File No. 250306 **Committee Item No.** 3
Board Item No. _____

COMMITTEE/BOARD OF SUPERVISORS

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Committee: Rules Committee **Date** April 7, 2025

Board of Supervisors Meeting **Date** _____

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OTHER **(Use back side if additional space is needed)**

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Completed by: Victor Young **Date** April 3, 2025
Completed by: _____ **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): 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]

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 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.

FOR OFFICE USE ONLY:

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.

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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

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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

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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.
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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 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.

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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

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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.

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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

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

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.

SUGARY DRINKS DISTRIBUTOR TAX ADVISORY COMMITTEE

The below listed summary of seats, term expirations and membership information shall serve as notice of vacancies, upcoming term expirations, and information on currently held seats, appointed by the Board of Supervisors. Appointments by other bodies are listed, if available.

Seat numbers listed as "VACANT" are open for immediate appointment. However, you are able to submit applications for all seats and your application will be maintained for one year, in the event that an unexpected vacancy or opening occurs.

Membership and Seat Qualifications

Seat #	Appointing Authority	Seat Holder	Term Ending	Qualification
1	BOS	VACANT Term expired 12/31/24 – Holdover Chester Williams (residency waived)	12/31/26	Must be held by a representative of a nonprofit organization that advocate for health equity in communities that are disproportionately impacted by diseases related to the consumption of sugar-sweetened beverages. Term: 2-years
2	BOS	VACANT Term expired 12/31/24 – Holdover John Iesha Ena	12/31/26	
3	BOS	VACANT Term expired 12/31/24 – Holdover Melinda Burrus	12/31/26	
4	BOS	VACANT Term expired 12/31/24 – Holdover Frances Abigail Cabrera	12/31/26	Must be an individual who is employed at a medical institution in San Francisco and who has experience in the diagnosis or treatment of, or in research or education about, chronic and other diseases linked to the consumption of sugar-sweetened beverages. Term: 2-years
5	BOS	VACANT Term expired 12/31/24 – Holdover Jamey Schmidt	12/31/26	

Seat #	Appointing Authority	Seat Holder	Term Ending	Qualification
6	BOS	VACANT Term expired 12/31/24 – Holdover Linda Ye	12/31/26	Must be a person who is under 19 years old at the time of appointment and who may be a member of the Youth Commission, nominated by the Youth Commission and appointed by the Board of Supervisors, for a two-year term. (Note: If the person is under legal voting age and unable to be an elector for that reason, the person may hold this seat, but upon reaching legal voting age, the person shall relinquish the seat unless he or she becomes an elector, in which case the person shall retain the seat.)* Term: 2-years
7	OEWD	VACANT Term expired 12/31/24 – Holdover Alesandra Lozano	12/31/26	Shall be held by a person appointed by the Director of the Office of Economic and Workforce Development or any successor office. Term: 2-years
8	SFUSD	Saeeda Hafiz	12/31/24	Shall be held by persons appointed by the Board of Education of the San Francisco Unified School District. If at any time the Board of Education declines to appoint a member to Seat 8 or 9 and leaves the seat vacant for 60 days or longer, the Board of Supervisors may appoint a member of the public to fill the seat until such time as the Board of Education appoints a member. Term: 2-years
9	SFUSD	Jennifer Lebarre	12/31/24	

Seat #	Appointing Authority	Seat Holder	Term Ending	Qualification
10	Public Health	VACANT Term Expired 12/31/22 - Holdover Member Tiffany Kenison	12/31/24	Shall be held by an employee of the Department of Public Health who has experience or expertise in the field of chronic disease prevention or treatment, appointed by the Director of Health. Term: 2-years
11	Public Health	Irene Hilton	12/31/24	Shall be held by a person with experience or expertise in the field of oral health, appointed by the Director of Health. Term: 2-years
12	Public Health	Omar Flores	12/31/24	Shall be held by a person with experience or expertise in the field of food security or access, appointed by the Director of Health. Term: 2-years
13	DCYF	Michelle Kim	12/31/24	Shall be held by an employee of the Department of Children, Youth & Their Families, appointed by the Director of that Department. Term: 2-years
14	Recreation and Park	Linda Barnard	12/31/24	Shall be held by an employee of the Recreation and Park Department, appointed by the General Manager of that Department. Term: 2-years

Seat #	Appointing Authority	Seat Holder	Term Ending	Qualification
15	SFUSD	VACANT (Eva Holman resigned 11/6/24)	12/31/24	Shall be held by a parent or guardian of a student enrolled in the San Francisco Unified School District at the time of appointment, nominated by the San Francisco Unified School District's Parent Advisory Council, and appointed by the Board of Supervisors. If at any time the Parent Advisory Council declines to nominate a member to a vacant seat for 60 days or longer, the Board of Supervisors may appoint a member of the public to fill the seat until the seat becomes vacant again. Term: 2-years
16	BOS	VACANT Term expired 12/31/24 – Holdover Laura Urban	12/31/26	Shall be held by a person with experience or expertise in services and programs for children five and under, appointed by the Board of Supervisors. Term: 2-years

* Youth interested in applying to Seat 6 may also obtain more information from the Youth Commission website at http://sfgov.org/youthcommission or by contacting Director Kiely Hosmon at (415) 554-6464.

BOARD OF SUPERVISORS (BOS) APPLICATION FORMS AVAILABLE HERE

- English - https://sfbos.org/sites/default/files/vacancy_application.pdf
- 中文 - https://sfbos.org/sites/default/files/vacancy_application_CHI.pdf
- Español - https://sfbos.org/sites/default/files/vacancy_application_SPA.pdf
- Filipino - https://sfbos.org/sites/default/files/vacancy_application_FIL.pdf

In addition to the application form please complete the SDDTAC Supplemental Questionnaire (located at the end on this notice).

If you have any question regarding the questionnaire, please contact staff at the Advisory Committee (contact information listed below).

(For seats appointed by other Authorities please contact the Board / Commission / Committee / Task Force (see below) or the appointing authority directly.)

Please Note: Depending upon the posting date, a vacancy may have already been filled. To determine if a vacancy for this Commission is still available, or if you require additional information, please call the Rules Committee Clerk at (415) 554-5184.

Applications, Supplemental Questionnaires and other documents may be submitted to BOS-Appointments@sfgov.org

Next Steps: Applicants who meet minimum qualifications will be contacted by the Rules Committee Clerk once the Rules Committee Chair determines the date of the hearing. Members of the Rules Committee will consider the appointment(s) at the meeting and applicant(s) may be asked to state their qualifications. The appointment of the individual(s) who is recommended by the Rules Committee will be forwarded to the Board of Supervisors for final approval.

The general purpose of the Advisory Committee is to make recommendations to the Mayor and the Board of Supervisors on the effectiveness of the Sugary Drinks Distributor Tax in Business Tax and Regulations Code Article 8.

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

(a) Seats 1, 2, and 3 shall be held by representatives of nonprofit organizations that advocate for health equity in communities that are disproportionately impacted by diseases related to the consumption of Sugar-Sweetened Beverages, as defined in Business and Tax Regulations Code Section 552, appointed by the Board of Supervisors.
(b) Seats 4 and 5 shall be held by individuals who are employed at medical institutions in San Francisco and who have experience in the diagnosis or treatment of, or in research or education about, chronic and other diseases linked to the consumption of Sugar-Sweetened Beverages, appointed by the Board of Supervisors.
(c) Seat 6 shall be held by a person who is under 19 years old at the time of appointment and who may be a member of the Youth Commission, nominated by the Youth Commission and appointed by the Board of Supervisors. If the person is under legal voting age and unable to be an elector for that reason, the person may hold this seat, but upon reaching legal voting age, the person shall relinquish the seat unless he or she becomes an elector, in which case the person shall retain the seat.
(d) Seat 7 shall be held by a person appointed by the Director of the Office of Economic and Workforce Development or any successor office.

(e) Seats 8 and 9 shall be held by persons appointed by the Board of Education of the San Francisco Unified School District. If at any time the Board of Education declines to appoint a member to Seat 8 or 9 and leaves the seat vacant for 60 days or longer, the Board of Supervisors may appoint a member of the public to fill the seat until such time as the Board of Education appoints a member.
(f) Seat 10 shall be held by an employee of the Department of Public Health who has experience or expertise in the field of chronic disease prevention or treatment, appointed by the Director of Health.
(g) Seat 11 shall be held by a person with experience or expertise in the field of oral health, appointed by the Director of Health.
(h) Seat 12 shall be held by a person with experience or expertise in the field of food security or access, appointed by the Director of Health.
(i) Seat 13 shall be held by an employee of the Department of Children, Youth & Their Families, appointed by the Director of that Department.
(j) Seat 14 shall be held by an employee of the Recreation and Park Department, appointed by the General Manager of that Department.
(k) Seat 15 shall be held by a parent or guardian of a student enrolled in the San Francisco Unified School District at the time of appointment, nominated by the San Francisco Unified School District's Parent Advisory Council, and appointed by the Board of Supervisors. If at any time the Parent Advisory Council declines to nominate a member to a vacant seat for 60 days or longer, the Board of Supervisors may appoint a member of the public to fill the seat until the seat becomes vacant again.
(l) Seat 16 shall be held by a person with experience or expertise in services and programs for children five and under, appointed by the Board of Supervisors.

Appointing authorities shall make initial appointments to the Advisory Committee by no later than September 1, 2017. The initial term for each seat on the Advisory Committee shall begin September 1, 2017, and end on December 31, 2018.

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

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

Report: Starting in 2018, by March 1 of each year, the Advisory Committee shall submit to the Board of Supervisors and the Mayor a report that (a) evaluates the impact of the Sugary Drinks

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

Holdover Limit: Not Applicable

Authority: Business and Tax Regulations Code, Article VIII, Sections 550 through 560; Administrative Code, Chapter 5, Article XXXIII, Sections 5.33-1 through 5.33-6; Proposition V (2016)

Sunset Date: December 31, 2028

Contact: Christina Goette
Melinda Martin
Department of Public Health
San Francisco, CA
(628) 206-7630
christina.goette@sfdph.org
Melinda.martin@sfdph.org

Updated: December 31, 2024

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.
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.

DEPARTMENT ON THE STATUS OF

WOMEN

CITY AND COUNTY OF SAN FRANCISCO

Gender Analysis
San Francisco Commissions and Boards
FY 2020-2021

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City and County of San Francisco
Department on the Status of Women

London N. Breed
Mayor

Dear Honorable Mayor London N. Breed and Board of Supervisors:

Please find attached the 2021 Gender Analysis of Commissions and Boards Report. We are pleased to share that under Mayor Breed's leadership, representation of women, people of color, and women of color on policy bodies continues to increase. Mayoral appointments are more diverse based on gender and race compared to both supervisorial appointments and appointments in general.

Overall, policy bodies have a larger percentage of women, members of the LGBTQIA+ community, and Veterans[1] than the general San Francisco population. The percentage of women of color and people with disabilities appointed to policy bodies is near equal to the general population. Fiscal year 2020-2021 saw the largest increase in representation of women on policy bodies since the Department on the Status of Women started collecting data in 2009. Women of color have the highest representation of appointees to date.

Black and African American women and men are notably well-represented on San Francisco policy bodies. Black women are 8 percent of appointees compared to 2.4 percent of the general San Francisco population, and Black men are 4 percent of appointees compared to 2.5 percent of the general San Francisco population. Additionally, almost 1-in-4 appointees who responded to the survey question identify as a member of the LGBTQIA+ community.

Commissions that oversee the largest budgets have members of the LGBTQIA+ community, people with disabilities, and Veterans represented at higher percentages than the general population.

While San Francisco continues to make strides in diversity, there is still work to do in achieving parity of representation for Latinx and Asian groups in appointed positions overall, as well as women, people of color, and women of color on Commissions overseeing the largest budgets. The Department applauds Mayor Breed for remaining committed to diversifying policy body appointments across all diversity categories, including for positions of influence and authority.

Thank you to Department staff who worked on this report and to members of the Commission on the Status of Women for their ongoing advocacy for intersectional gender equity efforts.

