue deposition. These tissues do not respond to glucose and insulin signals properly, and the peripheral insulin resistance strains the pancreas and accelerates the development of type 2 diabetes. We have now likely witnessed insulin resistance unfold at the level of population health as an entire nation over the past 25 years. In the early 1990s, the United States experienced an epidemic of obesity, followed by an epidemic of diabetes that spiked a decade later. A similar process is now being recognized around the world, jeopardizing global public health. A 2012 *Harvard Gazette* article featuring researchers who were "targeting obesity and its cousin diabetes" reflected that, as a nation, the United States "have been set up" (Powell 2012). We have witnessed an "obese nation, a health crisis," and a "hard-to-escape cycle of weight gain, insulin resistance, and weight-retaining diabetic medication, leading to more pounds." One Harvard professor summarized: "it's not just a trap, it's a trap and a downward spiral."

SUGAR-SWEETENED BEVERAGES AND INSULIN RESISTANCE

Sugary drinks highlight the harm of "liquid sugar." High fructose corn syrup is the most common sweetener used by the beverage industry, and the excess sugar consumption it engenders can also lead to addiction. Consuming solid food sends signals to the brain through a combination of gastric distension, vagal nerve activation, and hormones such as ghrelin that one is full and to stop eating. But these signals to stop eating are reduced from a concentrated liquid sugar diet. Unlike solid foods, our bodies cannot effectively process sugar in liquid form, creating a stress to the liver and pancreas that result in a greater weight gain than from consuming solid food with an equal calorie content. The danger from the average 12-ounce soda is the 10 teaspoons of sugar dissolved within—a danger that is not obvious to the drinker, who may mistakenly believe that the caloric content is similar to water. On average, the content of a packet of sugar is one teaspoon. Imagine if you were to observe someone at a café adding eight packets of sugar to their coffee. Individuals who regularly drink sugar-sweetened beverages also often have less healthy diets, containing fewer vegetables, higher sodium, and more processed meats, and they often are consuming empty calories with fewer nutritional benefits (Micha et al. 2017). Sodas are the number one source of added sugars in U.S. diets. Combined with inadequate physical activity, excessive sugar-sweetened beverage consumption has contributed to millions of individuals becoming overweight and obese over the past years; these actions are also detrimental to heart and brain health. Drinking just one sugary beverage a day increases the risk of developing type 2 diabetes by 26%.

EMERGING AWARENESS OF A NEW PUBLIC HEALTH PROBLEM

In the early 2000s, the AHA led the way in characterizing the accelerating public health crisis of both childhood and adult obesity. As early as 1977, internal Coca-Cola documents discussed the possible connection between soda consumption and obesity and tried to counterargue that genetics was the key determinant of obesity (Nestle 2015). The dramatic increase in obesity rates that first began in the 1980s and then spiked in the 1990s (following the popularity of supersized soft drinks) was the focus of several AHA initiatives. In 2000, the World Health Organization recognized obesity as a global epidemic. In 2006, the Alliance for a Healthier Generation, a joint AHA initiative in partnership with the Clinton Foundation, was formed to address childhood obesity. One area of focus was the removal of full-calorie soft drinks in schools across the country and their replacement with smaller, lower-calorie options (Laberthe 2011). The spike in diabetes was not yet fully recognized because of the time lag of years between first becoming obese, then developing insulin resistance and later diabetes. But the diabetes

spike would logically follow in the mid-1990s and peak by 2003. The increased rates of adult onset diabetes in children and adolescents have been relatively recent in most populations (Dabalea et al. 2017).

My own awareness of the soda-related obesity problem emerged after I finished my residency in general surgery in 2002 and became a health-care policy fellow at the University of California–San Francisco, where I learned about the decades-long tobacco wars, the tobacco control champions at UCSF, and the tactics and strategy of Big Tobacco to confuse the science, influence our legislators, and challenge public health legislation in court. Subsequently, as a junior faculty member at UCSF, I met pediatric endocrinologist Robert Lustig. In 2009, Lustig produced a YouTube video on "The Bitter Truth" about sugar, which has now been viewed by nearly 7 million people. In that video, Lustig highlights the special health hazards from sugar in its liquid form. The *Financial Times* has called the revelations in the video "sugar's tobacco moment" (Kaminska 2016). I also worked with health services researcher Laura Schmidt at UCSF, who has made invaluable academic contributions towards the conceptualization of a soda tax in San Francisco.

TAXING SODA AND THE PARALLELS WITH BIG TOBACCO

The goal of the soda tax efforts is to find an alternative, nonsurgical solution to the global obesity and diabetes epidemics. The major value of the soda tax campaigns is to raise awareness among regular sugary beverage drinkers so that they reduce their sugar intake for their own benefit. From that perspective, even soda tax campaigns that result in defeat at the ballot box remain a victory by educating voters of the health hazards of sugary drinks.

When President Obama raised the concept of a national soda tax in 2009, the beverage industry went into overdrive and spent millions of dollars to lobby Congress to ensure this idea was never introduced into the drafting of the Affordable Care Act. In California, efforts to tax soda statewide trace back to Senate Bill 1520, which was introduced in 2002, but decades of overwhelming beverage industry lobbying had resulted in the defeat of the handful of soda tax bills in Sacramento. In 2009, the San Francisco Medical Society (SFMS) succeeded in having the California Medical Association (CMA) support increased taxes on sodas and other relevant sugar-sweetened beverages, but an early effort in 2011 to introduce a soda tax in San Francisco vanished under an onslaught of soda industry lobbying. That same year, the SFMS introduced a second CMA resolution to reduce the marketing of unhealthy foods and beverages to children, which would lead to legislative efforts in Sacramento to ban sugary drinks from being sold on school campuses. This would help to inspire Senate Bill 1000 in Sacramento in 2014, which sought to place a warning label on sodas. The bill was defeated in the face of overwhelming industry lobbying (Maa 2014).

My professional research had been focused on reducing the impact of smoking on surgical outcomes, leading me to become very involved with the Proposition 29 tobacco tax campaign in June 2012. In the fall of 2012, I attended a presentation in which Councilman Jeff Ritterman, a doctor, spoke about a recent effort to tax soda in Richmond, a city across the Bay from San Francisco. What I heard from Ritterman was an inspiration. Though the Richmond soda tax was defeated by a two-to-one margin, it was one of the first salvos in the U.S. soda wars. Ritterman also pointed to how Big Soda was using strategies earlier employed by Big Tobacco to defeat the soda tax campaign. There were striking similarities in the overall messaging by the opposition, particularly in the attempts to minimize the overall dangers of their products to the health of the public. One of the most powerful arguments in support of the Richmond soda tax was the effectiveness of cigarette taxes in significantly reducing the smoking epidemic. The numerous precedents for warning labels, advertising restrictions, and policies restricting use of public funds for substances such as tobacco and alcohol would also prove very powerful in the Richmond soda tax campaign.

Within months, Lustig's work with the Mexican government resulted in passage of Mexico's landmark 2013 soda tax, which would accelerate efforts back home in the United States. The early data after Mexico instituted its tax in January 2014 demonstrated an immediate effect, with national soda consumption falling by an estimated 7%. In the latter half of 2013, I received a call from the communications firm of Erwin and Muir inviting me to assist with the San Francisco soda tax (Proposition E, or Prop E) campaign that was beginning to organize, and to speak at the press conference kickoff with San Francisco Supervisors Scott Wiener, Malia Cohen, David Chiu, and Eric Mar. I serve on the Board of Directors of both the AHA and the SFMS, two organizations that have endorsed sugar-sweetened beverage bills in Sacramento and San Francisco. Both organizations would later speak at the San Francisco City Hall hearings, press events, and newspaper editorial meetings on behalf of the soda tax, and they were featured in the Voter Information pamphlet in support of the measure.

Prop E sought to provide up to $54 million for physical education and nutrition programs in San Francisco public schools, active recreation programs, food access, oral health and dental programs, water fountains, and water bottle filling stations citywide through a 2¢ per ounce special tax, paid by the distributors of sugary beverages (Maa 2014). As a special tax, it would require a two-thirds majority to pass, and the revenue would not go into the general program but instead support the designated special programs. The effort was supported by the CMA, the California Nurses Association, and the California Dental Association. Several months later, soda tax advocates announced that the City of Berkeley would place a 1¢ per ounce tax on the November 2014 ballot; as a general tax, it would only require a simple majority to pass. Instead of supporting specific programs, the funds would be deposited into the City's general fund.

The Bay Area campaigns that ensued in the following months were followed closely across the nation. The soda industry shattered all local records by spending more than $10 million to defeat Prop E in San Francisco, utilizing the funds for an aggressive mail, television, billboard, and marketing campaign to portray the tax as regressive, and arguing that its passage would make living in San Francisco unaffordable. The Yes campaign was massively outspent and relied heavily on earned media counter-messages against the avalanche of soda industry advertising. In the smaller city of Berkeley, campaign manager Larry Tramutola focused on a door-to-door campaign and community activism to build public support; the campaign eventually attracted a major financial investment by Bloomberg Philanthropies to run television advertisements in support of the tax and to combat the tidal wave of $2.4 million spent by Big Soda. The proximity of a sister campaign across the Bay benefitted both the Berkeley and San Francisco campaigns, and as the election approached, the two campaigns began to host joint press events to unify their efforts. This twin-city approach was highly effective. Earned media carried a double impact, and paid media reached voters in both cities, some of whom might work in San Francisco and live in Berkeley or vice versa. Election night was a success on both fronts: Prop D passed with over 75% of the vote, as Berkeley became the first city in America to pass a soda tax. Although Prop E in San Francisco failed, there was a silver lining in the defeat. Despite being heavily outspent 35 to 1, Prop E had garnered nearly 56% of the vote. This was short of the two-thirds majority required for passage, but the fact that a majority of voters had supported the soda tax provided the strongest polling data that a general soda tax effort (requiring only a simple majority) could succeed in San Francisco in the future. The only question would be when?

In the afterglow of the Berkeley Prop D victory, valuable lessons were identified. Berkeley's mayor and the entire City Council endorsed Prop D, unlike San Francisco, where four Supervisors voted against placing Prop E on the ballot. Matching the soda industry dollar-for-dollar in raising campaign funds was not required: instead, keeping the ratio of being outspent by the industry to around three to one could successfully get the message out. For me, the most striking realization was that nearly the identical public relations, campaign managers, communications firms, lobbyists, and legal teams used by Big Tobacco to defeat Prop 29 had been employed to defeat Prop E. We were fighting a common opponent.

In 2016, Philadelphia Mayor Jim Kenney looked to improve health outcomes in Philadelphia, as well as to provide needed improvements to city services, and proposed a tax on sugary beverages. Unlike California cities, in Philadelphia, the City Council has taxing authority. New York Mayor Michael Bloomberg and the AHA helped Mayor Kenney stand up against a vigorous $11.2 million campaign by the beverage industry, and Philadelphia Council members voted to support the tax.

In the fall of 2016, the San Francisco Bay Area became ground zero for the soda wars. In the intervening 20 months, Supervisors Wiener, Mar, and Cohen had kept busy at San Francisco City Hall with a set of legislative proposals signed by the Mayor to place a warning label about sugary drinks on billboards, buses, transit shelters, sports stadiums, and posters, to limit sugary drink sales on City property and in vending machines, and to reduce the impact of industry advertising (Maa 2015). These efforts kept the American Beverage Association (ABA) attorneys occupied, as a legal challenge to the warning label would find its way first to federal court and then to an appeal in the 9th District Court. An injunction motion by the ABA blocking the implementation of the San Francisco soda warning label is still waiting to be ruled upon as of the writing of this article. Another focus in the intervening months was to organize and strengthen the scientific arguments for the upcoming public debate.

The successful 2016 efforts in San Francisco with Prop V rested on the foundation built by the 2014 Prop E campaign. Larry Tramutola, the winning campaign manager from Berkeley's Prop D, was brought back to lead another twin-city effort: San Francisco and Oakland. After careful consideration, the San Francisco soda tax Prop V was placed on the ballot by Supervisor Cohen, this time as a general tax without the need for a full vote at City Hall, and with a strong endorsement by Mayor Ed Lee. Only a simple majority would be needed for victory. In Oakland, a nearly identical Measure HH was spearheaded by Vice Mayor Annie Campbell Washington and received the support of the entire City Council and Oakland Mayor Libby Schaaf.