Kimberly Ellis, Director of the Department on the Status of Women

[1] "Veterans" refers to people who have served and/or have an immediate family member who has served in the military.

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Executive Summary

In 2008, San Francisco voters approved a City Charter Amendment (section 4.101) establishing as City policy for the membership of Commissions and Boards to reflect the diversity of San Francisco's population and appointing officials be urged to support the nomination, appointment, and confirmation of these candidates. Additionally, it requires the San Francisco Department on the Status of Women to conduct and publish a gender analysis of Commissions and Boards every two years.

The 2021 Gender Analysis of Commissions and Boards Report (2021 Gender Analysis Report) evaluates representation of the following groups across appointments to San Francisco policy bodies:

- Women
- People of color
- LGBTQIA+ individuals
- People with disabilities
- Veterans (or people who have immediate family members that have served)
- Various religious affiliations

The report includes policy bodies such as task forces, committees, and Advisory Bodies, in addition to Commissions and Boards.

This year, data was collected from 92 policy bodies and from a total of 349 members, mostly appointed by the Mayor and Board of Supervisors. The policy bodies surveyed for the 2021 Gender Analysis Report fall under two categories designated by the San Francisco Office of the City Attorney.[2] The first category, referred to as "Commissions and Boards," are policy bodies with decision-making authority and whose members are required to submit financial disclosures to the Ethics Commission. The second category, referred to as "Advisory Bodies," are policy bodies with advisory function whose members do not submit financial disclosures to the Ethics Commission. The report examines policy bodies and appointees both comprehensively as a whole and separately by the two categories.

Several changes were made to the survey questions for the 2021 Gender Analysis Report. Sexual Orientation and Gender Identity (SOGI) categories were aligned with the latest classifications used by the Office of Transgender Initiatives. The classification of Veteran Status was also expanded to include individuals with close family members that have served in the military and armed forces. This addition to Veteran Status was adopted based on feedback from previous reports.

While the overall number of policy bodies that submitted data increased compared to 2019, the total number of individual members who participated in the survey was dramatically less than the number who participated in 2019. Due to the pandemic, data collection methods

[2] "Sec. 3.1-103. Filing Officers." *American Legal Publishing Corporation*, https://codelibrary.amlegal.com/codes/san_francisco/latest/sf_campaign/0-0-0-979.

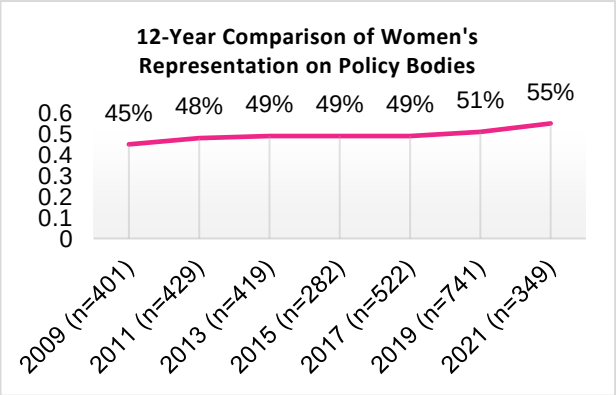
were limited compared to previous years, including the ability to conduct paper surveys and in-person meetings. Reliance on online surveying significantly reduced the level of participation, despite three to five direct contact efforts with policy bodies via phone and email. Moving forward, in addition to collecting data through paper/in-person surveys, when possible, the Department on the Status of Women recommends that all policy body appointees be required to take a training on the Gender Analysis survey process, alongside the required Ethics training, to guarantee participation.

Similarly, due to census data not being collected during COVID-19, updated demographic information on the general population of San Francisco was not available for years more recent than 2019. In this report, data on the San Francisco population references data from previous years (2015-2019) populations.

Key Findings

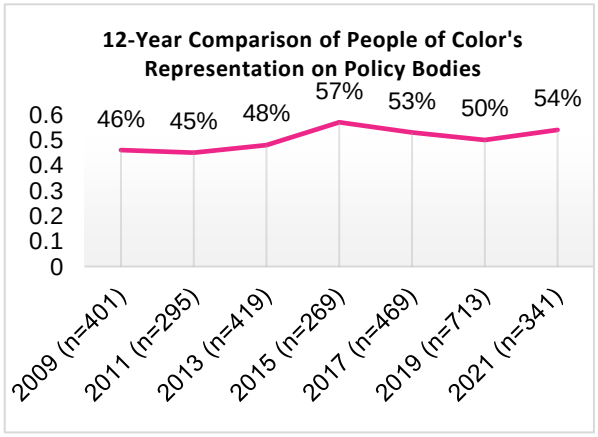
Gender

- Women's representation on policy bodies is 55%, above parity with the San Francisco female population of 49%.
- FY 2021 oversaw the largest increase in the representation of women on San Francisco policy bodies since 2009.



Race and Ethnicity

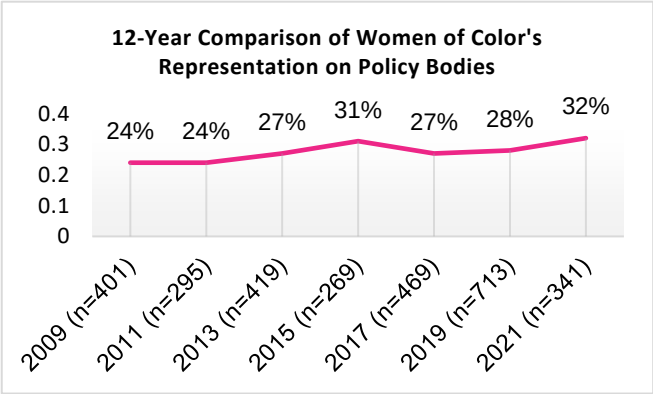
- The representation of people of color on policy bodies is 54%. Comparatively, in San Francisco, 62% of the population identifies with a race other than white.
- While the overall representation of people of color has increased since the 2019 report at 50%, representation has still decreased compared to 57% in 2015.
- As found in previous reports, Latinx and Asian groups are underrepresented on San Francisco policy bodies as compared to the population. Latinx individuals are 15% of the population but make up only 9% of appointees. Asian individuals are 36% of the population but make up only 26% of appointees.



Race and Ethnicity by Gender

- On the whole, women of color are 32% of the San Francisco population and 32% of appointees. This 4% increase is the highest representation of women of color appointees to date.

- Meanwhile, men of color are underrepresented at 21% of appointees compared to 31% of the San Francisco population.



- Both white women and men are overrepresented on San Francisco policy bodies. White women are 25% of appointees compared to 17% of the San Francisco population. White men are 21% of appointees compared to 20% of the population.

- Black and African American women and men are well-represented on San Francisco policy bodies. Black women are 8% of appointees compared to 2.4% of the population, and Black men are 4% of appointees compared to 2.5% of the population.

- Latinx women are 7% of the San Francisco population but 4% of appointees, and Latinx men are 7% of the population but 4% of appointees.

- Asian women are 17% of the San Francisco population but 15% of appointees, and Asian men are 15% of the population but 11% of appointees.

Additional Demographics

- Out of the 74% of appointees who responded to the survey question on LGBTQIA+ identity, 23% identify as lesbian, gay, bisexual, transgender, nonbinary, queer, or questioning, and 77% of appointees identify as straight/heterosexual.

- Out of the 70% of appointees who responded to the question on Disability Status, 12.6% identify as having one or more disabilities, which is just above parity of the 12% of the adult population with a Disability Status in San Francisco.

- Out of the 67% of appointees who responded to the question on Veteran Status, 22% have served in the military (or have an immediate family member who has served) compared to 3% of the San Francisco population (census data on military service does not include immediate family members who have served).

Proxies for Influence: Budget and Authority

- Although women are half of all appointees, those Commissions and Boards with the largest budgets have fewer women, and especially fewer women of color. Meanwhile, representation of women on Boards and Commissions with the smallest budgets are just below parity with the San Francisco population.

- Although still underrepresented relative to the San Francisco population, there is a larger percentage of people of color on Commissions and Boards with both the largest and smallest budgets compared to overall appointees.

- The percentage of total women is greater on Advisory Bodies than Commissions and Boards. Women are 60% of appointees on Advisory Bodies and 53% of appointees on Commissions and Boards. The percentage of women of color on Advisory Bodies is also higher than on Commissions and Boards.

Appointing Authorities

- Mayoral appointments include 60% women, 59% people of color, and 37% women of color, which is more diverse by gender and race compared to both Supervisorial appointments and total appointments.

Demographics of Appointees Compared to the San Francisco Population

	Women	People of Color	Women of Color	LGBTQIA+	Disability Status	Veteran Status
San Francisco Population**	49%	62%	32%	6%-15%*	12%	2.7%
Total Appointees	55%	54%	32%	23%	13%	22%
10 Largest Budgeted Commissions and Boards	43%	44%	21%	16%	15%	20%
10 Smallest Budgeted Commissions and Boards	48%	43%	29%	17%	9%	12%
Commissions and Boards	53%	53%	30%	18%	11%	21%
Advisory Bodies	60%	53%	33%	31%	15%	20%

San Francisco population estimates come from the 2017 and 2018 American Community Survey 5-Year Estimates, SF DOSW Data Collection and Analysis Report, 2021.

**Note: Estimates vary by source. See page 16 for a detailed breakdown.*

***Due to the COVID-19 pandemic, updated data is unavailable for race/ethnicity, LGBTQIA+ status, Disability Status, and Veteran Status in 2021. Therefore, the data used to represent the San Francisco population is from the 2019 Gender Analysis Report.*

I. Introduction

Inspired by the fourth U.N. World Conference on Women in Beijing, San Francisco became the first city in the world to adopt a local ordinance reflecting the principles of the U.N. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), an international bill of rights for women. The CEDAW Ordinance was passed unanimously by the San Francisco Board of Supervisors and signed into law by Mayor Willie L. Brown, Jr. on April 13, 1998.[3] In 2002, the CEDAW Ordinance was revised to address the intersection of race and gender and incorporate reference to the U.N. Convention on the Elimination of all Forms of Race Discrimination. The Ordinance requires the City to take proactive steps to ensure gender equity and specifies "gender analysis" as a preventive tool to identify and address discrimination. Since 1998, the Department on the Status of Women has employed this tool to analyze the operations of 10 City Departments using a gender lens.

In 2007, the Department on the Status of Women conducted the first gender analysis to evaluate the number of women appointed to City Commissions and Boards. The findings of this analysis informed a City Charter Amendment developed by the Board of Supervisors for the June 2008 Election. This City Charter Amendment (section 4.101) was overwhelmingly approved by voters and made it City policy that:

- The membership of Commissions and Boards are to reflect the diversity of San Francisco's population,
- Appointing officials are to be urged to support the nomination, appointment, and confirmation of these candidates, and
- The Department on the Status of Women is required to conduct and publish a gender analysis of Commissions and Boards every two years.

The 2021 Gender Analysis Report examines the representation of women, people of color, LGBTQIA+ individuals, people with disabilities, Veterans, and religious affiliations of appointees on San Francisco policy bodies. As was the case for the 2019 Gender Analysis Report, this year's analysis involved increased outreach to policy bodies as compared to previous analyses that were limited to Commissions and Boards. As a result, the data collection and analysis examine a more diverse and expansive layout of City policy bodies. These policy bodies fall under two categories designated by the San Francisco Office of the City Attorney. The first category, referred to as "Commissions and Boards," are policy bodies with decision-making authority and whose members are required to submit financial disclosures to the Ethics Commission. The second category, referred to as "Advisory Bodies," are policy bodies with advisory function whose members do not submit financial disclosures to the Ethics Commission. A detailed description of methodology and limitations can be found on page 27.

[3] San Francisco Administrative Code Chapter 33.A. http://library.amlegal.com/nxt/gateway.dll/California/administrative/chapter33alocalimplementationoftheunited?f=templates$fn=default.htm$3.0$vid=amlegal:sanfrancisco_ca$anc=JD_Chapter33A.

II. Findings

Many aspects of San Francisco's diversity are reflected in the overall population of appointees on San Francisco policy bodies. The analysis includes data from 92 policy bodies, of which 788 of the 979 seats are filled, leaving 20% vacant. As outlined below in Figure 1, slightly more than half of appointees are women and people of color, 32% are women of color, 23% identify as LGBTQIA+, 13% have a disability, and 22% are Veterans.

Figure 1: Summary Data of Policy Body Demographics, 2021

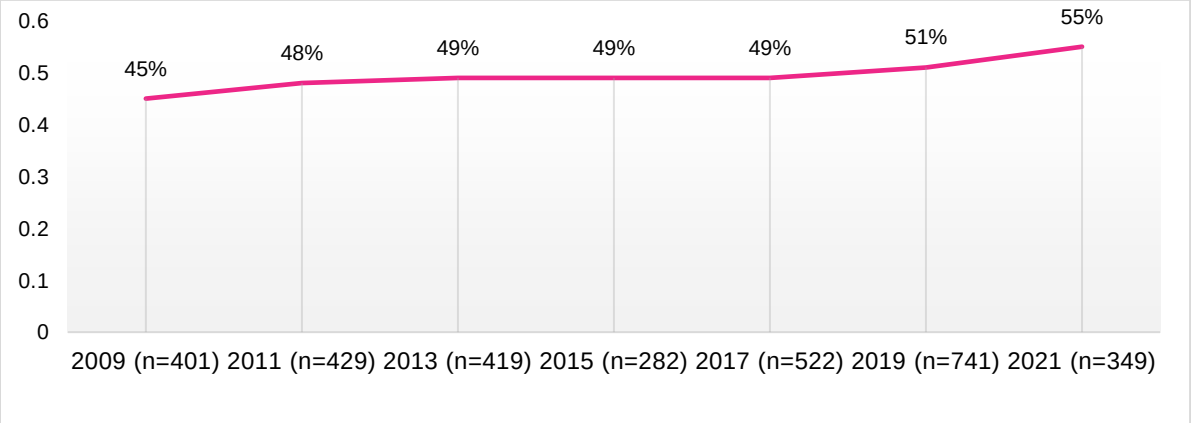
Appointee Demographics	Percentage of Appointees
Women (n=349)	55%
People of Color (n=341)	54%
Women of Color (n=341)	32%
LGBTQIA+ Identifying (n=334)	23%
People with Disabilities (n=349)	13%
Veteran Status (n=349)	22%

However, further analysis reveals underrepresentation of particular groups. Subsequent sections present comprehensive data analysis providing comparison to previous years, detailing the variables of gender, race/ethnicity, LGBTQIA+ identity, Disability Status, Veteran Status, religious affiliations, and policy body characteristics of budget size, decision-making authority, and appointment authority.

A. Gender

On San Francisco policy bodies, 55% of appointees identify as women, which is above parity compared to the San Francisco female population of 49%. The representation of women remained stable at 49% from 2013 until 2017, with a slight increase to 51% in 2019. This increase could be partly due to the larger sample size used in the 2019 analysis compared to previous years. A 12-year comparison shows that the representation of women appointees has gradually increased since 2009 by a total of ten percentage points.

Figure 2: 12-year Comparison of Representation of Women on Policy Bodies



Figures 3 and 4 analyze Commissions and Boards. Figure 3 showcases the five Commissions and Boards with the highest representation of women appointees as compared to 2017 and 2019. The Commission on the Status of Women is currently comprised of all women appointees. This finding has been consistent for the Commission on the Status of Women since 2015. The Aging and Adult Services Commission, Health Commission, and Library Commission are all at 71%, respectively.

Figure 3: Commissions and Boards with the Highest Percentages of Women, 2021 Compared to 2017 and 2019

Policy Body	Percent of Women	Response Rate	2019 Percent	2017 Percent
Commission on the Status of Women	100%	100%	100%	100%
Arts Commission	79%	100%	67%	60%
Children and Families (First 5) Commission	75%	75%	100%	100%
Aging and Adult Services Commission	71%	86%	57%	40%
Health Commission	71%	100%	43%	29%
Library Commission	71%	100%	71%	80%

Out of the Commissions and Boards in this section, 6 have 40% or less women. The Commissions and Boards with the lowest representation of women are displayed in Figure 4. The lowest percentage is found on the Board of Examiners, which has 90% of responses from the Board, but 0 members identifying as women. Unfortunately, demographic data is unavailable for the Board of Examiners for 2017, however there was 0% of female representation in 2019 as well. The Police Commission, Human Services Commission, and Access Appeals Commission all have entirely completed the demographics survey at 100%, yet still have some of the lowest percentages of women at 20%. It should be noted that policy bodies with a small number of members, such as the Residential Users Appeal Board (which currently has two members), means that minimal changes in its demographic composition greatly impacts percentages. Additionally, several policy bodies had low response rates to the demographics survey, ultimately impacting the representation for their respective policy body accordingly.

Figure 4: Commissions and Boards with Lowest Percentage of Women, 2021 Compared to 2017 and 2019

Policy Body	Percent of Women	Response Rate	2019 Percent	2017 Percent
Residential Users Appeal Board	0%	50%	0%	N/A
Board of Examiners	0%	90%	0%	N/A
Assessment Appeals Board No. 3	0%	67%	50%	N/A
Assessment Appeals Board No. 2	0%	100%	50%	N/A
Rent Board Commission	10%	60%	44%	30%
Small Business Commission	14%	43%	43%	43%
Retirement System Board	14%	57%	43%	43%
Health Service Board	14%	43%	33%	29%
Children, Youth, and Their Families Oversight and Advisory Committee	14%	14%	50%	N/A
Treasure Island Development Authority	17%	50%	50%	43%
Public Utilities Commission	20%	60%	67%	40%
Police Commission	20%	100%	43%	29%

Figure 4: Commissions and Boards with Lowest Percentage of Women, 2021 Compared to 2017 and 2019, Continued

Policy Body	Percent of Women	Response Rate	2019 Percent	2017 Percent
Human Services Commission	20%	100%	40%	20%
Access Appeals Commission	20%	100%	N/A	N/A
Public Utilities Rate Fairness Board	25%	75%	33%	33%
Ethics Commission	25%	25%	100%	33%

**Commission and Boards with 70% response rates or higher are highlighted in grey.*

In addition to Commissions and Boards, Advisory Bodies were examined for the highest and lowest percentages of women. This is the second year such bodies have been included, thus comparison to previous years before 2019 is unavailable. Figure 5 below displays the five Advisory Bodies with the highest representations of women. Due to a lack of survey responses from several Advisory Bodies, analysis on the five lowest representations of women is unavailable. The Office of Early Care and Education Citizens' Advisory Committee has the greatest representation of women at 67%, followed closely by the Citizen's Committee on Community Development at 63%.

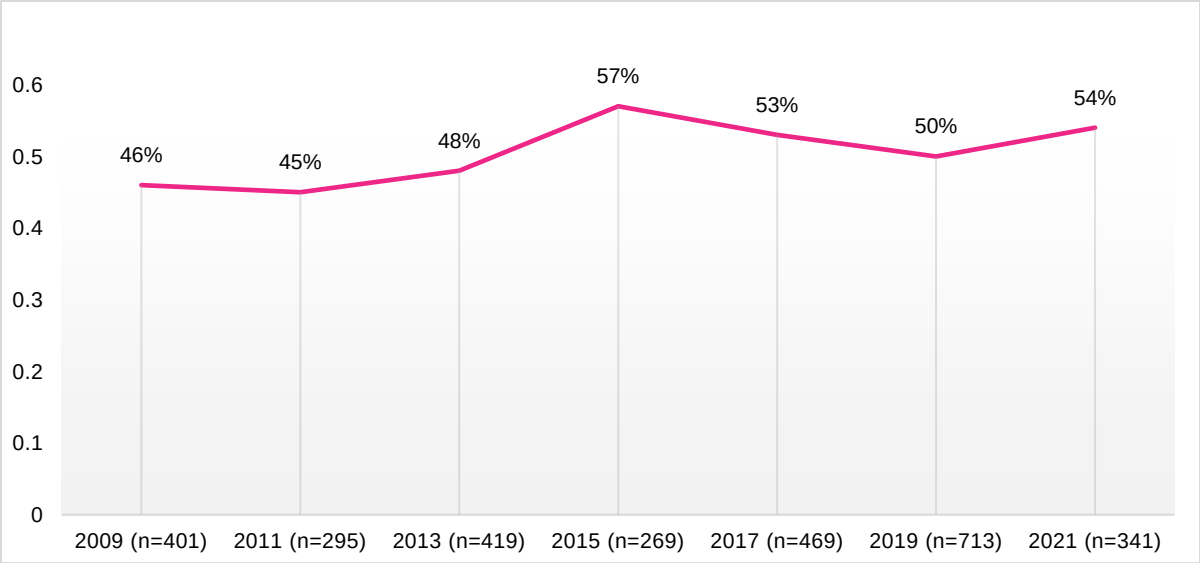
Figure 5: Advisory Bodies with the Highest Percentage of Women, 2021

Policy Body	Percent of Women	Response Rate	2019 Percent
Office of Early Care and Education Citizens' Advisory Committee	67%	78%	89%
Citizens' Committee on Community Development	63%	63%	75%
Ballot Simplification Committee	50%	75%	75%
Immigrant Rights Commission	43%	57%	54%
Municipal Green Building Task Force	43%	67%	50%

B. Race and Ethnicity

Data on racial and ethnic identity was collected from 341 participants, or 98% of the surveyed appointees. Although half of appointees identify as a race or ethnicity other than white or Caucasian, people of color are still underrepresented compared to the San Francisco population of 62%. The representation of people of color has increased since 2009 but has decreased following 2015. The number of appointees analyzed increased substantially in 2017 and 2019, as compared to 2015. These larger data samples have coincided with smaller percentages of people of color.

Figure 6: 12-year Comparison of Representation of People of Color on Policy Bodies



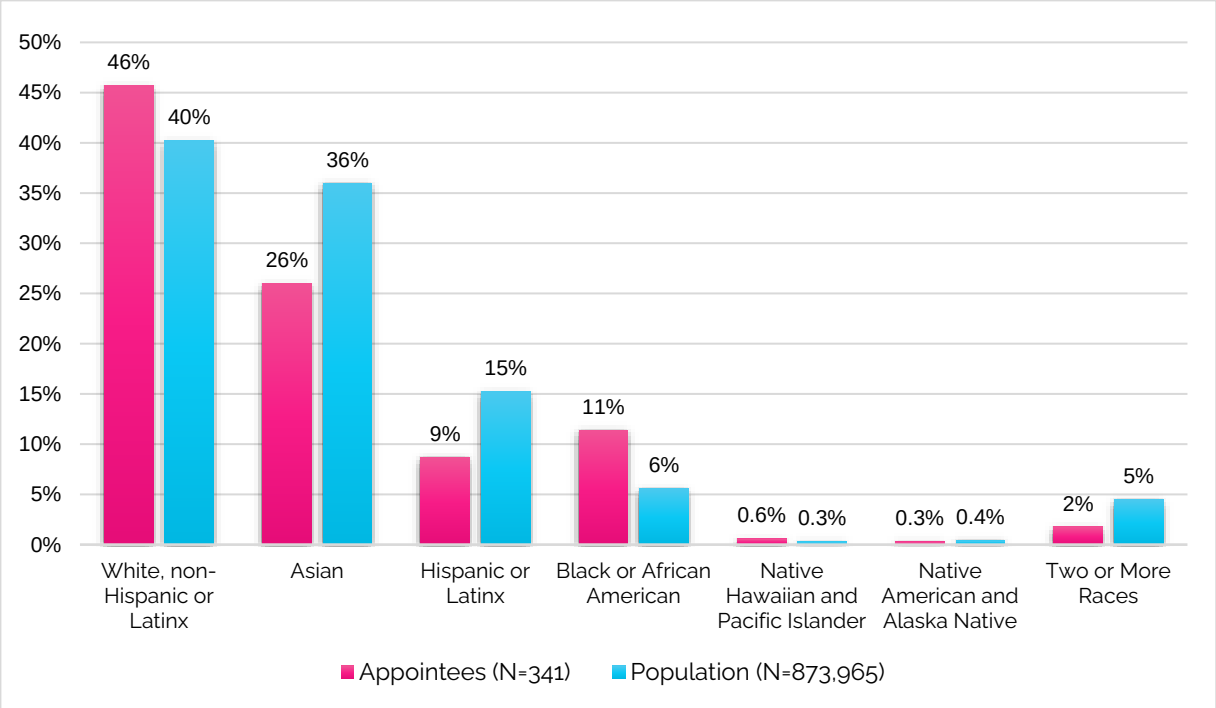
The racial and ethnic breakdown of policy body members compared to the San Francisco population is shown in Figure 7. This analysis reveals underrepresentation and overrepresentation in San Francisco policy bodies for certain racial and ethnic groups. Nearly half of all appointees are white, an overrepresentation by 6 percentage points. The Black community is represented on appointed policy bodies at 11% compared to 6% of the population of San Francisco.[4] This is a decrease of representation compared to the 14% representation in 2019. Characterizing these as overrepresentations is inaccurate given the representation of Black or African American people on policy bodies has been consistent over the years, while the San Francisco population has declined over the same period.[5]

[4] US Census Bureau, 2018, Retrieved from https://www.census.gov/quickfacts/fact/table/US/PST045218.