The game changer in San Francisco was the generous $10 million support from Michael Bloomberg, who, along with the Arnold family, contributed over $12 million to oppose the $22.6 million spent by Big Soda to defeat Prop V. This total of nearly $35 million spent by both sides on a local initiative in San Francisco easily dwarfed the record $10 million spent in 2014 to defeat Prop E, and stands as a record nationally for the amount spent on a local measure in a single city. A similar investment was made in Oakland, and the final expenditures by the beverage industry to defeat both Prop V and Measure HH surpassed $30 million.

Another change in 2016 was that the messaging was crystal clear, concise, and scientifically strong, and the talking points encompassed the dual threats of obesity and diabetes, along with tooth decay. The extra campaign funds helped support phone banking, canvassing, social media, technology devices, and additional outreach that had been unavailable for Prop E. Separate campaign managers were brought on in both Oakland (Diane Woloshin) and San Francisco (Monica Chinchilla) to implement the overarching plan of Larry Tramutola. The aerial coverage in support of both soda taxes with paid media, mailers, and signage complemented a series of earned media in *Politico*, the Associated Press, Reuters, the *New York Times*, the *San Francisco Chronicle* (by journalist Heather Knight), and elsewhere.

The passion, determination, dedication and hard work of the coordinated campaign teams in both cities are what ultimately carried the campaign to victory.

Another beneficiary was the tiny city of Albany, which neighbors Berkeley to the north, and which placed an identical 1¢ per ounce general tax named Measure O1 on the same ballot. Advocates raised just over $6,000, and the ABA spent $185,000 to try to defeat this measure, which quietly moved forward in the updraft of the massive battles in neighboring Oakland and San Francisco.

Soda taxes in the Bay Area became a Goliath versus Goliath battle of epic media proportions, dominating the television airwaves through the election season. It was noteworthy that the spokespersons for the soda industry had become repetitive and tangential in their media response, choosing an unusual path of trying to argue that the soda tax was a grocery tax. This argument failed in Philadelphia, failed again to resonate with voters in the Bay Area, and would result in ethics complaints against the ABA in both cities after an Alameda County Superior Court judge ruled that the soda tax was not a grocery tax. Another error on the part on the ABA was to use archived video of Senator Bernie Sanders to imply that he opposed PropV and Measure HH. Senator Sanders's subsequent request to the ABA to stop utilizing his likeness in their television commercials would garner national attention and raise public suspicion of the Big Soda ads with the voters.

After overwhelming victories on the November 8, 2016 ballot in San Francisco (won with 62%), Oakland (won with 61%), Albany (won with 71%) and Boulder, Colorado (won by an eight-point margin), other cities quickly followed suit. A movement had caught fire. In Cook County, Illinois (which includes Chicago), a 1¢ per ounce soda tax was approved by the City Council on November 10. Santa Fe, New Mexico, announced plans for a 2017 soda ballot measure shortly thereafter, and Seattle and Portland would soon follow. A media spokeswoman for the soda industry tried to downplay the significance of these ballot victories, claiming that the taxes had only passed in the most liberal of American cities. But the attention of the world had been captured. The string of victories in the United States has sent a strong message with worldwide significance. At the 3rd World Innovation Summit in Health in Doha, Qatar, in November 2016, 1,400 health leaders from over 100 nations convened to discuss novel strategies to reform health care and control rising global health-care costs. The momentum of soda taxes in America was discussed during the plenary sessions, and also during a special panel session on improving cardiovascular health. Ireland, Oman, South Africa, and the United Kingdom would soon either announce or finalize their plans for national soda taxes.

THE LEGAL CHALLENGES

Another beverage industry strategy borrowed from the tobacco industry has been to challenge soda taxes and advocacy successes in court, in an effort to either overturn or delay the implementation of sugary drink legislation. In 2014, the soft drink industry achieved a victory when the New York State Court of Appeals ruled that New York City could not limit sales on jumbo sugary drinks (Grynbaum 2014). Later that year, the Alameda County Superior Court ruled partly in favor of two Berkeley residents who filed a lawsuit to change the phrases "high-calorie, sugary drinks" and "high-calorie, low nutrition products" in ballot materials to the phrase "sugar sweetened beverages" (Raguso 2014). However, the judge dismissed their companion claim, which sought to remove the statement that the sugary drink tax would be paid by distributors, and "not the customer." This theme would return as the core of an August 2016 lawsuit by the ABA against the City of Oakland to remove the Measure HH ballot statement that "this tax is not paid by your local grocer." An Alameda County Court Commissioner ruled against the soda industry, writing further that Measure HH was indeed a soda tax, and not a grocery tax (BondGraham 2016).

In addition to the ABA litigation against the trio of San Francisco sugary drink bills in 2015, the beverage industry also filed a lawsuit over the Philadelphia soda tax in 2016, arguing that the soda tax there would duplicate existing sales taxes and interfere with a federal mandate regarding SNAP funds. The Court of Common Pleas struck down this lawsuit on all counts in December 2016 (Erb 2016); an immediate appeal was filed with the Commonwealth Court, and the matter is likely destined for the Pennsylvania Supreme Court. In the interim, the Philadelphia soda tax was implemented January 1, 2017, and in the first month collected $5.7 million in revenue for the city (Zwirn 2017). Throughout the Philadelphia soda tax campaign, the beverage industry had promised swift legal action to challenge the tax in court if it passed. Similar pledges were made against Measure HH and Prop V, and time will reveal if similar legal efforts to block soda tax implementation are filed in San Francisco, Oakland, Albany, Boulder, or Cook County. The outcomes of both the soda warning label litigation currently in the 9th District Court of Appeals, and the soda tax litigation headed to the Philadelphia Supreme Court will likely guide the next steps by the beverage industry in the courtroom. If an increasing number of cities nationally pass soda taxes through the ballot box, the ability of the industry to challenge each in local courts may be strained; a likely alternative strategy will be to file a challenge directly with the U.S. Supreme Court.

Thus far, the legal actions by the beverage industry have followed the early tobacco industry playbook, using the legal system to protect their interests or oppose control legislation in the role of plaintiff. But the tables turned for the tobacco industry following the disclosure of cigarette industry documents revealing that the tobacco companies were aware of the addictive properties of tobacco.

The tipping point for Big Tobacco came with the Tobacco Master Settlement of 1998, after the Attorneys General of 46 states successfully sued the largest cigarette manufacturers for tobacco-related health-care costs and the adverse impact on Medicaid. In early 2017, the Center for Science in the Public Interest and the Praxis Project jointly filed a lawsuit in federal court alleging that Coca-Cola and the ABA had misled the public about the health hazards of sugary drinks (Rodionova 2017). The case was later dropped by the plaintiffs, but it signaled a new era of litigation where the beverage industry was placed in the role of defendant.

FUTURE POLICY INITIATIVES

Soda tax advocacy efforts nationally should continue as a multi-pronged effort that includes warning labels on sugary drinks, changing to milk and water as the default options for kids' meals in restaurants, and reforms to procurement policies to reduce the amount of processed foods and sugar-sweetened beverages in government cafeterias, vending machines, and in schools. A major victory for public health that came during the 2016 soda tax campaigns was the announcement from the FDA and the Obama Administration that an "added sugar" label for packaged foods would be required by July of 2018. This new label would allow consumers to compare foods and make more informed choices about their intake to promote health, but the implementation of the new rule was placed on hold by the Trump Administration in 2017. In 2014, Congresswoman Rosa DeLauro (D, Connecticut) introduced the Sugar-Sweetened Beverages Tax Act (the SWEET Act), and efforts at the federal level to tax sugary drinks merit careful consideration. Another area of further discussion at the federal level is the removal of sugary drinks from purchasing in the SNAP program, as the billions of dollars spent nationally on soda represents an estimated $4 billion annual subsidy to the soda industry (Nestle 2015). Any changes to the SNAP program should be undertaken without creating an undue economic burden or stigma on low-income consumers. The special area of focus remains low-income consumers and communities of color, where policy leaders will need to intervene to help decrease consumption of soda and sugary beverages. Their neighborhoods are aggressively marketed to, and many times a bottle of soda is less expensive than a bottle of water at a corner store. Ultimately, a deeper understanding of the business model of the beverage industry, their sources of federal and state support, and drivers of their profitability may enable the creation of a new mechanism to tax sugary drinks that cannot be passed on to consumers.

In the aftermath of these advocacy successes, AHA CEO Nancy Brown reflected that the soda tax victories have demonstrated that cities and residents have the power to initiate positive change. After the victory in Philadelphia, she remarked, "What really excites me is the chance this is the beginning of a trend. Simply put, it's a movement that prioritizes heart-healthy habits over beverage in-

dustry profits" (Brown 2016). Summarizing the keys to success, Brown concluded: "We've been there all along—representing all Americans—with our science, education, and advocacy."

THE FUTURE FROM THE SURGEON'S PERSPECTIVE

Over the ensuing decades, millions of lives and precious health-care resources will be saved by these national efforts to tax sugary drinks. As a general surgeon, I have witnessed firsthand the epidemic of obesity and diabetes that has ravaged the United States over the past decades, and it was in an effort to reverse these national trends that I first became involved with Prop E in 2014. The passage of Prop V will help greatly in the larger goal. Lives will be saved, and quality of life will be improved for diabetics who no longer suffer falls after losing their eyesight from diabetic retinopathy, suffer complications from dialysis after suffering kidney failure, sustain heart attacks from coronary arterial disease, or struggle with disability after an amputation. Obese patients will experience fewer cases of osteoarthritis leading to joint replacements, sleep apnea and respiratory disease, gallstone formation leading to episodes of pancreatitis and acute inflammation, and fatty liver disease leading to liver transplant. Healthier patients will suffer fewer episodes of depression or bullying in school over their weight, and will experience longer and more productive and satisfying lives. The funds from the tax will help improve nutrition, physical activity, and water access for children, and the health of the public will be promoted as these children return home to educate their parents, siblings, grandparents, and friends about healthier lifestyles and beverage choices. Medical students in the future will read in their physiology textbooks about the enormous impact of Prop V and soda taxes in improving patient health across organ systems.

CONCLUSION

Given the current and projected severity of the obesity and diabetes epidemics among children and adults, a coordinated strategy is necessary to assist individuals in achieving and maintaining healthy weight. If we do nothing to address this health crisis, one in three children today will develop type 2 diabetes in their lifetime; for children of color, the risk is one in two. The consequences of obesity and diabetes are many and severe, including health concerns and economic costs. The decade-long movement to tax soda has likely reached an inflection point that signals the start of a movement to adopt healthy and viable taxes on sugar. Ultimately, the larger purpose of the soda tax effort is to raise awareness among the general public of the high sugar content in sugary drinks and to empower them to make healthier decisions for their own nutrition and health. Most importantly, the soda industry is now presented with the opportunity to change, and to not follow the path of the tobacco industry. By crafting healthier beverages with lower sugar and calorie content, it can be a win-win for the United States.

REFERENCES

Al Mohaidly, M., A. Suliman, and H. Malawi. 2013. "Laparoscopic Sleeve Gastrectomy for a Two-and-a-Half-Year-Old Morbidly Obese Child." *Int J Surg Case Rep* 4 (11): 1057–60.

Arterburn, D., and D. McCullock. 2016. "Bariatric Surgery for Type 2 Diabetes: Getting Closer to the Long-Term Goal." *JAMA* 315 (12): 1276–77.

Begley, S. 2012. "As America's Waistline Expands, Costs Soar." *Reuters*. April 30. http://www.reuters.com/article/us-obesity-idUSBRE83T0C820120430.

Blackstone, R. P. 2015. "Is Metabolic and Bariatric Surgery a Population Solution for Obesity and Type 2 Diabetes?" *JAMA Surg* 150 (12): 1124–25.

BondGraham, D. 2016. "'Big Soda' Loses in Court to Oakland." *East Bay Express*, Sept. 2.

Brito, J. P., V. M. Montori, and A. M. Davis. 2017. "Metabolic Surgery in the Treatment Algorithm for Type 2 Diabetes: A Joint Statement by International Diabetes Organizations." *JAMA* 317 (6): 635–36.

Brown, N. 2016. "Cheers! Why I'm Celebrating the Sweet Victory of the Philadelphia Sugary Drink Tax." *Huffington Post*, June 16.

Castellano, D. 2016. "Before You Spend $26,000 on Weight-Loss Surgery, Do This." *NY Times*, Sept. 10.

Centers for Disease Control and Prevention (CDC). 2011. *National Diabetes Fact Sheet, 2011*. Atlanta: HHS/CDC. https://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

Centers for Disease Control and Prevention (CDC). 2014. *National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2014*. Atlanta: CDC. http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf.