[5] Samir Gambhir and Stephen Menendian, "Racial Segregation in the Bay Area, Part 2," Haas Institute for a Fair and Inclusive Society (2018).

Considerably underrepresented racial and ethnic groups on San Francisco policy bodies compared to the San Francisco population are individuals who identify as Asian or Latinx. While the Asian population is 36% of the San Francisco population, they make up 26% of appointees. While the Latinx population of San Francisco is 15%, 9% of appointees are Latinx. Although there is a small population of Native Americans and Alaska Natives in San Francisco of 0.4%, only one (0.3%) surveyed appointee identified themselves as such. The San Francisco population of Native Hawaiians and Pacific Islanders is 0.3%, which slightly less than the 0.6% of identifying appointees.

Figure 7: Race and Ethnicity of Appointees Compared to San Francisco Population, 2021



Note: Due to the COVID-19 pandemic, updated data is unavailable for race/ethnicity in 2021. Therefore, the data used to represent the San Francisco population is from the 2019 Gender Analysis Report.

The next two figures illustrate Commissions and Boards with the highest and lowest percentages of people of color. As shown in Figure 8, the Commission on the Status of Women holds the highest representation of people of color at 86%, with a 100% response rate. Both the Health Commission and Juvenile Probation Commission have decreased their percentages of people of color since 2019 and 2017.

Figure 8: Commission and Boards with Highest Percentage of People of Color, 2021 Compared to 2019 and 2017

Policy Body	Percent of POC	Response Rate	2019 Percent	2017 Percent
Commission on the Status of Women	86%	100%	71%	71%
Police Commission	80%	100%	71%	71%
Arts Commission	71%	100%	60%	53%
Health Commission	71%	100%	86%	86%
Library Commission	71%	100%	57%	60%
Juvenile Probation Commission	67%	83%	100%	86%
Board of Appeals	60%	100%	40%	40%
Fire Commission	60%	100%	40%	60%
Human Services Commission	60%	100%	40%	60%
Asian Art Commission	54%	81%	59%	59%
Assessment Appeals Board No.2	50%	100%	63%	N/A
Children and Families (First 5) Commission	50%	75%	75%	63%

There are 28 Commissions and Boards that have 40% or less appointees who identified a racial and ethnic category other than white. None of the current appointees of the Access Appeals Commission identified as people of color. Additionally, the Historic Preservation Commission remains at 14% representation since 2019. The Citizens General Obligation Bond Oversight Committee and Assessment Appeals Board No.1 are both at 17% representation for people of color. Lastly, the Public Utilities Rate Fairness Board had a large drop in representation of people of color going from 67% in 2019 to 25% this year.

Figure 9: Commissions and Boards with Lowest Percentage of People of Color, 2021 Compared to 2019 and 2017

Policy Body	Percent of POC	Response Rate*	2019 Percent	2017 Percent
Residential Users Appeal Board	0%	50%	50%	N/A
Children, Youth, and Their Families Oversight and Advisory Committee	0%	14%	75%	N/A
Building Inspection Commission	0%	50%	14%	14%
Access Appeals Commission	0%	100%	N/A	N/A
Small Business Commission	14%	43%	43%	50%
Historic Preservation Commission	14%	71%	14%	17%
Health Service Board	14%	43%	50%	29%
Citizens General Obligation Bond Oversight Committee	17%	100%	N/A	N/A
Assessment Appeals Board No.1	17%	100%	20%	N/A
War Memorial Board of Trustees	18%	45%	18%	18%
Public Utilities Commission	20%	60%	0%	33%
Public Utilities Rate Fairness Board	25%	75%	67%	67%

Figure 9: Commissions and Boards with Lowest Percentage of People of Color, 2021 Compared to 2019 and 2017, Continued

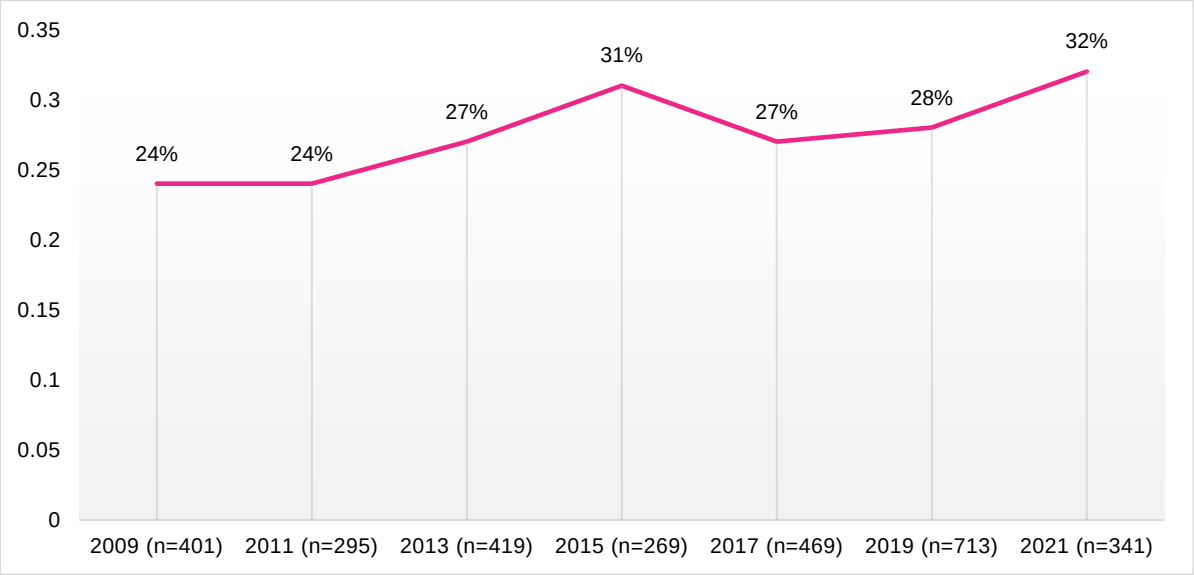
Policy Body	Percent of POC	Response Rate*	2019 Percent	2017 Percent
Ethics Commission	25%	25%	50%	67%
Retirement System Board	29%	57%	29%	29%
Recreation and Park Commission	29%	43%	43%	43%
Rent Board Commission	30%	60%	33%	50%

Commission and Boards with 70% response rates or higher are highlighted in grey.

C. Race and Ethnicity by Gender

Both white men and women are overrepresented on San Francisco policy bodies, while Asian and Latinx men and women are underrepresented. The representation of women of color at 32% is equal to the San Francisco population of 32%, which is a notable increase compared to the 2019 percentage of 28%. Meanwhile, men of color are 21% of appointees compared to 31% of the San Francisco population.

Figure 10: 12-Year Comparison of Representation of Women of Color on Policy Bodies



The following figures present the breakdown for appointees and the San Francisco population by race, ethnicity, and gender. Both white men and women are overrepresented, holding 24% and 20% of appointments, respectively, compared to 20% and 17% of the population. Asian men and women are slightly underrepresented with Asian women making up 15% of appointees compared to 17% of the population, while Asian men comprise 11% of appointees and 15% of the population. Latinx men and women are also slightly underrepresented, with Latinx men and women comprising 4% of appointees each and 7% of the population each. Black men and women are well-represented with Black women comprising 8% of appointees, compared to 2.4% of the general San Francisco population, and Black men comprising 4% of appointees,

compared to 2.5% of the general San Francisco population. Native Hawaiian and Pacific Islander men and women, and multiracial women are below parity with the population. Similarly, although Native American and Alaska Native men and women make up only 0.4% of San Francisco's population, only one (0.3%) of the surveyed appointees identified as such.

Figure 11: Appointees by Race/Ethnicity and Gender, 2021

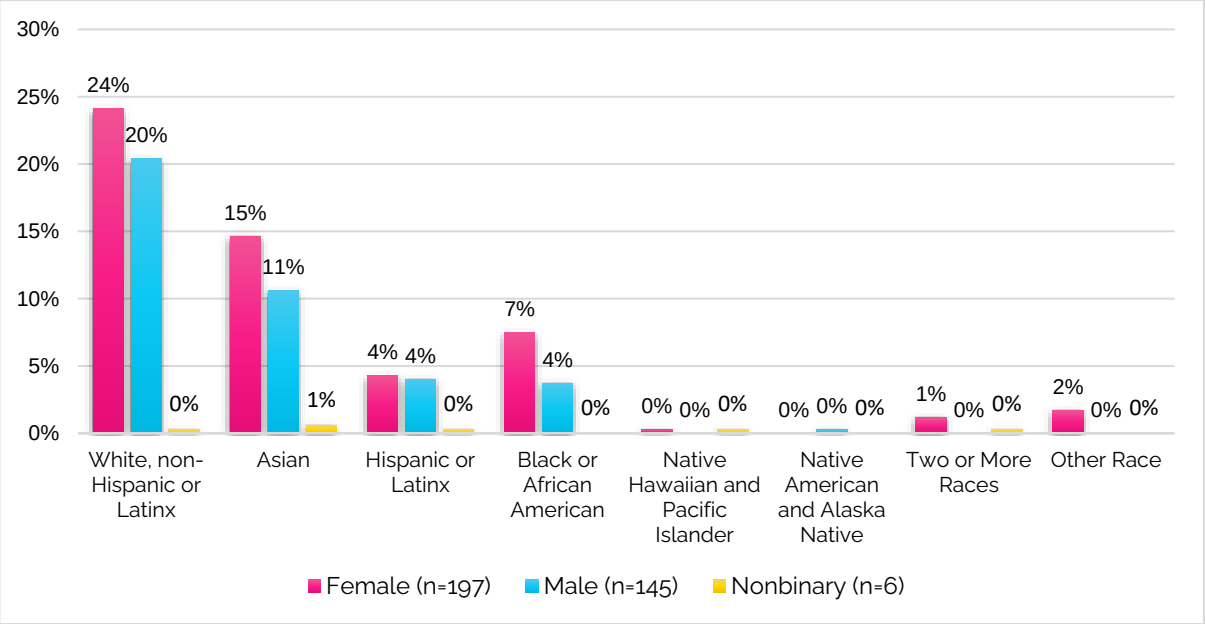
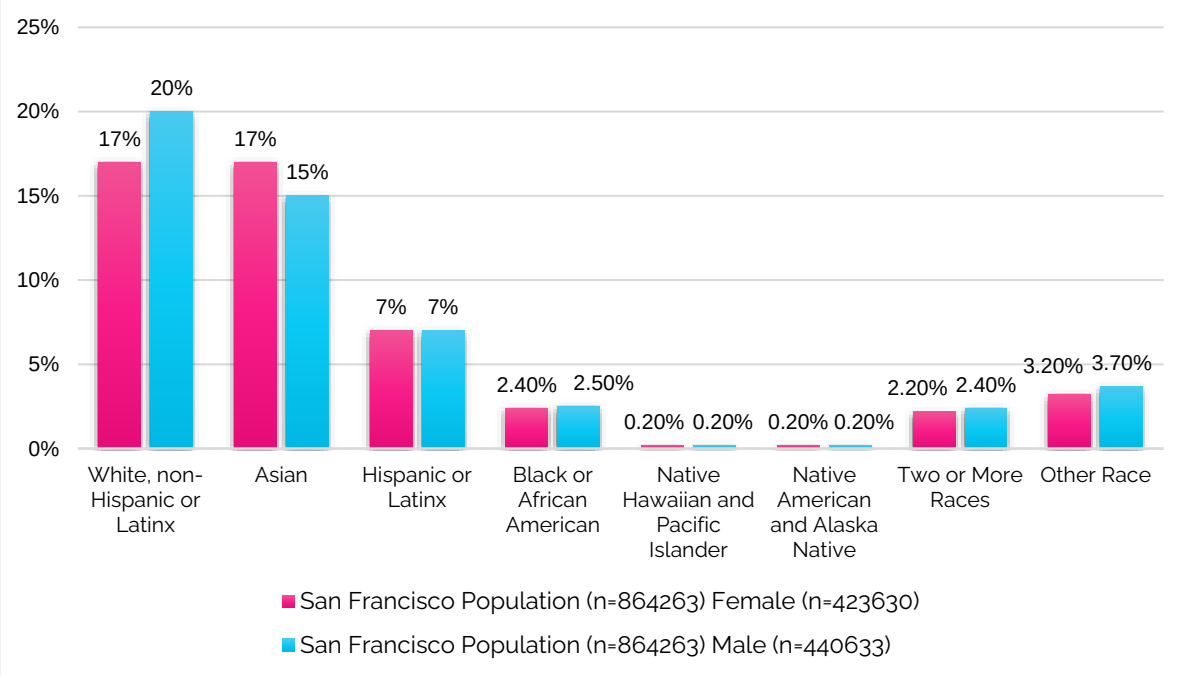


Figure 12: San Francisco Population by Race/Ethnicity

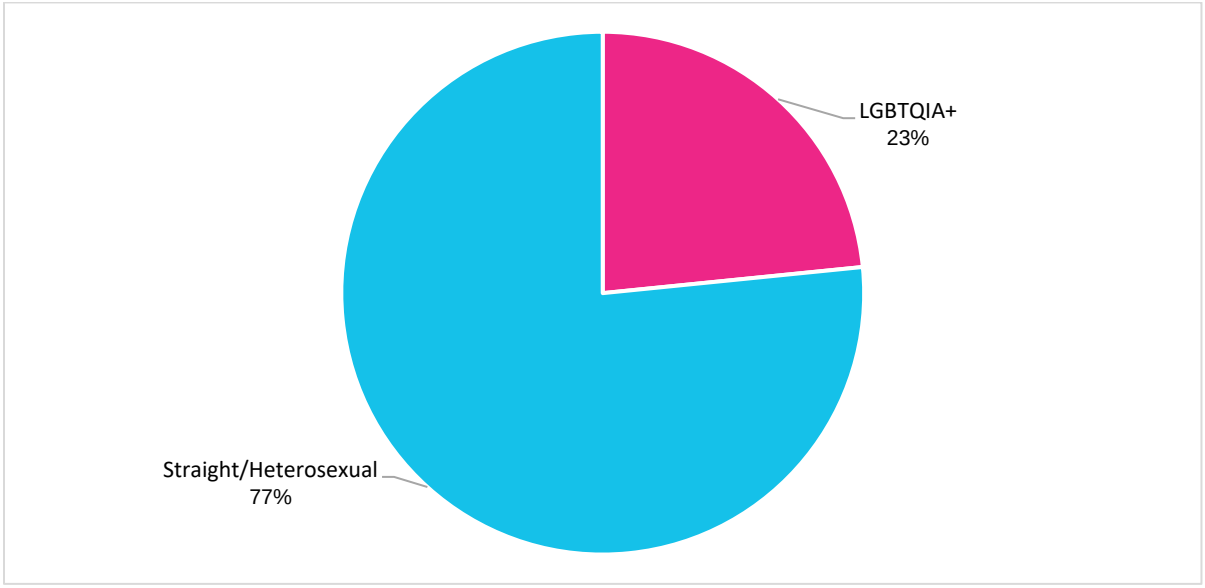


D. LGBTQIA+ Identity

LGBTQIA+ identity data was collected from 334 participants, or 96% of the surveyed appointees. This is a notable increase in data on LGBTQIA+ identity compared to previous reports. Due to limited and outdated information on the population of the LGBTQIA+ community in San Francisco, it is difficult to adequately assess the representation of the LGBTQIA+ community. However, compared to available San Francisco, greater Bay Area, and national data, the LGBTQIA+ community is well represented on San Francisco policy bodies. Recent research estimates the California LGBTQIA+ population is 5.3%[6]. The LGBTQIA+ population of the San Francisco and greater Bay Area is estimated to rank the highest of U.S. cities at 6.2%,[7] while a 2006 survey found that 15.4% of adults in San Francisco identify as LGBTQIA+[8] .

Of the appointees who responded to this question, 23% identify as LGBTQIA+ and 77% identify as straight or heterosexual. Of the LGBTQIA+ appointees, 56% identify as gay/lesbian, 20% as bisexual, 9% as queer, 9% as transgender, 2% as questioning, and 4% as other LGBTQIA+ identities. Data on LGBTQIA+ identity by race was not captured. Efforts to capture data on LGBTQIA+ identity by race for future reports would enable more intersectional analysis.

Figure 13: LGBTQIA+ Identity of Appointees, 2021

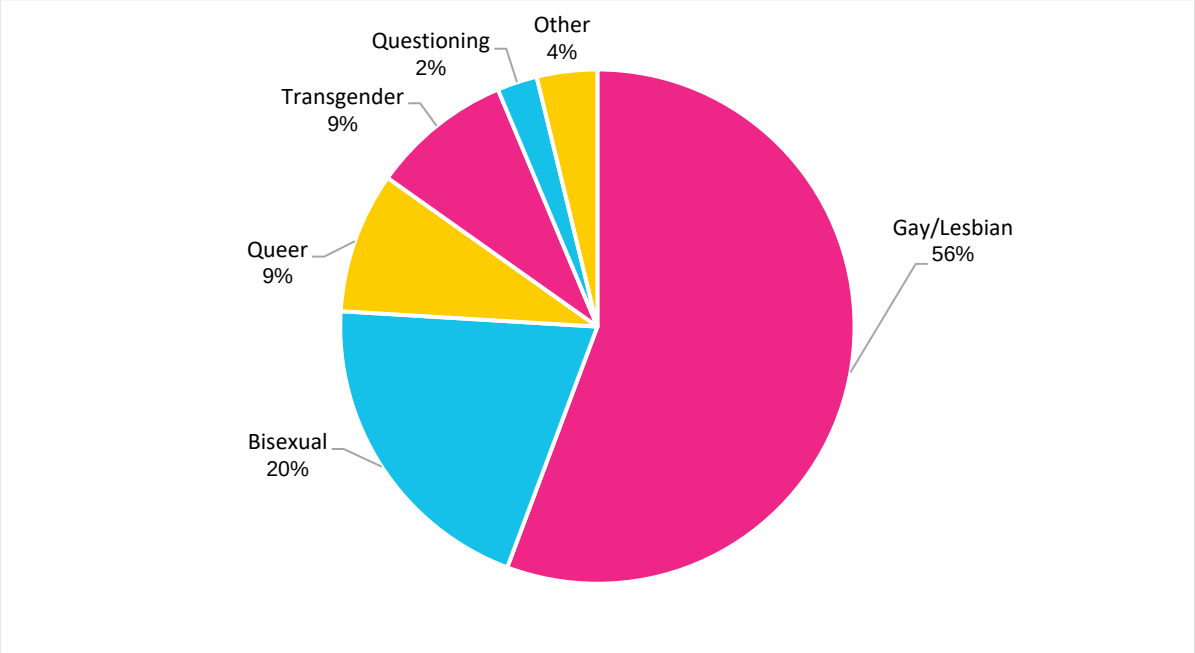


[6] https://williamsinstitute.law.ucla.edu/publications/adult-lgbt-pop-us/

[7] Gary J. Gates and Frank Newport, "San Francisco Metro Area Ranks Highest in LBGT Percentage," GALLUP (March 20, 2015) https://news.gallup.com/poll/182051/san-francisco-metro-area-ranks-highest-lgbtpercentage.aspx?utm_source=Social%20Issues&utm_medium=newsfeed&utm_campaign=tiles.

[8] Gary J. Gates, "Same Sex Couples and the Gay, Lesbian, Bisexual Population: New Estimates from the American Community Survey," The Williams Institute on Sexual Orientation Law and Public Policy, UCLA School of Law (2006).

Figure 14: LGBTQIA+ Population of Appointees, 2021



E. Disability Status

Overall, more than one in twenty adults in San Francisco live with one or more disabilities. Data on Disability Status was obtained from nearly 100% of the appointees who participated in the survey. 12.6% of participating appointees reported to have one or more disabilities. Of these appointees with one or more disabilities, 56% are women, 30% are men, 2% are trans women, 5% are trans men, and 7% are nonbinary individuals.

Figure 15: Disability Status of Appointees, 2021

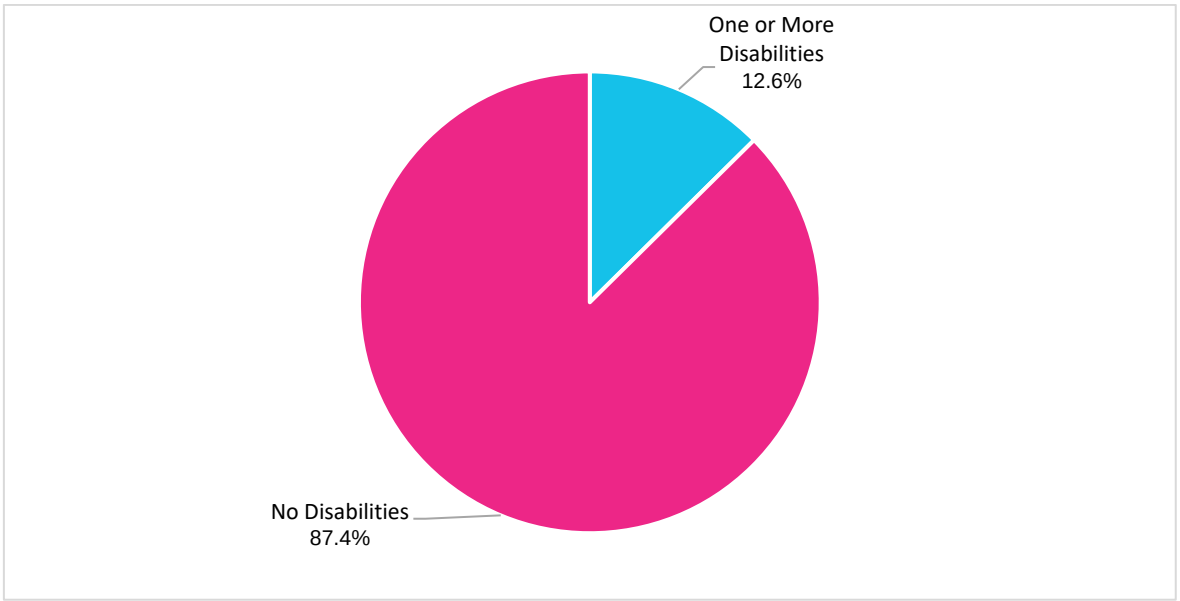
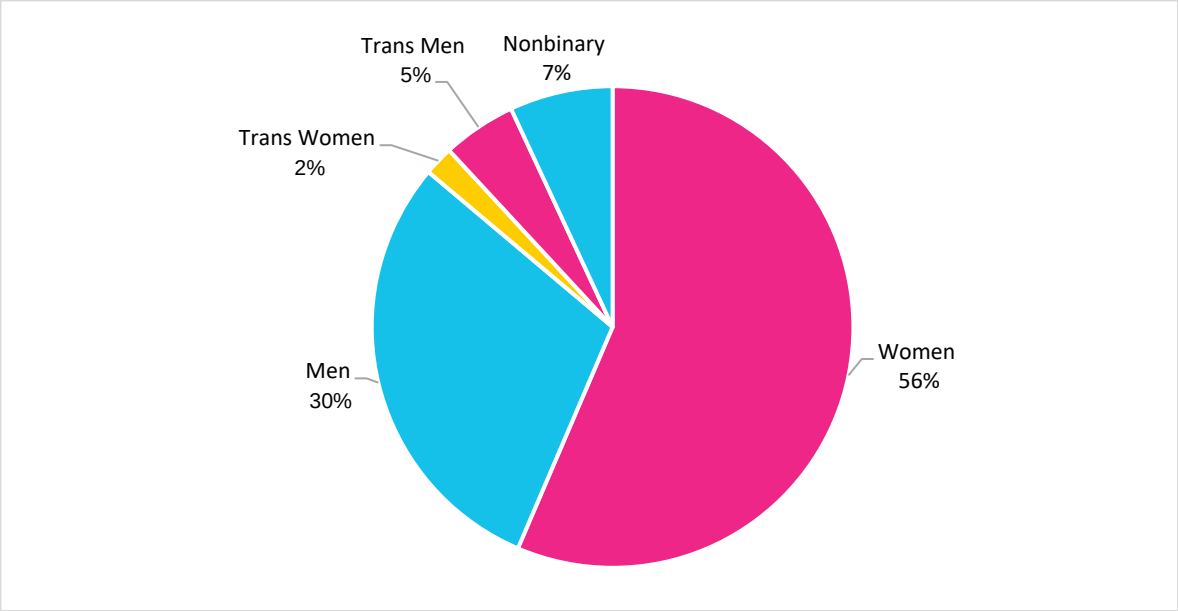