Chan, J. M., et al. 1994. "Obesity, Fat Distribution, and Weight Gain as Risk Factors for Clinical Diabetes in Men." *Diabetes Care* 17 (9): 961–69.

Dabalea, D., et al. 2017. "Association of Type 1 Diabetes vs Type 2 Diabetes Diagnosed During Childhood and Adolescence with Complications During Teenage Years and Young Adulthood." *JAMA* 317 (8): 825–35.

Erb, K. P. 2016. "Judge Dismisses Soda Tax Lawsuit Against City of Philadelphia." *Forbes*, Dec. 19.

Glickman, D., et al. 2012. *Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation*. Washington, DC: National Academies Press.

Golomb, I., et al. 2015. "Long Term Metabolic Effects of Laparoscopic Sleeve Gastrectomy." *JAMA Surg* 150 (11): 1051–57.

Grynbaum, M. M. 2014. "New York's Ban on Big Sodas Is Rejected by Final Court." *NY Times*, June 26.

Hill, J., M. Nielsen, and M. H. Fox. 2013. "Understanding the Social Factors that Contribute to Diabetes: A Means to Informing Health Care and Social Policies for the Chronically Ill." *Perm J* 17 (2): 67–72.

Johnson, B. L., et al. 2013. "Bariatric Surgery Is Associated with a Reduction in Major Macrovascular and Microvascular Complications in Moderately to Severely Obese Patients with Type 2 Diabetes Mellitus." *J Am Coll Surg* 216 (4): 545–56.

Kaminska, I. 2016. "Robert Lustig: Godfather of the Sugar Tax." *Financial Times*, March 18.

Klebanoff, M. J., et al. 2017. "Cost-Effectiveness of Bariatric Surgery in Adolescents with Obesity." *JAMA Surg* 152 (2): 136–41.

Laberthe, D. R. 2011. *Epidemiology and Prevention of Cardiovascular Diseases: A Global Challenge.* Burlington, MA: Jones and Bartlett.

Laiteerapong, N., and A. S. Cifu. 2016. "Screening for Prediabetes and Type 2 Diabetes Mellitus." *JAMA* 315 (7): 697–98.

Lim, R. B., G. L. Blackburn, and D. B. Jones. 2010. "Benchmarking Best Practices in Weight Loss Surgery." *Curr Probl Surg* 47 (2): 79–174.

Livingston, E. H. 2010. "The Incidence of Bariatric Surgery Has Plateaued in the US." *Am J Surg* 200 (3): 378–85.

Maa, J. 2014. "Vote Yes on Proposition E: The SFMS Champions the San Francisco Soda Tax." *San Fran Med* 87 (8): 16.

Maa, J. 2015. "Mayor Ed Lee Approves SFMS-Endorsed Sugar Sweetened Beverage Ordinances." *San Fran Med* 88 (6): 29–31.

Menke, A., et al. 2015. "Prevalence and Trends in Diabetes Among Adults in the United States, 1988–2012." *JAMA* 314 (10): 1021–29.

Micha, R., et al. 2017. "Association Between Dietary Factors and Mortality from Heart Disease, Stroke, and Type 2 Diabetes in the United States." *JAMA* 317 (9): 921–24.

Nestle, M. 2015. *Soda Politics: Taking on Big Soda (and Winning).* Oxford: Oxford University Press.

Nguyen, N. T., et. al. 2011. "Trends in Use of Bariatric Surgery, 2003–2008." *J Am Coll Surg* 213 (2): 261–66.

"Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation." 2000. *World Health Organ Tech Rep Ser* 894: i–xii, 1–253.

Powell, A. 2012. "Obesity? Diabetes? We've Been Set Up." *Harvard Gazette*, March 7.

Raguso, E. 2014. "Judge Changes Berkeley 'Soda Tax' Ballot Language." *Berkeleyside*, Sept. 14.

Reusch, J. E. B., and J. E. Manson. 2017. "Management of Type 2 Diabetes in 2017: Getting to Goal." *JAMA* 317 (10): 1015–16.

Rodionova, Z. 2017. "Coca-Cola Accused of Using Tobacco Industry Tactics to Mislead Public over Health Effects of Its Fizzy Drinks." *Independent*, Jan. 5.

Singh, D., et. al. 2009. "Jejunoileal Bypass: A Surgery of the Past and a Review of Its Complications." *World J Gastroenterol* 15 (18): 2277–79.

Zwirn, E. 2017. "Philly's Soda Tax Is Crushing the City's Beverage Business." *NY Post*, March 5.

Taxing Soda

strategies for dealing with the obesity and diabetes epidemic

John Maa

ABSTRACT Over the past several decades, the United States has been experiencing a twin epidemic of obesity and type 2 diabetes. Recently, advocacy efforts to tax sugary drinks, place warning labels on soda, improve nutritional labeling, and reduce sugar overconsumption have swept across the nation to address public health concerns from sugary drinks that strain our nation's health-care resources. In this article, the historical and scientific framework of this public health policy and valuable lessons learned from implementation efforts thus far will be examined to shape the next steps forward for the movement. Additional goals of this article are to share a surgeon's perspective about trends in bariatric surgery and the link between obesity and type 2 diabetes as a result of peripheral insulin resistance.

Obesity is one of the most common health problems facing children and society today. Since 1960, the obesity rate among adults has risen to 34% in the United States, and morbid obesity is up six-fold (Glickman et al. 2012). In

Division of General and Trauma Surgery, Marin General Hospital, Greenbrae, CA.
Correspondence: 5 Bon Air Road, #101, Larkspur, CA 94939.
E-mail: maaj@maringeneral.org.

Decades from now, the benefits from the passage of Prop V will likely have an enduring impact in San Francisco, across the nation, and around the globe. The world may likely not recall the names of those individuals who decades earlier battled the soda industry over this life-saving measure in 2016, but the intent of this article is to chronicle those individuals who played an important role in this victory. The author would like to dedicate this article in deep appreciation and gratitude to Mayor Michael Bloomberg, for making the difference and being the margin of victory in Berkeley, Philadelphia, San Francisco, and Oakland in particular.

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1980, only 14% of adult Americans were obese, but this figure had skyrocketed to 31% by 2000 (nearly 85 million Americans). Two out of three Americans today are overweight or obese, and one in 20 suffers from extreme obesity. In 2012, Reuters reported that obesity in America added $190 billion to annual national health-care costs, passing smoking for the first time (Begley 2012).

Following closely on the heels of this epidemic is an explosion in the number of cases of diabetes, particularly among children, which has been steadily increasing since a spike in 2003. According to the Centers for Disease Control, the rate of diabetes soared from 5.8 million in 1980, to 17.9 million in 2009, and reached 29.1 million in 2014 (1 of 11 people in the United States) (Reusch and Manson 2017). This represents 9.3% of the population (21 million diabetics are diagnosed, while another 8.1 million are undiagnosed). Diabetes added another $245 billion to national costs in 2012, including both medical costs and lost wages, and one out of 10 health-care dollars is attributed to the care of patients with diabetes (Hill, Nielsen, and Fox 2013; Menke et al. 2015). Particularly concerning is the explosion of type 2 "adult onset" diabetes that is now being increasingly diagnosed in adolescents and teenagers (Dabalea et al. 2017). Many researchers attribute this second wave as resulting from the epidemic of childhood obesity. Together, obesity and diabetes increase the risk of cardiovascular disease (both heart disease and stroke), renal failure, peripheral vascular disease, depression, dementia, retinal disease, and the risk of amputation (Laiteerapong and Cifu 2016). Type 2 diabetes and obesity are both a cyclical process; they result from and contribute to poorer health-care outcomes (Hill, Nielsen, and Fox 2013). Strategies to reduce the trillions spent each year on health care must find ways to curb the dual tidal waves of obesity and diabetes and the resulting economic burden.

The Rise of Bariatric Surgery

As a medical student in the early 1990s, I never scrubbed for an operation of a patient requiring obesity surgery. This was likely the result of a very valuable lesson learned by the profession of general surgery decades prior. Between the 1960s and the 1980s, the jejunoileal bypass (which bypassed all but 30 cm of the intestinal tract) had been championed as the solution to morbid obesity. The procedure was abandoned as dangerous years later, when it was recognized that some patients developed serious complications of malnutrition, leading to liver failure requiring transplantation (Singh et al. 2009). In the absence of any effective therapy for obesity, some advocated wiring the jaws of obese patients shut, but for the most part, surgical intervention for morbid obesity was regarded as unfruitful.

During the first three years of my general surgery residency, I cared for only a handful of patients with morbid obesity, mostly those who had suffered serious complications from the jejunoileal bypass. But something changed during the years I spent in the research laboratory in the middle of my residency. The first

bariatric programs were being introduced in academic medical centers in the mid-1990s, and by the time I returned to finish my training in 2000 after three years in the laboratory, the Roux-en-y gastric bypass (commonly known as stomach stapling) had become one of the most popular treatments for morbid obesity. The procedure had been championed by organizations such as the American Society for Metabolic and Bariatric Surgery (ASMBS), founded in 1983.

Between 1998 and 2004, the national annual rate of "stomach stapling" for obesity would soar by 800% (Lim, Blackburn, and Jones 2010). The field of "bariatric surgery" soon became a very active and lucrative service line within hospitals, and membership in the ASMBS soared to 4,000 surgeons. Caring for morbidly obese patients in America's hospitals required modifications, including larger-sized hospital gurneys and beds, waiting room chairs, CT scanners, operating tables, and other special equipment to accommodate patients over 350 pounds. The gastric bypass became one of the most common operations I performed in the last two years of my surgical residency. According to the Agency for Healthcare Research and Quality, the number of bariatric operations nationally rose nine-fold, from 13,386 in 1998 to 121,055 in 2004 (Nguyen et al. 2011). In 2008, nearly 220,000 patients in America underwent surgery for weight control (at which time the rates plateaued) (Livingston 2010), and the ASMBS estimates that between 2010 and 2015, nearly 1 million Americans underwent one of the various types of bariatric procedures, of which stomach stapling is the most commonly performed procedure.

Ethical controversies and debate arose when the first bariatric procedures were performed on adolescents. Some argued that it was unethical to alter the internal anatomy of teenagers who were suffering from a simple condition that might respond to exercise and diet change. In 2004, Lucille Packard Children's Hospital performed the first adolescent bariatric procedure in California on a teenager, though choosing the laparoscopic band procedure rather than the more radical anatomy-altering gastric bypass. Between 2005 and 2007, 590 adolescents underwent bariatric surgery in California, and by 2009 an estimated 1,000 adolescents in America underwent bariatric surgery annually (Klebanoff et al. 2017). The new thresholds in bariatric surgery from preschoolers in Saudi Arabia have been even more concerning. In 2010, a two-and-a-half-year-old child underwent a sleeve gastrectomy for obesity, following on the heels of a five-year-old who had undergone a similar procedure (Al Mohaidly, Suliman, and Malawi 2013).

But there is a downside of the rise of bariatric surgery too, beyond the anticipated long-term nutrition and micronutrient deficiency (Brito, Montori, and Davis 2017). Complications and catastrophic outcomes from bariatric surgery have become a prime source of medical liability litigation, and there is a lack of surgeons with expertise in bariatric surgery to solve the obesity crisis at a population level (Blackstone 2015). The extra procedures and caring for the complications of bariatric surgery add enormous costs to the health-care delivery system and strain

operating room resources and schedules across America. Later modifications of the gastric bypass that are technically easier to perform (the sleeve gastrectomy), as well as the laparoscopic banding procedure, have proved to be less effective in achieving long-term sustained weight loss or a decrease in cure rates of diabetes after longer-term follow-up, and they have fallen into disfavor (Golomb et al. 2015). For patients who underwent these less invasive procedures, surgery has proved to be a temporary solution.

Hollywood celebrities who have had their stomachs stapled may have contributed to making Americans less concerned about the health risks of being obese and leading them to regard bariatric surgery as a permanent solution. Hearing only the success stories after bariatric surgery (and not the treatment failures with weight regain) may have encouraged Americans to mistakenly believe that being obese is not a problem—and that surgeons have perfected a simple "solution." Celebrity stories are amplified in the media, and perhaps serve as an impetus for others to choose surgery over natural approaches for weight control. The more cautious approach to weight loss, through improved nutrition and increased activity, was reflected in a recent *New York Times* article titled "Think About Options Before Spending $26,000 on Bariatric Surgery" (Castellano 2016).

What Is Driving the Epidemic?

More Americans, including children, either have diabetes or are in the early stages of diabetes than at any time in our history. The increase has come primarily from the increased consumption of sugary beverages. Yet if one reads the arguments of the soda industry and other opponents of warning labels on sugary beverages and soda taxes, the source of this dual epidemic of obesity and diabetes is a mystery. Culprits, they claim, include a lack of exercise, poor parenting, a possible virus, a lack of walkable neighborhoods, processed foods, and lower smoking rates (smoking suppresses appetite), among others (Nestle 2015).

The medical community, including respected organizations like the American Heart Association (AHA) and American Diabetes Association (ADA), has attempted to raise awareness of the problem and promote civic action to build support for education campaigns and taxes on sugary drinks. The soda industry response has catalyzed the soda tax campaigns nationally and worldwide. To try to weaken the further connection to diabetes, industry proponents often argue anecdotally about a thin diabetic that they know personally who consumes soda regularly. What the industry experts are doing here is citing the minority of cases and ignoring the overwhelming majority of obese type 2 diabetics. Part of the confusion also stems from the existence of two distinct types of diabetes. Type 1 juvenile diabetics are often thin due to the inability to store carbohydrates, and this genetic condition typically does not result from soda consumption. Type 2 diabetes accounts for an estimated 90 to 95% of all diabetes cases in the United States, and almost 90% of

people with type 2 diabetes are either obese or overweight. Thus over 80% of all diabetics in America are obese or overweight diabetics (CDC 2011). Soda remains a major source of excess dietary sugar and calories in U.S. diets.

The Missing Link: Insulin Resistance

As a medical student, one of the more intriguing lessons I learned in physiology classes was the principle of insulin resistance—the inability of peripheral fatty tissues and cells to properly respond to the hormone insulin. Insulin is the hormone of anabolism, telling the body that there are plenty of nutrients around, and to store them. In type 1 juvenile diabetes, the body does not make enough insulin in the pancreas, resulting in elevated blood sugars. These cases represent a small fraction of total diabetes cases (5%), and what is confusing is that type 1 diabetics are often thin, as a dramatic loss of weight is a key symptom of type 1 diabetes. In type 2 diabetes, the body makes normal amounts of insulin, but the peripheral fatty tissues—in other words, obesity—cannot respond properly to the hormonal signals. Type 2 diabetes can be prevented and also cured by losing weight, healthy eating, and being more active.

The current projected risk is that one of every three Americans will develop type 2 diabetes in their lifetime, and the greater concern is that the risk of diabetes rises exponentially as one's BMI increases in a nonlinear fashion. Being overweight increases the risk of developing diabetes five-fold, but being seriously obese increases the risk over 40-fold (Chan et al. 1994). Even more concerning is that while type 2 diabetes is commonly described as "adult onset," it is increasingly being diagnosed in adolescents and teenagers. People who develop type 2 diabetes often have undiagnosed insulin resistance first, before progressing to full-blown diabetes. This is a common precursor in the condition known as prediabetes, which afflicts an estimated 86 million Americans (CDC 2014). The fascinating silver lining is that this condition is reversible. If the excess weight is lost, then the diabetes often resolves. Not many conditions in medicine are so easily curable through a balance of exercise and dietary change.

The other challenge is that this constellation of obesity and diabetes can be wrapped up with other co-morbidities in a condition known as the metabolic syndrome, which includes a whole package of troubling health problems once the BMI crosses 35, including sleep apnea, hypertension, depression, decreased fertility, heartburn, arthritis, and urinary stress incontinence. A BMI between 25 and 30 is defined as overweight, over 30 is obese, and morbid obesity is reached either at a BMI over 35, or if one is over 100 pounds over ideal weight. Recognizing the effectiveness of surgery in treating co-morbidities, the National Institutes of Health recommends that those with coexisting diabetes undergo surgery at a lower BMI threshold of 30, instead of 35 (Arterburn and McCullock 2016). Most insurers will authorize bariatric surgery if the BMI is over 30 and there is coexisting di-

abetes. In 2006, nearly one-third of all patients in the United States undergoing bariatric surgery had coexisting obesity and diabetes (Nguyen et al. 2011). Up to 80% of bariatric patients are able to stop taking diabetes medications two years after surgery as they shed their extra weight—further proof of the relationship between obesity and diabetes (Johnson et al. 2013). The temporary diabetes induced by the weight gain of pregnancy (gestational diabetes) is also further proof of the role of insulin resistance.

As a surgeon, I saw in an interesting manifestation of this silver lining. One of the common procedures a general surgeon performs is to repair incisional hernias, which often result from diabetes, obesity, and smoking. We would routinely counsel patients to lose 10% of their body weight preoperatively. Many frustrated patients would say that losing even five pounds was hard, but others succeeded in losing 50 or 75 pounds or even more. They would often share that while losing the first pounds was the hardest, afterwards the weight loss would accelerate. It became easier to exercise as they carried less body extra weight, they spent less time snacking on processed foods, and their spirits lifted as their body image improved. I also believe they were losing the peripheral fat with insulin resistance first, especially those with an "apple" body type, where they carry more weight around their waist, than those with a "pear" body type, who carry more weight in their hips and thighs.

The triple hazard of soda derives first from undesired weight gain, which results in peripheral insulin resistance and in turn leads to diabetes as a third adverse health impact. Insulin resistance is the missing link. What the soda industry counterarguments are ignoring is the critical link—the fact that the chronic consumption of beverages containing 10 teaspoons of added sugar will contribute to obesity and peripheral fatty tissue deposition. These tissues do not respond to glucose and insulin signals properly, and the peripheral insulin resistance strains the pancreas and accelerates the development of type 2 diabetes. We have now likely witnessed insulin resistance unfold at the level of population health as an entire nation over the past 25 years. In the early 1990s, the United States experienced an epidemic of obesity, followed by an epidemic of diabetes that spiked a decade later. A similar process is now being recognized around the world, jeopardizing global public health. A 2012 *Harvard Gazette* article featuring researchers who were "targeting obesity and its cousin diabetes" reflected that, as a nation, the United States "have been set up" (Powell 2012). We have witnessed an "obese nation, a health crisis," and a "hard-to-escape cycle of weight gain, insulin resistance, and weight-retaining diabetic medication, leading to more pounds." One Harvard professor summarized: "it's not just a trap, it's a trap and a downward spiral."

Sugar-Sweetened Beverages and Insulin Resistance

Sugary drinks highlight the harm of "liquid sugar." High fructose corn syrup is the most common sweetener used by the beverage industry, and the excess sugar consumption it engenders can also lead to addiction. Consuming solid food sends signals to the brain through a combination of gastric distension, vagal nerve activation, and hormones such as ghrelin that one is full and to stop eating. But these signals to stop eating are reduced from a concentrated liquid sugar diet. Unlike solid foods, our bodies cannot effectively process sugar in liquid form, creating a stress to the liver and pancreas that result in a greater weight gain than from consuming solid food with an equal calorie content. The danger from the average 12-ounce soda is the 10 teaspoons of sugar dissolved within—a danger that is not obvious to the drinker, who may mistakenly believe that the caloric content is similar to water. On average, the content of a packet of sugar is one teaspoon. Imagine if you were to observe someone at a café adding eight packets of sugar to their coffee. Individuals who regularly drink sugar-sweetened beverages also often have less healthy diets, containing fewer vegetables, higher sodium, and more processed meats, and they often are consuming empty calories with fewer nutritional benefits (Micha et al. 2017). Sodas are the number one source of added sugars in U.S. diets. Combined with inadequate physical activity, excessive sugar-sweetened beverage consumption has contributed to millions of individuals becoming overweight and obese over the past years; these actions are also detrimental to heart and brain health. Drinking just one sugary beverage a day increases the risk of developing type 2 diabetes by 26%.

Emerging Awareness of a New Public Health Problem

In the early 2000s, the AHA led the way in characterizing the accelerating public health crisis of both childhood and adult obesity. As early as 1977, internal Coca-Cola documents discussed the possible connection between soda consumption and obesity and tried to counterargue that genetics was the key determinant of obesity (Nestle 2015). The dramatic increase in obesity rates that first began in the 1980s and then spiked in the 1990s (following the popularity of supersized soft drinks) was the focus of several AHA initiatives. In 2000, the World Health Organization recognized obesity as a global epidemic. In 2006, the Alliance for a Healthier Generation, a joint AHA initiative in partnership with the Clinton Foundation, was formed to address childhood obesity. One area of focus was the removal of full-calorie soft drinks in schools across the country and their replacement with smaller, lower-calorie options (Laberthe 2011). The spike in diabetes was not yet fully recognized because of the time lag of years between first becoming obese, then developing insulin resistance and later diabetes. But the diabetes

spike would logically follow in the mid-1990s and peak by 2003. The increased rates of adult onset diabetes in children and adolescents have been relatively recent in most populations (Dabalea et al. 2017).

My own awareness of the soda-related obesity problem emerged after I finished my residency in general surgery in 2002 and became a health-care policy fellow at the University of California–San Francisco, where I learned about the decades-long tobacco wars, the tobacco control champions at UCSF, and the tactics and strategy of Big Tobacco to confuse the science, influence our legislators, and challenge public health legislation in court. Subsequently, as a junior faculty member at UCSF, I met pediatric endocrinologist Robert Lustig. In 2009, Lustig produced a YouTube video on "The Bitter Truth" about sugar, which has now been viewed by nearly 7 million people. In that video, Lustig highlights the special health hazards from sugar in its liquid form. The *Financial Times* has called the revelations in the video "sugar's tobacco moment" (Kaminska 2016). I also worked with health services researcher Laura Schmidt at UCSF, who has made invaluable academic contributions towards the conceptualization of a soda tax in San Francisco.

Taxing Soda and the Parallels with Big Tobacco

The goal of the soda tax efforts is to find an alternative, nonsurgical solution to the global obesity and diabetes epidemics. The major value of the soda tax campaigns is to raise awareness among regular sugary beverage drinkers so that they reduce their sugar intake for their own benefit. From that perspective, even soda tax campaigns that result in defeat at the ballot box remain a victory by educating voters of the health hazards of sugary drinks.

When President Obama raised the concept of a national soda tax in 2009, the beverage industry went into overdrive and spent millions of dollars to lobby Congress to ensure this idea was never introduced into the drafting of the Affordable Care Act. In California, efforts to tax soda statewide trace back to Senate Bill 1520, which was introduced in 2002, but decades of overwhelming beverage industry lobbying had resulted in the defeat of the handful of soda tax bills in Sacramento. In 2009, the San Francisco Medical Society (SFMS) succeeded in having the California Medical Association (CMA) support increased taxes on sodas and other relevant sugar-sweetened beverages, but an early effort in 2011 to introduce a soda tax in San Francisco vanished under an onslaught of soda industry lobbying. That same year, the SFMS introduced a second CMA resolution to reduce the marketing of unhealthy foods and beverages to children, which would lead to legislative efforts in Sacramento to ban sugary drinks from being sold on school campuses. This would help to inspire Senate Bill 1000 in Sacramento in 2014, which sought to place a warning label on sodas. The bill was defeated in the face of overwhelming industry lobbying (Maa 2014).

My professional research had been focused on reducing the impact of smoking on surgical outcomes, leading me to become very involved with the Proposition 29 tobacco tax campaign in June 2012. In the fall of 2012, I attended a presentation in which Councilman Jeff Ritterman, a doctor, spoke about a recent effort to tax soda in Richmond, a city across the Bay from San Francisco. What I heard from Ritterman was an inspiration. Though the Richmond soda tax was defeated by a two-to-one margin, it was one of the first salvos in the U.S. soda wars. Ritterman also pointed to how Big Soda was using strategies earlier employed by Big Tobacco to defeat the soda tax campaign. There were striking similarities in the overall messaging by the opposition, particularly in the attempts to minimize the overall dangers of their products to the health of the public. One of the most powerful arguments in support of the Richmond soda tax was the effectiveness of cigarette taxes in significantly reducing the smoking epidemic. The numerous precedents for warning labels, advertising restrictions, and policies restricting use of public funds for substances such as tobacco and alcohol would also prove very powerful in the Richmond soda tax campaign.

Within months, Lustig's work with the Mexican government resulted in passage of Mexico's landmark 2013 soda tax, which would accelerate efforts back home in the United States. The early data after Mexico instituted its tax in January 2014 demonstrated an immediate effect, with national soda consumption falling by an estimated 7%. In the latter half of 2013, I received a call from the communications firm of Erwin and Muir inviting me to assist with the San Francisco soda tax (Proposition E, or Prop E) campaign that was beginning to organize, and to speak at the press conference kickoff with San Francisco Supervisors Scott Wiener, Malia Cohen, David Chiu, and Eric Mar. I serve on the Board of Directors of both the AHA and the SFMS, two organizations that have endorsed sugar-sweetened beverage bills in Sacramento and San Francisco. Both organizations would later speak at the San Francisco City Hall hearings, press events, and newspaper editorial meetings on behalf of the soda tax, and they were featured in the Voter Information pamphlet in support of the measure.