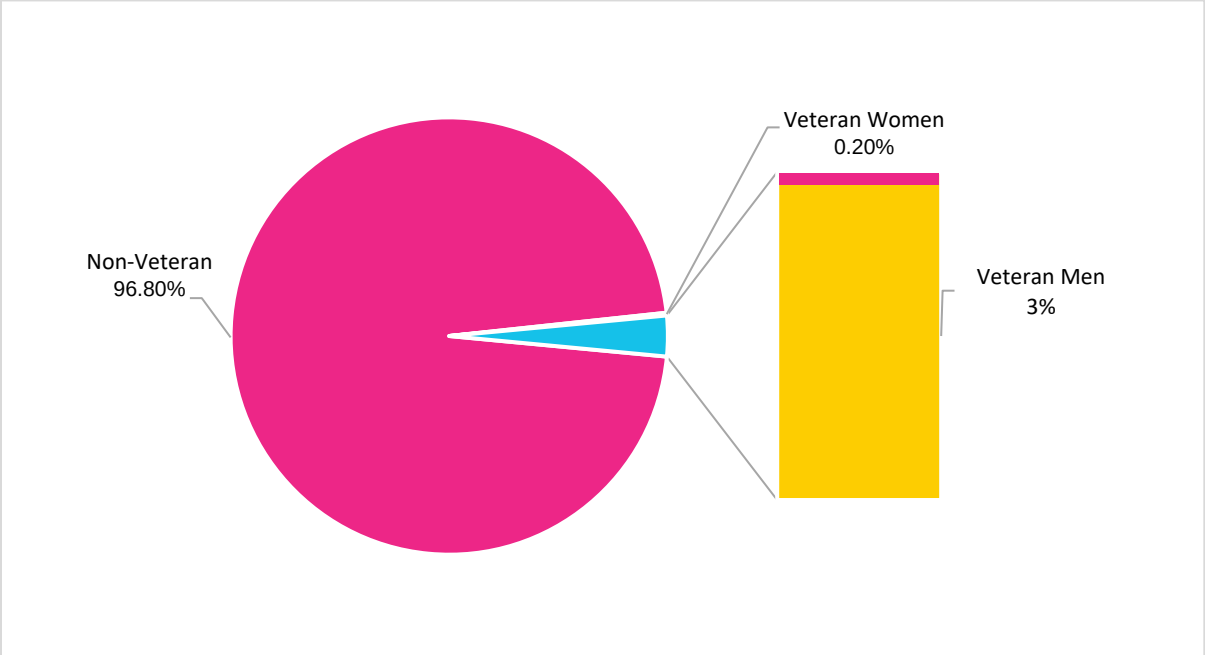
Figure 16: Appointees with One or More Disabilities by Gender Identity, 2021



F. Veteran Status

Overall, 2.7% of the adult population in San Francisco have served in the military. Data on Veteran status was obtained from 334 appointees who participated in the survey. Of the 334 appointees who responded to this question, 22% served in the military. Men comprise 47.2% and women make up 51.4% of the total number of Veteran appointees. Of participating appointees, 1.4% are nonbinary individuals. Veteran status data on transgender and gender-nonconforming individuals in San Francisco is currently unavailable. The vast increase of appointees with military service compared to 2019's 7.1% of appointees is likely due to the change in wording in the 2021 Gender Analysis Report from previous years, which defines an appointee with Veteran status as someone with a spouse or direct family member who has served, as opposed to only oneself or their spouse. This change was implemented based on feedback from prior reports. Future analyses may want to ask separate questions regarding one's personal experience with military service and one's familial ties to military service, in order to distinguish the most accurate and aggregated data results.

Figure 17: San Francisco Adult Population with Military Service by Gender*



**This graph is from the 2019 Gender Analysis Report. Due to the COVID-19 pandemic, updated data on the gendered population of Veterans in San Francisco is unavailable. This graph fails to identify nonbinary individuals with military experience. However, this graph highlights the gender disparity amongst male and female Veterans, with only 0.2% identifying as women.*

Figure 18: Appointees with Military Service, 2021

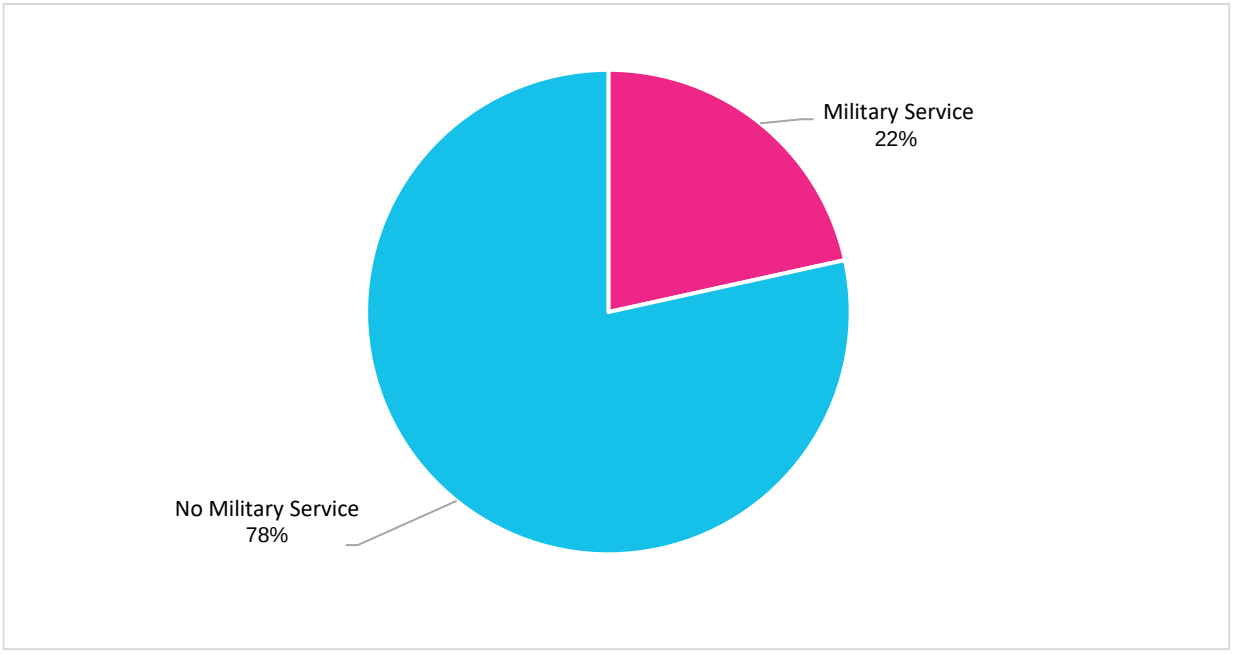
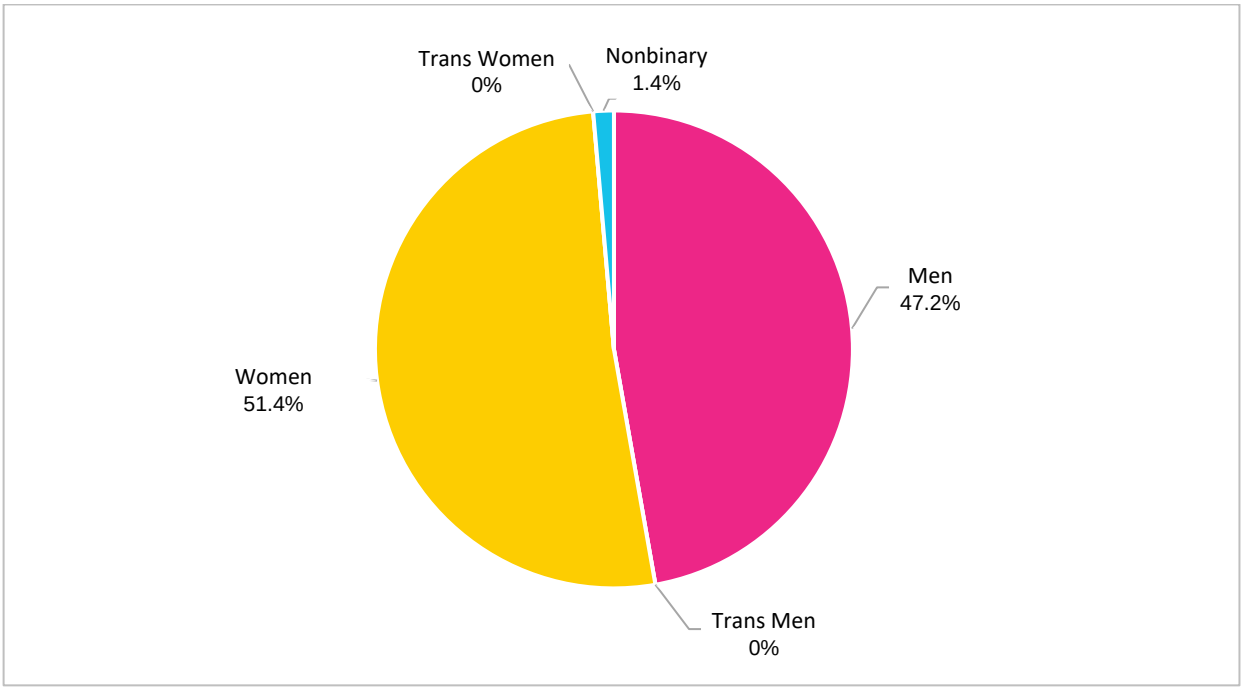


Figure 19: Appointees with Military Service by Gender, 2021



G. Policy Bodies by Budget

This 2021 Gender Analysis Report examines the demographic representativeness of policy bodies by budget size. Budget size is used as a proxy for influence. Although this report has expanded the scope of analysis to include more policy bodies compared to previous reports, this section of analysis was limited to Commissions and Boards with decision-making authority and whose members file financial disclosures with the Ethics Commission.

Overall, appointees from the 10 **largest** budgeted Commissions and Boards are 44% people of color, 43% women, and 21% women of color. Appointees from the 10 **smallest** budgeted Commissions and Boards are 43% people of color, 48% women, and 29% women of color.