Prop E sought to provide up to $54 million for physical education and nutrition programs in San Francisco public schools, active recreation programs, food access, oral health and dental programs, water fountains, and water bottle filling stations citywide through a 2¢ per ounce special tax, paid by the distributors of sugary beverages (Maa 2014). As a special tax, it would require a two-thirds majority to pass, and the revenue would not go into the general program but instead support the designated special programs. The effort was supported by the CMA, the California Nurses Association, and the California Dental Association. Several months later, soda tax advocates announced that the City of Berkeley would place a 1¢ per ounce tax on the November 2014 ballot; as a general tax, it would only require a simple majority to pass. Instead of supporting specific programs, the funds would be deposited into the City's general fund.

The Bay Area campaigns that ensued in the following months were followed closely across the nation. The soda industry shattered all local records by spending more than $10 million to defeat Prop E in San Francisco, utilizing the funds for an aggressive mail, television, billboard, and marketing campaign to portray the tax as regressive, and arguing that its passage would make living in San Francisco unaffordable. The Yes campaign was massively outspent and relied heavily on earned media counter-messages against the avalanche of soda industry advertising. In the smaller city of Berkeley, campaign manager Larry Tramutola focused on a door-to-door campaign and community activism to build public support; the campaign eventually attracted a major financial investment by Bloomberg Philanthropies to run television advertisements in support of the tax and to combat the tidal wave of $2.4 million spent by Big Soda. The proximity of a sister campaign across the Bay benefitted both the Berkeley and San Francisco campaigns, and as the election approached, the two campaigns began to host joint press events to unify their efforts. This twin-city approach was highly effective. Earned media carried a double impact, and paid media reached voters in both cities, some of whom might work in San Francisco and live in Berkeley or vice versa. Election night was a success on both fronts: Prop D passed with over 75% of the vote, as Berkeley became the first city in America to pass a soda tax. Although Prop E in San Francisco failed, there was a silver lining in the defeat. Despite being heavily outspent 35 to 1, Prop E had garnered nearly 56% of the vote. This was short of the two-thirds majority required for passage, but the fact that a majority of voters had supported the soda tax provided the strongest polling data that a general soda tax effort (requiring only a simple majority) could succeed in San Francisco in the future. The only question would be when?

In the afterglow of the Berkeley Prop D victory, valuable lessons were identified. Berkeley's mayor and the entire City Council endorsed Prop D, unlike San Francisco, where four Supervisors voted against placing Prop E on the ballot. Matching the soda industry dollar-for-dollar in raising campaign funds was not required: instead, keeping the ratio of being outspent by the industry to around three to one could successfully get the message out. For me, the most striking realization was that nearly the identical public relations, campaign managers, communications firms, lobbyists, and legal teams used by Big Tobacco to defeat Prop 29 had been employed to defeat Prop E. We were fighting a common opponent.

In 2016, Philadelphia Mayor Jim Kenney looked to improve health outcomes in Philadelphia, as well as to provide needed improvements to city services, and proposed a tax on sugary beverages. Unlike California cities, in Philadelphia, the City Council has taxing authority. New York Mayor Michael Bloomberg and the AHA helped Mayor Kenney stand up against a vigorous $11.2 million campaign by the beverage industry, and Philadelphia Council members voted to support the tax.

In the fall of 2016, the San Francisco Bay Area became ground zero for the soda wars. In the intervening 20 months, Supervisors Wiener, Mar, and Cohen had kept busy at San Francisco City Hall with a set of legislative proposals signed by the Mayor to place a warning label about sugary drinks on billboards, buses, transit shelters, sports stadiums, and posters, to limit sugary drink sales on City property and in vending machines, and to reduce the impact of industry advertising (Maa 2015). These efforts kept the American Beverage Association (ABA) attorneys occupied, as a legal challenge to the warning label would find its way first to federal court and then to an appeal in the 9th District Court. An injunction motion by the ABA blocking the implementation of the San Francisco soda warning label is still waiting to be ruled upon as of the writing of this article. Another focus in the intervening months was to organize and strengthen the scientific arguments for the upcoming public debate.

The successful 2016 efforts in San Francisco with Prop V rested on the foundation built by the 2014 Prop E campaign. Larry Tramutola, the winning campaign manager from Berkeley's Prop D, was brought back to lead another twin-city effort: San Francisco and Oakland. After careful consideration, the San Francisco soda tax Prop V was placed on the ballot by Supervisor Cohen, this time as a general tax without the need for a full vote at City Hall, and with a strong endorsement by Mayor Ed Lee. Only a simple majority would be needed for victory. In Oakland, a nearly identical Measure HH was spearheaded by Vice Mayor Annie Campbell Washington and received the support of the entire City Council and Oakland Mayor Libby Schaaf.

The game changer in San Francisco was the generous $10 million support from Michael Bloomberg, who, along with the Arnold family, contributed over $12 million to oppose the $22.6 million spent by Big Soda to defeat Prop V. This total of nearly $35 million spent by both sides on a local initiative in San Francisco easily dwarfed the record $10 million spent in 2014 to defeat Prop E, and stands as a record nationally for the amount spent on a local measure in a single city. A similar investment was made in Oakland, and the final expenditures by the beverage industry to defeat both Prop V and Measure HH surpassed $30 million.

Another change in 2016 was that the messaging was crystal clear, concise, and scientifically strong, and the talking points encompassed the dual threats of obesity and diabetes, along with tooth decay. The extra campaign funds helped support phone banking, canvassing, social media, technology devices, and additional outreach that had been unavailable for Prop E. Separate campaign managers were brought on in both Oakland (Diane Woloshin) and San Francisco (Monica Chinchilla) to implement the overarching plan of Larry Tramutola. The aerial coverage in support of both soda taxes with paid media, mailers, and signage complemented a series of earned media in *Politico*, the Associated Press, Reuters, the *New York Times*, the *San Francisco Chronicle* (by journalist Heather Knight), and elsewhere.

The passion, determination, dedication and hard work of the coordinated campaign teams in both cities are what ultimately carried the campaign to victory.

Another beneficiary was the tiny city of Albany, which neighbors Berkeley to the north, and which placed an identical 1¢ per ounce general tax named Measure O1 on the same ballot. Advocates raised just over $6,000, and the ABA spent $185,000 to try to defeat this measure, which quietly moved forward in the updraft of the massive battles in neighboring Oakland and San Francisco.

Soda taxes in the Bay Area became a Goliath versus Goliath battle of epic media proportions, dominating the television airwaves through the election season. It was noteworthy that the spokespersons for the soda industry had become repetitive and tangential in their media response, choosing an unusual path of trying to argue that the soda tax was a grocery tax. This argument failed in Philadelphia, failed again to resonate with voters in the Bay Area, and would result in ethics complaints against the ABA in both cities after an Alameda County Superior Court judge ruled that the soda tax was not a grocery tax. Another error on the part on the ABA was to use archived video of Senator Bernie Sanders to imply that he opposed Prop V and Measure HH. Senator Sanders's subsequent request to the ABA to stop utilizing his likeness in their television commercials would garner national attention and raise public suspicion of the Big Soda ads with the voters.

After overwhelming victories on the November 8, 2016 ballot in San Francisco (won with 62%), Oakland (won with 61%), Albany (won with 71%) and Boulder, Colorado (won by an eight-point margin), other cities quickly followed suit. A movement had caught fire. In Cook County, Illinois (which includes Chicago), a 1¢ per ounce soda tax was approved by the City Council on November 10. Santa Fe, New Mexico, announced plans for a 2017 soda ballot measure shortly thereafter, and Seattle and Portland would soon follow. A media spokeswoman for the soda industry tried to downplay the significance of these ballot victories, claiming that the taxes had only passed in the most liberal of American cities. But the attention of the world had been captured. The string of victories in the United States has sent a strong message with worldwide significance. At the 3rd World Innovation Summit in Health in Doha, Qatar, in November 2016, 1,400 health leaders from over 100 nations convened to discuss novel strategies to reform health care and control rising global health-care costs. The momentum of soda taxes in America was discussed during the plenary sessions, and also during a special panel session on improving cardiovascular health. Ireland, Oman, South Africa, and the United Kingdom would soon either announce or finalize their plans for national soda taxes.

The Legal Challenges

Another beverage industry strategy borrowed from the tobacco industry has been to challenge soda taxes and advocacy successes in court, in an effort to either overturn or delay the implementation of sugary drink legislation. In 2014, the soft drink industry achieved a victory when the New York State Court of Appeals ruled that New York City could not limit sales on jumbo sugary drinks (Grynbaum 2014). Later that year, the Alameda County Superior Court ruled partly in favor of two Berkeley residents who filed a lawsuit to change the phrases "high-calorie, sugary drinks" and "high-calorie, low nutrition products" in ballot materials to the phrase "sugar sweetened beverages" (Raguso 2014). However, the judge dismissed their companion claim, which sought to remove the statement that the sugary drink tax would be paid by distributors, and "not the customer." This theme would return as the core of an August 2016 lawsuit by the ABA against the City of Oakland to remove the Measure HH ballot statement that "this tax is not paid by your local grocer." An Alameda County Court Commissioner ruled against the soda industry, writing further that Measure HH was indeed a soda tax, and not a grocery tax (BondGraham 2016).

In addition to the ABA litigation against the trio of San Francisco sugary drink bills in 2015, the beverage industry also filed a lawsuit over the Philadelphia soda tax in 2016, arguing that the soda tax there would duplicate existing sales taxes and interfere with a federal mandate regarding SNAP funds. The Court of Common Pleas struck down this lawsuit on all counts in December 2016 (Erb 2016); an immediate appeal was filed with the Commonwealth Court, and the matter is likely destined for the Pennsylvania Supreme Court. In the interim, the Philadelphia soda tax was implemented January 1, 2017, and in the first month collected $5.7 million in revenue for the city (Zwirn 2017). Throughout the Philadelphia soda tax campaign, the beverage industry had promised swift legal action to challenge the tax in court if it passed. Similar pledges were made against Measure HH and Prop V, and time will reveal if similar legal efforts to block soda tax implementation are filed in San Francisco, Oakland, Albany, Boulder, or Cook County. The outcomes of both the soda warning label litigation currently in the 9th District Court of Appeals, and the soda tax litigation headed to the Philadelphia Supreme Court will likely guide the next steps by the beverage industry in the courtroom. If an increasing number of cities nationally pass soda taxes through the ballot box, the ability of the industry to challenge each in local courts may be strained; a likely alternative strategy will be to file a challenge directly with the U.S. Supreme Court.

Thus far, the legal actions by the beverage industry have followed the early tobacco industry playbook, using the legal system to protect their interests or oppose control legislation in the role of plaintiff. But the tables turned for the tobacco industry following the disclosure of cigarette industry documents revealing that the tobacco companies were aware of the addictive properties of tobacco.

The tipping point for Big Tobacco came with the Tobacco Master Settlement of 1998, after the Attorneys General of 46 states successfully sued the largest cigarette manufacturers for tobacco-related health-care costs and the adverse impact on Medicaid. In early 2017, the Center for Science in the Public Interest and the Praxis Project jointly filed a lawsuit in federal court alleging that Coca-Cola and the ABA had misled the public about the health hazards of sugary drinks (Rodionova 2017). The case was later dropped by the plaintiffs, but it signaled a new era of litigation where the beverage industry was placed in the role of defendant.

Future Policy Initiatives

Soda tax advocacy efforts nationally should continue as a multi-pronged effort that includes warning labels on sugary drinks, changing to milk and water as the default options for kids' meals in restaurants, and reforms to procurement policies to reduce the amount of processed foods and sugar-sweetened beverages in government cafeterias, vending machines, and in schools. A major victory for public health that came during the 2016 soda tax campaigns was the announcement from the FDA and the Obama Administration that an "added sugar" label for packaged foods would be required by July of 2018. This new label would allow consumers to compare foods and make more informed choices about their intake to promote health, but the implementation of the new rule was placed on hold by the Trump Administration in 2017. In 2014, Congresswoman Rosa DeLauro (D, Connecticut) introduced the Sugar-Sweetened Beverages Tax Act (the SWEET Act), and efforts at the federal level to tax sugary drinks merit careful consideration. Another area of further discussion at the federal level is the removal of sugary drinks from purchasing in the SNAP program, as the billions of dollars spent nationally on soda represents an estimated $4 billion annual subsidy to the soda industry (Nestle 2015). Any changes to the SNAP program should be undertaken without creating an undue economic burden or stigma on low-income consumers. The special area of focus remains low-income consumers and communities of color, where policy leaders will need to intervene to help decrease consumption of soda and sugary beverages. Their neighborhoods are aggressively marketed to, and many times a bottle of soda is less expensive than a bottle of water at a corner store. Ultimately, a deeper understanding of the business model of the beverage industry, their sources of federal and state support, and drivers of their profitability may enable the creation of a new mechanism to tax sugary drinks that cannot be passed on to consumers.

In the aftermath of these advocacy successes, AHA CEO Nancy Brown reflected that the soda tax victories have demonstrated that cities and residents have the power to initiate positive change. After the victory in Philadelphia, she remarked, "What really excites me is the chance this is the beginning of a trend. Simply put, it's a movement that prioritizes heart-healthy habits over beverage in-

dustry profits" (Brown 2016). Summarizing the keys to success, Brown concluded: "We've been there all along—representing all Americans—with our science, education, and advocacy."

The Future from the Surgeon's Perspective

Over the ensuing decades, millions of lives and precious health-care resources will be saved by these national efforts to tax sugary drinks. As a general surgeon, I have witnessed firsthand the epidemic of obesity and diabetes that has ravaged the United States over the past decades, and it was in an effort to reverse these national trends that I first became involved with Prop E in 2014. The passage of Prop V will help greatly in the larger goal. Lives will be saved, and quality of life will be improved for diabetics who no longer suffer falls after losing their eyesight from diabetic retinopathy, suffer complications from dialysis after suffering kidney failure, sustain heart attacks from coronary arterial disease, or struggle with disability after an amputation. Obese patients will experience fewer cases of osteoarthritis leading to joint replacements, sleep apnea and respiratory disease, gallstone formation leading to episodes of pancreatitis and acute inflammation, and fatty liver disease leading to liver transplant. Healthier patients will suffer fewer episodes of depression or bullying in school over their weight, and will experience longer and more productive and satisfying lives. The funds from the tax will help improve nutrition, physical activity, and water access for children, and the health of the public will be promoted as these children return home to educate their parents, siblings, grandparents, and friends about healthier lifestyles and beverage choices. Medical students in the future will read in their physiology textbooks about the enormous impact of Prop V and soda taxes in improving patient health across organ systems.

Conclusion

Given the current and projected severity of the obesity and diabetes epidemics among children and adults, a coordinated strategy is necessary to assist individuals in achieving and maintaining healthy weight. If we do nothing to address this health crisis, one in three children today will develop type 2 diabetes in their lifetime; for children of color, the risk is one in two. The consequences of obesity and diabetes are many and severe, including health concerns and economic costs. The decade-long movement to tax soda has likely reached an inflection point that signals the start of a movement to adopt healthy and viable taxes on sugar. Ultimately, the larger purpose of the soda tax effort is to raise awareness among the general public of the high sugar content in sugary drinks and to empower them to make healthier decisions for their own nutrition and health. Most importantly, the soda industry is now presented with the opportunity to change, and to not follow the path of the tobacco industry. By crafting healthier beverages with lower sugar and calorie content, it can be a win-win for the United States.

References

Al Mohaidly, M., A. Suliman, and H. Malawi. 2013. "Laparoscopic Sleeve Gastrectomy for a Two-and-a-Half-Year-Old Morbidly Obese Child." *Int J Surg Case Rep* 4 (11): 1057–60.

Arterburn, D., and D. McCullock. 2016. "Bariatric Surgery for Type 2 Diabetes: Getting Closer to the Long-Term Goal." *JAMA* 315 (12): 1276–77.

Begley, S. 2012. "As America's Waistline Expands, Costs Soar." *Reuters*. April 30. http://www.reuters.com/article/us-obesity-idUSBRE83T0C820120430.

Blackstone, R. P. 2015. "Is Metabolic and Bariatric Surgery a Population Solution for Obesity and Type 2 Diabetes?" *JAMA Surg* 150 (12): 1124–25.

BondGraham, D. 2016. "'Big Soda' Loses in Court to Oakland." *East Bay Express,* Sept. 2.

Brito, J. P., V. M. Montori, and A. M. Davis. 2017. "Metabolic Surgery in the Treatment Algorithm for Type 2 Diabetes: A Joint Statement by International Diabetes Organizations." *JAMA* 317 (6): 635–36.

Brown, N. 2016. "Cheers! Why I'm Celebrating the Sweet Victory of the Philadelphia Sugary Drink Tax." *Huffington Post,* June 16.

Castellano, D. 2016. "Before You Spend $26,000 on Weight-Loss Surgery, Do This." *NY Times,* Sept. 10.

Centers for Disease Control and Prevention (CDC). 2011. *National Diabetes Fact Sheet, 2011.* Atlanta: HHS/CDC. https://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

Centers for Disease Control and Prevention (CDC). 2014. *National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2014.* Atlanta: CDC. http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf.

Chan, J. M., et al. 1994. "Obesity, Fat Distribution, and Weight Gain as Risk Factors for Clinical Diabetes in Men." *Diabetes Care* 17 (9): 961–69.

Dabalea, D., et al. 2017. "Association of Type 1 Diabetes vs Type 2 Diabetes Diagnosed During Childhood and Adolescence with Complications During Teenage Years and Young Adulthood." *JAMA* 317 (8): 825–35.

Erb, K. P. 2016. "Judge Dismisses Soda Tax Lawsuit Against City of Philadelphia." *Forbes*, Dec. 19.

Glickman, D., et al. 2012. *Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation*. Washington, DC: National Academies Press.

Golomb, I., et al. 2015. "Long Term Metabolic Effects of Laparoscopic Sleeve Gastrectomy." *JAMA Surg* 150 (11): 1051–57.

Grynbaum, M. M. 2014. "New York's Ban on Big Sodas Is Rejected by Final Court." *NY Times,* June 26.

Hill, J., M. Nielsen, and M. H. Fox. 2013. "Understanding the Social Factors that Contribute to Diabetes: A Means to Informing Health Care and Social Policies for the Chronically Ill." *Perm J* 17 (2): 67–72.

Johnson, B. L., et al. 2013. "Bariatric Surgery Is Associated with a Reduction in Major Macrovascular and Microvascular Complications in Moderately to Severely Obese Patients with Type 2 Diabetes Mellitus." *J Am Coll Surg* 216 (4): 545–56.

Kaminska, I. 2016. "Robert Lustig: Godfather of the Sugar Tax." *Financial Times*, March 18.

Klebanoff, M. J., et al. 2017. "Cost-Effectiveness of Bariatric Surgery in Adolescents with Obesity." *JAMA Surg* 152 (2): 136–41.

Laberthe, D. R. 2011. *Epidemiology and Prevention of Cardiovascular Diseases: A Global Challenge.* Burlington, MA: Jones and Bartlett.

Laiteerapong, N., and A. S. Cifu. 2016. "Screening for Prediabetes and Type 2 Diabetes Mellitus." *JAMA* 315 (7): 697–98.

Lim, R. B., G. L. Blackburn, and D. B. Jones. 2010. "Benchmarking Best Practices in Weight Loss Surgery." *Curr Probl Surg* 47 (2): 79–174.

Livingston, E. H. 2010. "The Incidence of Bariatric Surgery Has Plateaued in the US." *Am J Surg* 200 (3): 378–85.

Maa, J. 2014. "Vote Yes on Proposition E: The SFMS Champions the San Francisco Soda Tax." *San Fran Med* 87 (8): 16.

Maa, J. 2015. "Mayor Ed Lee Approves SFMS-Endorsed Sugar Sweetened Beverage Ordinances." *San Fran Med* 88 (6): 29–31.

Menke, A., et al. 2015. "Prevalence and Trends in Diabetes Among Adults in the United States, 1988–2012." *JAMA* 314 (10): 1021–29.

Micha, R., et al. 2017. "Association Between Dietary Factors and Mortality from Heart Disease, Stroke, and Type 2 Diabetes in the United States." *JAMA* 317 (9): 921–24.

Nestle, M. 2015. *Soda Politics: Taking on Big Soda (and Winning).* Oxford: Oxford University Press.

Nguyen, N. T., et. al. 2011. "Trends in Use of Bariatric Surgery, 2003–2008." *J Am Coll Surg* 213 (2): 261–66.

"Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation." 2000. *World Health Organ Tech Rep Ser* 894: i–xii, 1–253.

Powell, A. 2012. "Obesity? Diabetes? We've Been Set Up." *Harvard Gazette*, March 7.

Raguso, E. 2014. "Judge Changes Berkeley 'Soda Tax' Ballot Language." *Berkeleyside*, Sept. 14.

Reusch, J. E. B., and J. E. Manson. 2017. "Management of Type 2 Diabetes in 2017: Getting to Goal." *JAMA* 317 (10): 1015–16.

Rodionova, Z. 2017. "Coca-Cola Accused of Using Tobacco Industry Tactics to Mislead Public over Health Effects of Its Fizzy Drinks." *Independent*, Jan. 5.

Singh, D., et. al. 2009. "Jejunoileal Bypass: A Surgery of the Past and a Review of Its Complications." *World J Gastroenterol* 15 (18): 2277–79.

Zwirn, E. 2017. "Philly's Soda Tax Is Crushing the City's Beverage Business." *NY Post*, March 5.

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Application for Boards, Commissions, Committees, & Task Forces

Name of Board/Commission/Committee/Task Force: Soda Tax Fund

Seat # (Required - see Vacancy Notice for qualifications): Seat 3 and 2

Full Name: John iesha Ena

[redacted] Zip Code: 94124

[redacted] Occupation: Director of Programs

Work Phone: 6504523604 Employer: Samoan Community Development Center

Business Address: 2055 Sunnydale Avenue Zip Code: 94134

Business Email: john.ena@scdcsf.org Home Email [redacted]

Pursuant to Charter, Section 4.101(a)(2), Boards and Commissions estab
residents of the City and County of San Francisco who are 18 years of ag
authority). For certain appointments, the Board of Supervisors may waive the residency requirement.

Resident of San Francisco: Yes ■ No ☐ If No, place of residence: _____

18 Years of Age or Older: Yes ■ No ☐

Pursuant to Mayoral Order, members of boards/commissions are required to be Covid-19 vaccinated and attend in-person meetings.

Covid-19 Vaccinated: Yes ■ No ☐

Pursuant to Charter, Section 4.101(a)(1), please state how your qualifications represent the communities of interest, neighborhoods, and the diversity in ethnicity, race, age, sex, sexual orientation, gender identity, types of disabilities, and any other relevant demographic qualities of the City and County of San Francisco:

I am Samoan Transfemale. Born and raised here in the Bay Area; South San Francisco to be exact. Currently living in the Bayview Hunters Point. We have a variety of liquor and super markets that sell healthy beverages. However, they come at a cost. Our Samoan and PI community look for the most inexpensive beverages; coincidentally that would be soda. Rarely will you see any Polynesians on ANY CITY committees. It would be beneficial to our Samoan and PI community to have representation in this space; lend a cultural lense in reviewing grant proposals/RFP's. Witness first hand how people of color don't have equitable access to medical and clinical support; other than those free clinics that lack the funding to have follow ups with 1-time clients.

(Applications must be submitted to BOS-Appointments@sfgov.org or to the mailing address listed above.)

Business and/or Professional Experience:

Currently working for the Samoan Community Development Center located in the Visitacion Valley; Sunnydale to be exact. Creating and Developing for over 15 years for youth programming, parenting and senior programming. Years of experience in developing and creating culturally relevant workshops for youth seniors and community; infusing California's Education Common Core Standards into the workshops for youth. Experience in growing programs from start to implementation.

Civic Activities:

Community Cultural Celebrations; Annual Summer Program Celebration; Samoan Wellness Initiative Mental Health Celebration; Sunnydale Halloween Celebration; Sunnydale Family Day; API Heritage Month Celebration; Potrero Hill Day of Peace Celebration; Potrero Hill International Day Celebration and Backpack Giveaway; Sunnydale Christmas Toy Giveaway

Have you attended any meetings of the body to which you are applying? Yes ☐ No ■

An appearance before the Rules Committee may be required at a scheduled public hearing, prior to the Board of Supervisors considering the recommended appointment. Applications should be received ten (10) days prior to the scheduled public hearing.