Representation for women, women of color, and overall people of color is below parity with the population on both the 10 smallest and 10 largest budgeted bodies. The representation of women and women of color is greater on smaller budgeted policy bodies by 5% and 8%, respectively. The representation of people of color is 1% higher on Commissions and Boards with the largest budgets.

Figure 20: Percent of Women, Women of Color, and People of Color on Commissions and Boards with Largest and Smallest Budgets in Fiscal Year 2020-2021

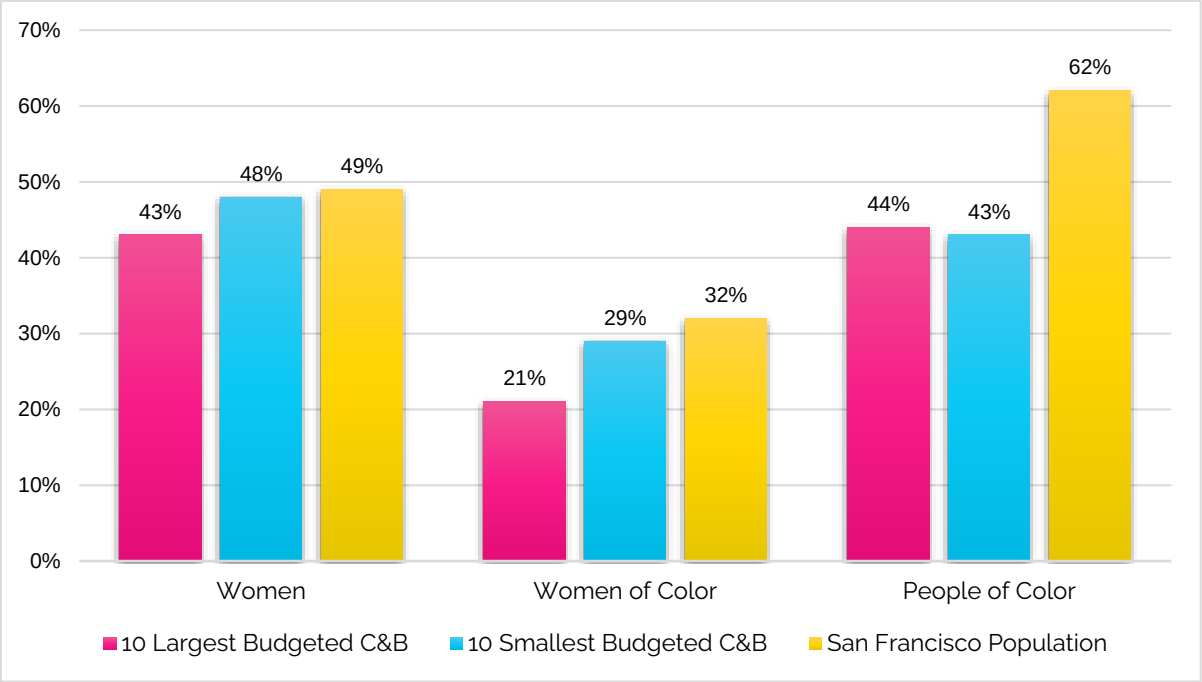


Figure 21: Demographics of Commissions and Boards with Largest Budgets, 2021

Policy Body	FY20-21 Budget	Total Seats	Filled Seats	Response Rate	Women	Women of Color	People of Color
Health Commission	$2.7B	7	7	100%	71%	43%	71%
Public Utilities Commission	$1.43B	5	5	60%	20%	20%	20%
Airport Commission	$1.37B	5	5	100%	40%	0%	40%
MTA Board of Directors and Parking Authority Commission	$1.26B	7	6	50%	33%	33%	50%
Human Services Commission	$604M	5	5	100%	20%	0%	60%
Aging and Adult Services Commission	$435M	7	7	86%	71%	29%	43%
Fire Commission	$414M	5	5	100%	40%	20%	60%
Library Commission	$341B	7	7	100%	71%	43%	71%
Recreation and Park Commission	$231.6M	7	7	43%	29%	14%	29%
Children, Youth, and Their Families Oversight and Advisory Committee	$171.5M	11	7	14%	14%	0%	0%
Total	**$8.9B**	**66**	**61**	**74%**	**58%**	**29%**	**60%**

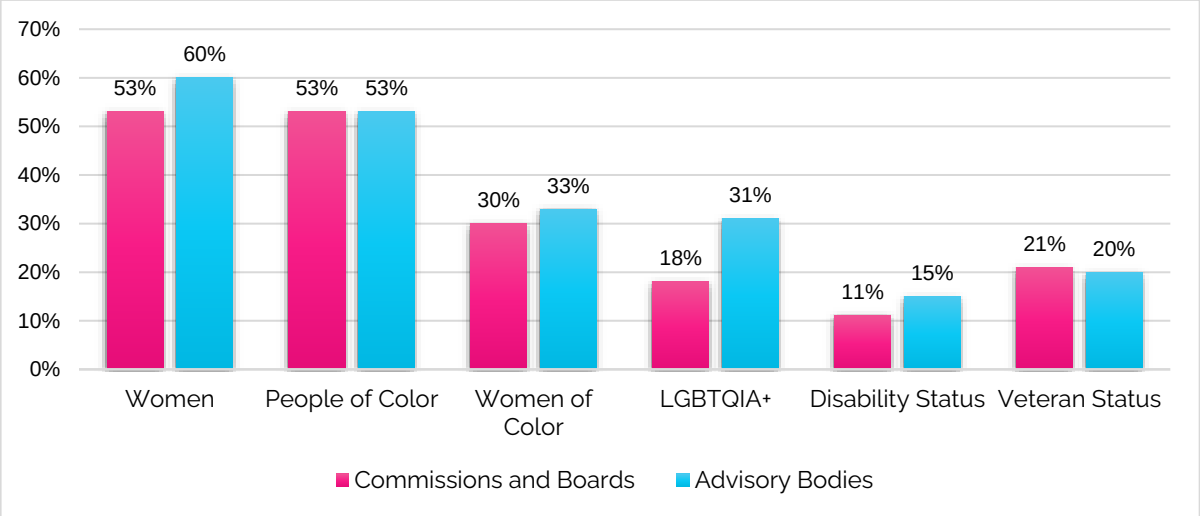
Figure 22: Demographics of Commissions and Boards with Smallest Budgets, 2021

Policy Body	FY20-21 Budget	Total Seats	Filled Seats	Response Rate	Women	Women of Color	People of Color
Commission on the Status of Women	$9M	7	7	100%	100%	86%	86%
Ethics Commission	$6.5M	5	4	25%	25%	25%	25%
Small Business Commission	$3.5M	7	7	43%	14%	0%	14%
Film Commission	$1.5M	11	11	100%	45%	27%	45%
Civil Service Commission	$1.3M	5	5	100%	60%	20%	40%
Entertainment Commission	$1.2M	7	7	100%	29%	14%	43%
Board of Appeals	$1.2M	5	5	100%	40%	20%	60%
Assessment Appeals Board No.1	$701,348	8	6	100%	50%	0%	17%
Local Agency Formation Commission	$427,685	7	4	50%	50%	50%	50%
Sunshine Ordinance Task Force	$172,373	11	9	89%	56%	44%	44%
Total	**$25.5M**	**73**	**65**	**86%**	**56%**	**35%**	**51%**

H. Comparison of Advisory Body and Commission and Board Demographics

The comparison of the two policy body categories in this section provides another proxy for influence. Commissions and Boards whose members file disclosures of economic interest have greater decision-making authority in San Francisco than Advisory Bodies whose members do not file economic interest disclosures. The percentages of total women, LGBTQIA+ people, people with disabilities, and women of color are larger for total appointees on Advisory Bodies. However, the percentages of Veterans on Commissions and Boards slightly exceeds the percentage on Advisory Bodies, and both Commissions and Boards and Advisory Bodies have 53% people of color.

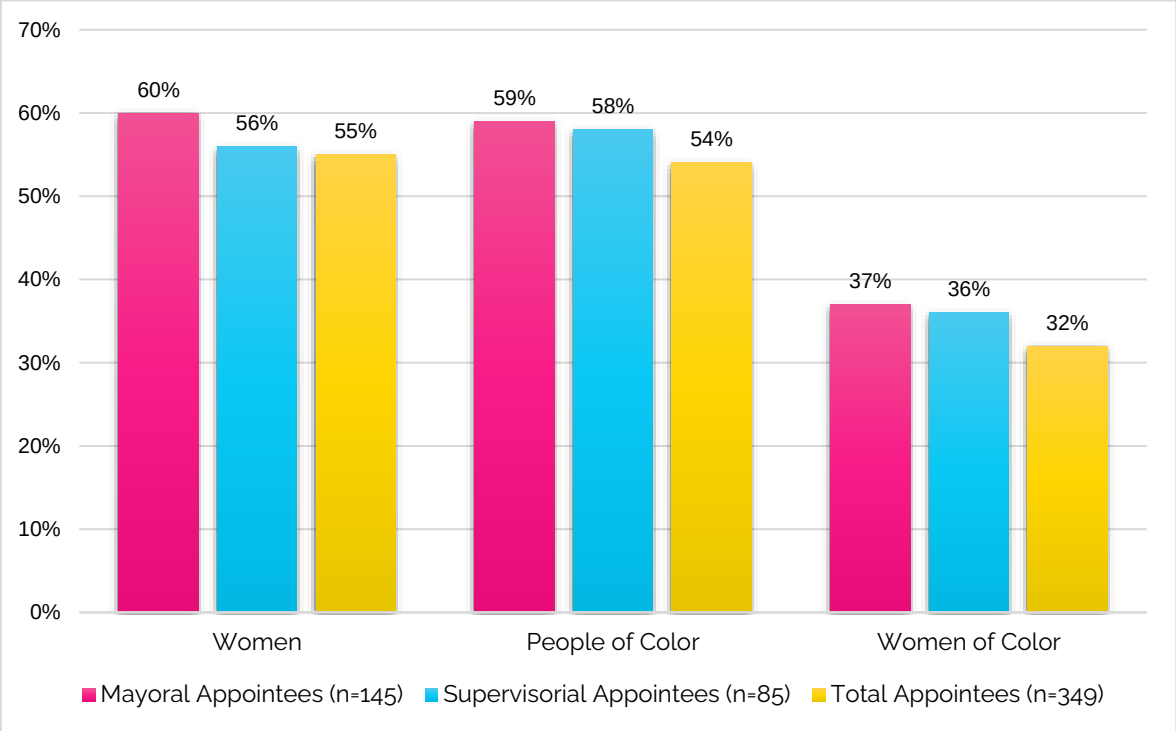
Figure 23: Demographics of Appointees on Commission and Boards and Advisory Bodies, 2021



I. Demographics of Mayoral, Supervisorial, and Total Appointees

Figure 24 compares the representation of women, women of color, and people of color for appointments made by the Mayor, Board of Supervisors, and by the total of all approving authorities combined. Mayoral appointments are more diverse, and consist of more women, women of color, and people of color compared to Supervisorial appointments. Mayoral appointments include 60% women, 37% women of color, and 59% people of color, while Supervisorial appointments are 56% women, 36% women of color, and 58% people of color. The total of all approving authorities combined average out at 55% women, 32% women of color, and 54% people of color. This disparity in diversity between Mayoral and Supervisorial appointments may be due in part to the appointment selection process for each authority. The 11-member Board of Supervisors only sees applicants for specific bodies through the 3- member Rules Committee or by designees, stipulated in legislation (e.g., "renter," "landlord," "consumer advocate"), whereas the Mayor typically has the ability to take total appointments into account during selections, and can therefore better address gaps in diversity.