Date: 01-12-2023 Applicant's Signature (required): John iesha Ena

(Manually sign or type your complete name. NOTE: By typing your complete name, you are hereby consenting to use of electronic signature.)

Please Note: Your application will be retained for one year. Once completed, this form, including all attachments, become public record.

FOR OFFICE USE ONLY:

Appointed to Seat #: _____ Term Expires: _____ Date Vacated: _____

Sugary Drinks Distributor Tax Advisory Committee (SDDTAC)

Supplemental Questionnaire

1. Please describe the experience you have in public health programs related to diabetes, oral health, obesity, and sugary drink consumption.

None

2. Please describe the ways in which sugary drinks impact diverse communities across San Francisco.

Sugary drinks have caused our Samoan & PI community to experience diabetes at a very alarming rate. 1 in 3 am. Samoans have diabetes; almost the same here in the U.S.

3. Please describe your experience in reaching out to community-based organizations that serve communities most impacted by sugary drinks.

n/a

4. Please describe your understanding of how businesses (soda industry, tobacco industry, etc.) impact chronic disease and community health.

When businesses focus on only making profits, they sell the most toxic ~~drinks~~ & profitable drinks. keeping our community locked in a generational unhealthyness.

5. Please describe how your work or life experience will inform the work of the committee.

I am obese and am now dealing w health issues because of unhealthy drinking & eating. Many of my family members have diabetes & do dialysis.

NEMS NORTH EAST MEDICAL SERVICES 東北醫療中心

a california health+ center

March 1, 2023

Supervisor Matt Dorsey, Chair
Supervisor Shamann Walton, Vice Chair
Supervisor Ahsha Safai, Member
Rules Committee
San Francisco Board of Supervisors

RE: Support for Sugary Drinks Distributor Tax Advisory Committee Candidacy for John Iesha Ena

Dear Chair Dorsey, Vice Chair Walton, and Supervisor Safai,

On behalf of North East Medical Services, I am writing in strong support of John Iesha Ena for Seat 2 on the Sugary Drinks Distributor Tax Advisory Committee (SDDTAC), which is the Asian/Pacific Islander Health Equity Seat that is appointed by the SF Board of Supervisors. I stand in support of Iesha because I believe that she has been an ardent advocate for advancing the health and well-being of San Francisco's Asian American, Native Hawaiian, and Pacific Islander (AANHPI) community for more than two decades; she also has a deep knowledge of the health statuses, needs, and experiences of our communities that she will bring to the SDDTAC.

Iesha serves as the lead of Community Engagement and Logistics at the Samoan Community Development Center (SCDC), a 501(c)3 non-profit with a mission to enhance the health and well-being of San Francisco Samoans and Pacific Islanders. SCDC has been a partner of the API Health Parity Coalition for over a decade. The Samoan Wellness Initiative (SWI), a program of SCDC, provides mental health activities for the Samoan and Pacific Islander community, including Siva for Wellness and Tupulaga, a youth leadership program that engages youth in the field of mental health.

Iesha has worked in this community in a variety of leadership roles to improve the health and welfare of the community and brings a wealth of knowledge and experience to address the health needs of the population in a culturally and linguistically responsive way through advocacy, research, training, coalition-building, and program implementation. She has extensive knowledge and experience in researching public health issues, implementing health education programs and campaigns, and spearheading community health initiatives.

For these reasons, I recommend Iesha for Seat 2 of the SDDTAC. Please feel free to reach out to Jessica Ho at Jessica.ho@nems.org or Vivian Liang at Vivian.liang@nems.org if you have any questions.

Sincerely,

Paul Fox, Chief Administrative Officer
North East Medical Services

NEMS NORTH EAST MEDICAL SERVICES 東北醫療中心

a california health+ center

March 1, 2023

Supervisor Matt Dorsey, Chair
Supervisor Shamann Walton, Vice Chair
Supervisor Ahsha Safai, Member
Rules Committee
San Francisco Board of Supervisors

RE: Support for Sugary Drinks Distributor Tax Advisory Committee Candidacy for John Iesha Ena

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Iesha serves as the lead of Community Engagement and Logistics at the Samoan Community Development Center (SCDC), a 501(c)3 non-profit with a mission to enhance the health and well-being of San Francisco Samoans and Pacific Islanders. SCDC has been a partner of the API Health Parity Coalition for over a decade. The Samoan Wellness Initiative (SWI), a program of SCDC, provides mental health activities for the Samoan and Pacific Islander community, including Siva for Wellness and Tupulaga, a youth leadership program that engages youth in the field of mental health.

Iesha has worked in this community in a variety of leadership roles to improve the health and welfare of the community and brings a wealth of knowledge and experience to address the health needs of the population in a culturally and linguistically responsive way through advocacy, research, training, coalition-building, and program implementation. She has extensive knowledge and experience in researching public health issues, implementing health education programs and campaigns, and spearheading community health initiatives.

For these reasons, I recommend Iesha for Seat 2 of the SDDTAC. Please feel free to reach out to Jessica Ho at Jessica.ho@nems.org or Vivian Liang at Vivian.liang@nems.org if you have any questions.

Sincerely,

Paul Fox, Chief Administrative Officer
North East Medical Services

API COUNCIL

Proudly consists of:

APA Family Support Services
APA Heritage Foundation
API Legal Outreach
ASIAN, Inc.
Asian & Pacific Islander Wellness Center
Asian Pacific American Community Center
Asian Pacific Islander Cultural Center
Asian Law Caucus, Inc.
Asian Neighborhood Design, Inc.
Bayanihan Equity Center
Be Chinatown
Bill Sorro Housing Program
Brightline Defense Project
Center for Asian American Media
Charity Cultural Services Center
Chinatown Community Children's Center
Chinatown Community Development Center
Chinatown Media and Arts Collaborative
Chinese Culture Center of San Francisco
Chinese for Affirmative Action
Chinese Historical Society of America
Chinese Newcomers Service Center
Chinese Progressive Association
Community Youth Center
Donaldina Cameron House
Filipina Women's Network
Filipino American Development Foundation
Filipino Community Center
First Voice
Gum Moon/Asian Women Resources Center
Japanese American Citizens League of SF
Japanese Community Youth Council
Japantown Community Benefit District
Japantown Task Force
Kai Ming Head Start
Kimochi, Inc.
Kultivate Labs
Manilatown Heritage Foundation
National Japanese American Historical Society
NICOS Chinese Health Coalition
Nihonmachi Street Fair
Northeast Community Credit Union
Northern California Cherry Blossom Festival
North East Medical Services
Richmond Area Multi-Services
Samoan Community Development Center
Self-Help for the Elderly
SF Hep B Free
SOMA Pilipinas
South of Market Community Action Network
Southeast Asian Community Center
Southeast Asian Development Center
The YMCA of San Francisco- Chinatown
Visitacion Valley Asian Alliance
West Bay Pilipino Multi-Service, Inc.
Wu Yee Children's Services

March 10, 2023

Supervisor Matt Dorsey, Chair
Supervisor Shamann Walton, Vice Chair
Supervisor Ahsha Safai, Member
Rules Committee
San Francisco Board of Supervisors

RE: Support for Sugary Drinks Distributor Tax Advisory Committee Candidacy for John Iesha Ena

Dear Chair Dorsey, Vice Chair Walton, and Supervisor Safai:

On behalf of the Asian and Pacific Islander Council of San Francisco (API Council), I am writing to provide my strong support of John Iesha Ena for Seat 2 on the Sugary Drinks Distributor Tax Advisory Committee (SDDTAC). The API Council stands in support of Iesha because we believe that she has been an ardent advocate for advancing the health and well-being of San Francisco's Asian American, Native Hawaiian, and Pacific Islander (AANHPI) community for more than two decades–she also has a deep knowledge of the health statuses, needs, and experiences of our communities that she will bring to the SDDTAC.

Currently, Iesha serves as the lead of Community Engagement and Logistics at the Samoan Community Development Center (SCDC), a 501(c)3 non-profit with a mission to enhance the health and well-being of San Francisco Samoans and Pacific Islanders. SCDC has been a partner of the API Health Parity Coalition for over a decade. The Samoan Wellness Initiative (SWI), a program of SCDC, provides mental health activities for the Samoan and Pacific Islander community, including Siva for Wellness and Tupulaga, a youth leadership program that engages youth in the field of mental health.

Iesha has worked in this community in a variety of leadership roles to improve the health and welfare of the community and brings a wealth of knowledge and experience to address the health needs of the population in a culturally and linguistically responsive way through advocacy, research, training, coalition building, and program implementation. She has extensive knowledge and experience in researching public health issues, implementing health education programs and campaigns, and spearheading community health initiatives.

I respectfully ask you for your consideration in supporting this effort. I am available anytime to discuss my support. Please reach out to me if you have any questions at: cally.wong@apicouncil.org.

Sincerely,

Cally Wong
Executive Director
API Council

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Application for Boards, Commissions, Committees, & Task Forces

Name of Board/Commission/Committee/Task Force: SUGARY DRINKS DISTRIBUTOR TAX ADVISORY COMMITTEE

Seat # (Required - see Vacancy Notice for qualifications): 3

Full Name: Melinda Burrus

[redacted] Zip Code: 94124

Occupation: Community Engagement Specialist

Work Phone: 650-442-6299 Employer: Leah's Pantry

Business Address: 3019 Mission st. Zip Code: 94110

Business Email: Melinda@leahspantry.org Home Email: [redacted]

Pursuant to Charter, Section 4.101(a)(2), Boards and Commissions established by the Charter must consist of residents of the City and County of San Francisco who are 18 years of age or older (unless otherwise stated in the code authority). For certain appointments, the Board of Supervisors may waive the residency requirement.

Resident of San Francisco: Yes ■ No ☐ If No, place of residence: _____

18 Years of Age or Older: Yes ■ No ☐

Pursuant to Charter, Section 4.101(a)(1), please state how your qualifications represent the communities of interest, neighborhoods, and the diversity in ethnicity, race, age, sex, sexual orientation, gender identity, types of disabilities, and any other relevant demographic qualities of the City and County of San Francisco:

As a Community Engagement Specialist at Leah's Pantry, my goal in my role is to create better health outcomes and equities in Bayview Hunter Point and Treasure Island by conduction community level policy, system and environmental work. My contract is specifically for older adults and people with disabilities in both neighborhoods. Just from the nature of my job, I work with some of San Francisco's more diverse and underserved communities. I usually interact with a lot of older Black, Latino, Pacific Islanders and Asians in my line of work, also many people with limited mobility. The end goal of my contract is to gather older adults and people with disabilities in both neighborhoods to create a Food Advisory group that will advocate for food security and health equity, ensuring older adults and people with disabilities also have their voice heard when new initiatives come to the neighborhood.

(Applications must be submitted to BOS-Appointments@sfgov.org or to the mailing address listed above.)

Business and/or Professional Experience:

-San Francisco Board of Supervisors; Intern, District 10 Office:

Worked under the legislative aide to assist analyzing local legislative and justice reform.
Conducted policy research.
Attended city hall budget committee meetings once a week, reporting back to legislative aides.
Attended community listening meetings regarding justice reform in regard to closing down Juvenile Detention Center.
Provided solutions to constitute complaints in person, phone or through email.

-Department of Children Youth and Their Families; Nutrition Program Monitor:

As a DCYF liaison to 13 sites that provide food services to 500+ children, the job was to make sure that sites were in compliance with the Department of Public Health, Children's Department of Education and USDA regulations.
Conducted 13 site visits in three months to sites who served children free meals.
Daily checks of sites compliance through DCYF's ETS and PowerBI databases.

Civic Activities:

Shape Up SF Coalition: January-present
FAACTS Food Sovereignty Task Force: January-present
San Francisco Young Democrats: August 2022-present

Have you attended any meetings of the body to which you are applying? Yes ☐ No ☐

An appearance before the Rules Committee may be required at a scheduled public hearing, prior to the Board of Supervisors considering the recommended appointment. Applications should be received ten (10) days prior to the scheduled public hearing.

Date: 08/05/2024 Applicant's Signature (required): _____

(Manually sign or type your complete name.
NOTE: By typing your complete name, you are hereby consenting to use of electronic signature.)

Please Note: Your application will be retained for one year. Once completed, this form, including all attachments, become public record.

FOR OFFICE USE ONLY:

Appointed to Seat #: _____ Term Expires: _____ Date Vacated: _____

Sugary Drinks Distributor Tax Advisory Committee (SDDTAC)

Supplemental Questionnaire

(Please include this questionnaire with application form)

1. Please describe the experience you have in public health programs related to diabetes, oral health, obesity, and sugary drink consumption.

-At San Francisco State University, I researched, analyzed, and wrote numerous essays on Health disparities in Bayview Hunterspoint, and one major health outcome is diabetes so, I analyzed health programs and polices in Bayview.

-At Leah's Pantry, I do food demostrations at a food pharmacy for oder adults diagnosed with type 2 diabetes and hypertension.

-At Leah's Pantry, I teach workshops in Bayview and Treasure Island about dangers of sugary drinks.

2. Please describe the ways in which sugary drinks impact diverse communities across San Francisco.

Sugary drinks are widely more available in lower income neighborhoods in SF, like Bayview because zoning laws allow for numerous liquor stores in these neighborhoods, with many sugar drink options. They are also marketed towards children with cool Packaging and colors. Also, sometimes, a soda can be cheaper than other options. Having these drinks more available, appealing and affordable in diverse communities creates long lasting health outcomes such as type 2 diabetes.

3. Please describe your experience in reaching out to community-based organizations that serve communities most impacted by sugary drinks.

For the 4 year duration of my Professional career, I have always worked with Bayview, which is a community very impacted by sugary drinks. But, as a Community Engagement specialist, I am constenty reaching out to programs in Bayview that serves the community to collaborate. I am now connected with the D10 Community Market, giving resources, recipes, and food demostrations to residents who come to get free food.

4. Please describe your understanding of how businesses (soda industry, tobacco industry, etc.) impact chronic disease and community health.

Businesses have a goal of profit while humans have a goal of consumption. Businesses have direct impact on chronic diseases and community health when they sell unhealthy items to consumers who may not know or have no other option of affordability. For example, a community where there is one grocery store but 12 liquor stores full of junk food, tobacco and alcohol, we start to see trends in the community because of what is available and businesses know this. Also, sugar and tobacco are addictive, so marketing towards a young crowd garentees future sales!

5. Please describe how your work or life experience will inform the work of the committee.

I am a product of a neighborhood impacted by sugar drinks with high rates of type 2 diabetes and obesity, Bayviews Hunters Point. My schooling was focused on different health disparities in my community causing patterns of health outcomes. I was interested because both my mother and grandmother were from Bayview and both passed away from diabetes complications at 55 and 72 years old. Now at my job. I get to help people just like my mom and grandma learn more about diabetes and how to manage it.

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Application for Boards, Commissions, Committees, & Task Forces

Name of Board/Commission/Committee/Task Force: Sugary Drink Distributor Tax Advisory Committee

Seat # (Required - see Vacancy Notice for qualifications): 1-3 or 15

Full Name: Prasanthi Patel

[redacted] Zip Code: 94132

[redacted] pation: Healthcare Administrator

Work Phone: _____ Employer: Sonrisas Dental Health

Business Address: 430 N El Camino Real, San Mateo, CA Zip Code: 94401

Business Email: ppatel@sonrisasdental.org Home Ema [redacted]

Pursuant to Charter, Section 4.101(a)(2), Boards and Commissions established by the Charter must consist of residents of the City and County of San Francisco who are 18 years of age or older (unless otherwise stated in the code authority). For certain appointments, the Board of Supervisors may waive the residency requirement.

Resident of San Francisco: Yes ■ No ☐ If No, place of residence: _____

18 Years of Age or Older: Yes ■ No ☐

Pursuant to Charter, Section 4.101(a)(1), please state how your qualifications represent the communities of interest, neighborhoods, and the diversity in ethnicity, race, age, sex, sexual orientation, gender identity, types of disabilities, and any other relevant demographic qualities of the City and County of San Francisco:

As an Indian American woman and mother of two children in SFUSD, I bring a unique perspective and lived experience that reflects the diversity of San Francisco's communities. My professional and personal life is deeply rooted in advancing equity and inclusion, particularly in healthcare and community settings.

I have firsthand experience navigating cultural expectations and systemic barriers as a child of immigrant parents, and I understand the challenges faced by communities of color, low-income families, and underserved populations in accessing healthcare, education, and community resources.

I am committed to advocating for policies and initiatives that uplift underrepresented voices, reduce health disparities, and ensure equitable access to resources and opportunities for all San Franciscans, regardless of their background, race, or socioeconomic status.

(Applications must be submitted to BOS-Appointments@sfgov.org or to the mailing address listed above.)

Business and/or Professional Experience:

I am an accomplished public health executive with over a decade of leadership experience in health equity, oral health, and chronic disease prevention.

My current role as Chief Operating Officer at Sonrisas Dental Health involves:
-Leading initiatives to improve healthcare access for underserved communities, including farmworkers, low-income families, and communities of color.
- Overseeing clinical standardization and operational efficiency, ensuring quality care and compliance with regulatory standards.
- Spearheading the acquisition of a mobile dental unit to expand sustainable dental care services to vulnerable populations.

Previously, as the Director of the Children's Oral Health Program for San Francisco, I managed:
- A multi-million-dollar budget, including Sugary Drink Distributor Tax (SDDT) funds, to reduce oral health disparities and promote nutrition education.
- Strategic partnerships with community-based organizations, public health agencies, and schools to address the impact of sugary drink consumption on chronic disease and oral health.
- Development of equity-focused public health policies, driving citywide initiatives that improved access to preventative dental care for Black, Latinx, and API communities.

I have also contributed to COVID-19 response efforts and managed complex projects that intersect with public health, healthcare delivery, and community engagement.

Civic Activities:

Beyond my professional work, I am deeply committed to community service and civic engagement, with a focus on health equity, youth development, and public health advocacy. My involvement includes:

Parent Advocacy in SFUSD – As a mother of two children in SFUSD, I am actively engaged in the Daniel Webster Elementary PTA prioritizing student health and well-being. I understand the challenges families face in accessing nutritious food and healthcare resources, and I am committed to advocating for policies that improve children's health and education.

Girl Scouts Troop Leadership – Through my role as a Multi-Level Troop Leader for Daisies and Brownies, I support girls' leadership development, confidence-building, and exposure to STEM, outdoor education, and health awareness activities. My work with Girl Scouts reflects my commitment to empowering the next generation and ensuring all children, regardless of background, have access to enriching experiences.

CAHL Bay Local Program Council (LPC) – As part of the California Association of Healthcare Leaders (CAHL), I engage in professional development and leadership initiatives aimed at strengthening healthcare management and policy advocacy. I am working to increase my involvement in organizing and supporting healthcare education events.

Oral Health & Public Health Advocacy – My work has allowed me to advocate for underserved populations in public health policy, especially in reducing health disparities linked to sugary drink consumption and chronic disease. I have worked closely with community-based organizations, SFUSD, and public health leaders to implement programs that benefit vulnerable communities.

Have you attended any meetings of the body to which you are applying? Yes ■ No ☐

An appearance before the Rules Committee may be required at a scheduled public hearing, prior to the Board of Supervisors considering the recommended appointment. Applications should be received ten (10) days prior to the scheduled public hearing.

Date: 3/4/2025 Applicant's Signature (required):  Digitally signed by Prasanthi Patel Date: 2025.03.04 20:17:13 -08'00'

(Manually sign or type your complete name. NOTE: By typing your complete name, you are hereby consenting to use of electronic signature.)

Please Note: Your application will be retained for one year. Once completed, this form, including all attachments, become public record.

FOR OFFICE USE ONLY:

Appointed to Seat #: _____ Term Expires: _____ Date Vacated: _____

Prasanthi Patel
Application for **Sugary Drinks Dist. Tax Advisory Committee (SDDTAC) – Seat # (1-3)**
Date: March 4, 2025

Supplemental Questionnaire

1. Please describe the experience you have in public health programs related to diabetes, oral health, obesity, and sugary drink consumption.

I have over a decade of experience in public health leadership, focusing on health equity, oral health, obesity prevention, and chronic disease management. As the Director of the Children's Oral Health Program for San Francisco, I led a citywide initiative addressing disparities in oral health, particularly in communities of color disproportionately impacted by sugary drink consumption.

In this role, I:

- Managed a multi-million-dollar budget, including Sugary Drink Distributor Tax (SDDT) funds, to implement programs targeting early childhood caries, school-based screenings, and parent education.
- Developed cross-sector collaborations with schools, community-based organizations, and public health agencies to integrate sugary drink education into broader health promotion efforts.
- Conducted policy advocacy and worked with city stakeholders to shape San Francisco's oral health policies.
- Led data-driven initiatives, using population-level metrics to track disparities in oral health, nutrition, and access to dental care.

Additionally, my work at Sonrisas Dental Health continues to center around reducing barriers to care, improving health literacy, and addressing systemic inequities that lead to chronic diseases, including those exacerbated by sugary drink consumption.

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2. Please describe the ways in which sugary drinks impact diverse communities across San Francisco.

Sugary drinks contribute to widening health disparities in San Francisco's low-income, immigrant, and Black and Brown communities, where access to preventative healthcare, dental care, and nutrition education is often limited.

Key impacts include:

- Higher Rates of Childhood Cavities – Among SFUSD students, Black and Latinx children experience disproportionately high rates of tooth decay, linked to sugary drink consumption and barriers to dental care.

- Increased Risk of Type 2 Diabetes & Obesity – Communities with limited access to healthy, affordable food options often rely on sugary drinks, fueling chronic disease disparities.
- Aggressive Marketing by the Beverage Industry – Research shows that soda companies target communities of color with advertising while opposing policies like the Sugary Drink Distributor Tax, further entrenching inequities.

As someone with direct experience in oral health equity and chronic disease prevention, I understand that addressing sugary drink consumption requires both community-driven education and systemic policy change.

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3. Please describe your experience in reaching out to community-based organizations that serve communities most impacted by sugary drinks.

I have led equity-focused partnerships with over 20+ community-based organizations (CBOs), public health agencies, and schools to address sugary drink consumption and chronic disease disparities.

Some of my key experiences include:

- Managing SDDT-Funded Programs – Oversaw funding allocation and implementation for programs designed to reduce oral health disparities in Black, Latinx, and API communities.
- Developing Culturally Tailored Outreach – Worked with Black and Brown community leaders to create multilingual health education campaigns, ensuring messaging around sugary drink consumption was culturally relevant and accessible.
- Collaborating with SFUSD & Family Resource Centers – Partnered with schools and FRCs to incorporate nutrition education and oral health screenings into existing community programs.
- Facilitating Capacity-Building for CBOs – Provided technical assistance and funding support to local nonprofits, enabling them to expand their work in diabetes prevention, obesity reduction, and oral health education.

My ability to bridge public health expertise with community-driven advocacy makes me well-positioned to advance SDDTAC's mission.

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4. Please describe your understanding of how businesses (soda industry, tobacco industry, etc.) impact chronic disease and community health.

Corporations, particularly in the soda and tobacco industries, have long played a role in perpetuating health inequities by prioritizing profit over public health.

Key concerns include:

- Targeted Marketing to Vulnerable Communities – Soda and tobacco companies disproportionately market their products to low-income communities and communities of color, increasing rates of diabetes, obesity, and oral disease.
- Policy Opposition & Misinformation – These industries use lobbying, lawsuits, and deceptive campaigns to undermine public health policies like the Sugary Drink Distributor Tax, warning labels, and school-based restrictions.
- Corporate Philanthropy as a Smokescreen – Beverage companies donate to schools and local nonprofits to maintain influence while continuing harmful practices.

I have direct experience countering these corporate tactics through policy advocacy, funding oversight, and community education—skills I would bring to SDDTAC to help protect the integrity of tax revenue allocations and public health efforts.

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5. Please describe how your work or life experience will inform the work of the committee.

My personal and professional experiences deeply align with the mission of SDDTAC.

- Public Health Leadership & Policy Expertise – I have years of experience leading citywide health initiatives, managing SDDT-funded programs, and advocating for policy solutions to reduce health disparities.
- Equity-Driven Approach – As an immigrant and a woman of color, I bring a personal understanding of systemic barriers that impact access to healthcare, nutritious food, and preventative care in marginalized communities.
- Nonprofit & Government Experience – Having worked across government agencies (SFDPH), nonprofits, and community-based organizations, I know how to navigate public funding, ensure transparency, and drive impact.
- Parent Perspective – As a mother of two children in San Francisco, I see firsthand how health disparities play out in schools and communities. I am invested in ensuring all families—regardless of income—have access to healthier options and the resources they need.

As a member of SDDTAC, I would leverage my expertise, leadership, and lived experience to advocate for equitable policies and funding decisions that truly serve communities most impacted by sugary drinks.