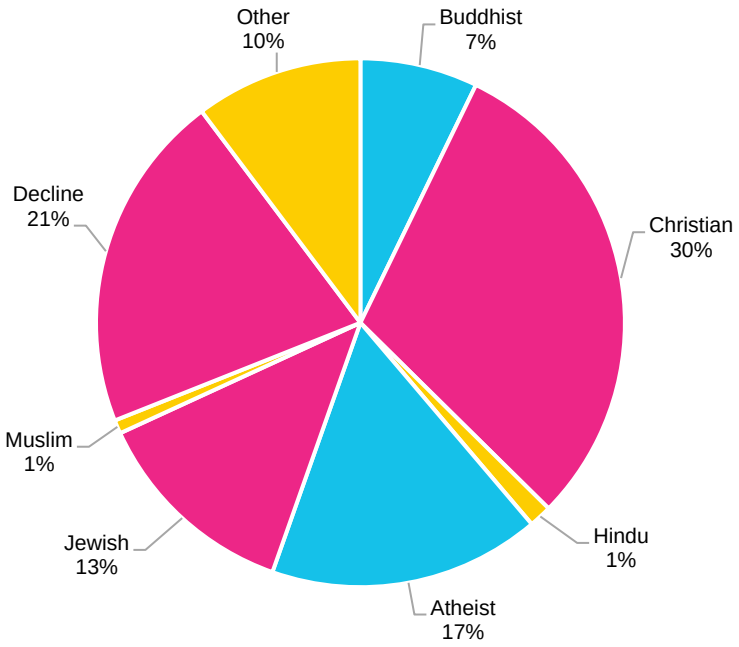
Figure 24: Demographics of Mayoral, Supervisorial, and Total Appointees, 2021



J. Religious Affiliations

The 2021 Gender Analysis Report collected data on religious affiliations to fully examine the demographics and representation of appointees. This is the first-year religious affiliations have been examined. Figure 25 illustrates the religious demographics of appointees, with the largest number of appointees identifying as Christian (30%), and the smallest number of appointees identifying as Hindu (1%) or Muslim (1%).

Figure 25: Religious Affiliations of Appointees, 2021



III. Methodology and Limitations

This report focuses on City and County of San Francisco Commissions, Boards, task forces, councils, and committees that have the majority of members appointed by the Mayor and Board of Supervisors and have jurisdiction limited to the City. The 2021 Gender Analysis Report reflects data from the policy bodies that provided information to the Department on the Status of Women through digital survey. Due to the COVID-19 pandemic, the normal outreach method of paper surveys and in-person meetings was unavailable, ultimately leaving all survey outreach and correspondence to be conducted online. Unfortunately, obtaining the data strictly online had a significant negative impact on participation rates. Following initial email outreach, policy bodies were contacted three to five times via email and phone, including two emails to Department Heads from Department on the Status of Women Director, Kimberly Ellis. All possible measures were taken to obtain accurate and complete data. While participation rates are lower than the 2019 Gender Analysis Report, this report features the most diverse individual responses, as well as participation of the largest number of Commission and Boards and Advisory Bodies to date.

Data was requested from 109 policy bodies and acquired from 92 of those bodies, a total of 349 appointees. Comparatively, the 2019 Gender Analysis Report received data from 84 policy bodies (380 Commission and Boards and 389 Advisory Bodies), a total of 741 total appointees. A Commissioner or Board member's gender identity, race/ethnicity, sexual orientation, Disability Status, Veteran Status, or religious affiliations were among data elements collected on a *voluntary* basis. Therefore, responses were incomplete or unavailable for some appointees but are included to the extent possible.

As the fundamental objective of this report is to surface patterns of underrepresentation, every attempt has been made to reflect accurate and complete information in this report. Data for some policy bodies was incomplete, and all appointees who responded were included in the total demographic categories. Only policy bodies with full data on gender and race for all appointees were included in sections comparing demographics of individual bodies. It should be noted that for policy bodies with a small number of members, the change of a single individual greatly impacts the percentages of demographic categories. This should be kept in mind when interpreting these percentages.

Several changes were made to the survey questions since the 2019 Gender Analysis Report with the goal of distinguishing all possible areas of underrepresentation. In addition to updating SOGI (sexual orientation and gender identity) categories to align with the latest classifications used by the Office of Transgender Initiatives, the 2021 Gender Analysis Report expanded its classification of Veteran Status to include individuals with close family members that have served, as opposed to only oneself or their spouse. This addition to Veteran Status was adopted based on feedback from previous reports.

As acquiring data was the biggest limitation of this report, ensuring participation from all policy bodies could significantly improve or further efforts to address underrepresentation. Some methods of guaranteeing participation include surveying all appointees during their initial onboarding training with the City, as well as relying on paper/in-person survey outreach for future reports.

The surveyed policy bodies fall under two categories designated by the San Francisco Office of the City Attorney document entitled List of City Boards, Commissions, and Advisory Bodies Created by Charter, Ordinance, or Statute.[9] This document separates San Francisco policy bodies into two different categories. The first category includes Commissions and Boards with decision-making authority and whose members are required to submit financial disclosures with the Ethics Commission. The second category encompasses Advisory Bodies whose members do not submit financial disclosures with the Ethics Commission. Depending on the analysis criteria in each section of this report, the surveyed policy bodies and appointees are either examined comprehensively as a whole or examined separately in the two categories designated by the Office of the City Attorney.

Data from the U.S. Census American Community Survey 5-Year Estimates provides a comparison to the San Francisco population. Due to census data not being collected during COVID-19, updated demographic information on the general population of San Francisco was not available for years more recent than 2019. Comparisons of 2021 demographic data to data on the San Francisco population reference population data from previous years (2015-2019) and will be noted as such. Figures 26 and 27 in the Appendix display these population estimates by race/ethnicity and gender.

[9] "List of City Boards, Commissions, and Advisory Bodies Created by Charter, Ordinance, or Statute," Office of the City Attorney, https://www.sfcityattorney.org/wp-content/uploads/2016/01/Commission-List-08252017.pdf, (August 25, 2017).

IV. Conclusion

Since the first Gender Analysis of Commissions and Boards in 2007, the representation of women appointees on San Francisco policy bodies has gradually increased. The 2021 Gender Analysis Report finds the percentage of women appointees is 55%, which exceeds the population of women in San Francisco.

When appointee demographics are analyzed by gender and race, the representation of women of color has increased to 32%, which is 4% higher than 2019 representation, matching the San Francisco population. Most notably, underrepresented are individuals identifying as Asian, making up 36% of the San Francisco population but only 26% of appointees, and Latinx-identifying individuals who make up 15% of the population but only 9% of appointees. Additionally, men of color are underrepresented at 21% of appointees relative to their San Francisco population, 31%.

Furthermore, when analyzing the demographic composition of larger and smaller budgeted Commissions and Boards, women of color are underrepresented on Commission and Boards with both the largest and smallest budgets. Women comprise 43% of total appointees on the largest budgeted policy bodies compared to the population of 49%, and women of color comprise 21% of total appointees on the largest budgeted policy bodies, with the San Francisco population at 32%. Comparatively, women are 48% of total appointees on the smallest budgeted policy bodies, and women of color are 29% of appointees. However, the representation of people of color is higher on larger budgeted policy bodies by 1%. People of color make up 44% of appointees on the largest budgeted policy bodies and 43% of appointees on the smallest budgeted policy bodies compared to 54% of total appointees. The San Francisco population of people of color exceeds these percentages at 62%.

In addition to using budget size as a proxy for influence, this report analyzed demographic characteristics of appointees on Commissions and Boards who file disclosures of economic interest and have decision-making authority and appointees on Advisory Bodies who do not file economic interest disclosures. Over half (60%) of appointees on Advisory Bodies are women, while 53% of appointees on Commissions and Boards are women. Ultimately, women comprise a higher percentage of appointees on Advisory Bodies compared to Commissions and Boards.

The 2021 Gender Analysis Report found a relatively high representation of LGBTQIA+ individuals on San Francisco policy bodies. For the appointees that provided LGBTQIA+ identity information, 23% identify as LGBTQIA+ with the largest subset identifying as gay or lesbian (56%), 16% of appointees from the largest budgeted policy bodies identify as LGBTQIA+, and 17% from the smallest budgeted bodies. However, there is a significant difference of LGBTQIA+ representation when comparing Commissions and Boards (18%) and Advisory Bodies (31%). The representation of appointees with disabilities is 13%, slightly exceeding the 12% population. Veterans are highly represented on San Francisco policy bodies at 22% compared to the Veteran population of 2.7%, which could be due to differences in each source's classification of Veteran Status.

Additionally, this report evaluates and compares the representation of women, women of color, and people of color appointees by the Mayor, Board of Supervisors, and by the total of

all approving authorities combined. Mayoral appointees include 60% women, 37% women of color, and 59% people of color, which overall is more diverse by gender and race compared to both Supervisorial appointees and total appointees.

This report is intended to advise the Mayor, Board of Supervisors, and other appointing authorities, as they select appointments to policy bodies for the City and County of San Francisco. In the spirit of the 2008 City Charter Amendment that establishes this biennial Gender Analysis Report requirement and the importance of diversity on San Francisco policy bodies, efforts to address gaps in diversity and inclusion should remain at the forefront when making appointments, in order to accurately reflect the population of San Francisco.

The San Francisco Department on the Status of Women would like to thank the various Policy Body members, Commission secretaries, and Department staff who graciously assisted in collecting demographic data and providing information about their respective policy bodies, particularly Department Interns Charly De Nocker and Brooklynn McPherson for the data collection and analysis of this report.

San Francisco Commission on the Status of Women
President Breanna Zwart
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Commissioner Ani Rivera

Kimberly Ellis, Director
Department on the Status of Women

This report is available at the San Francisco Department on the Status of Women website, **https://sfgov.org/dosw/gender-analysis-reports.**

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Appendix

Figure 26: Policy Body Demographics, 2021

Policy Body*	Total Seats	Filled Seats	FY20-21 Budget	Women	Women of Color	People of Color	Survey Response Rate
Access Appeals Commission	**5**	**5**	**$0**	**20%**	**0%**	**0%**	**100%**
Advisory Committee of Street Artists and Craft Examiners	5	5	$0	20%	20%	20%	20%
African American Reparations Committee	15	15	$0	0%	0%	0%	0%
Aging and Adult Services Commission	**7**	**7**	**$ 435,011,663**	**71%**	**29%**	**43%**	**86%**
Airport Commission	**5**	**5**	**$ 1,370,000,000**	**40%**	**0%**	**40%**	**100%**
Animal Control and Welfare Commission	7	7	$0	29%	14%	29%	43%
Arts Commission	**15**	**14**	**$ 23,762,015**	**79%**	**57%**	**71%**	**100%**
Asian Art Commission	**27**	**26**	**$ 10,200,000**	**50%**	**35%**	**54%**	**81%**
Assessment Appeals Board No.1	**8**	**6**	**$ -**	**50%**	**0%**	**17%**	**100%**
Assessment Appeals Board No.2	**8**	**4**	**$ -**	**0%**	**0%**	**50%**	**100%**
Assessment Appeals Board No.3	**8**	**3**	**$ -**	**0%**	**0%**	**33%**	**67%**
Ballot Simplification Committee	5	4	$0	50%	0%	0%	75%
Bayview Hunters Point Citizens Advisory Committee	12	8	$0	0%	0%	0%	0%
Board of Appeals	**5**	**5**	**$ 1,177,452**	**40%**	**20%**	**60%**	**100%**
Board Of Examiners	**13**	**10**	**$0**	**0%**	**0%**	**40%**	**90%**
Building Inspection Commission	**7**	**6**	**$ 89,600,000**	**33%**	**0%**	**0%**	**50%**
Cannabis Oversight Committee	16	16	$0	19%	31%	38%	25%

Figure 26: Policy Body Demographics, 2021, Continued

Policy Body*	Total Seats	Filled Seats	FY20-21 Budget	Women	Women of Color	People of Color	Survey Response Rate
Central Subway Community Advisory Group	21	14	$0	0%	0%	0%	0%
Children and Families Commission (First 5)	**9**	**8**	**$ 31,019,003**	**75%**	**50%**	**50%**	**75%**
Children, Youth, and Their Families Oversight and Advisory Committee	**11**	**7**	**$ 171,481,507**	**14%**	**0%**	**0%**	**14%**
Citizen's Advisory Committee for the Central Market Street and Tenderloin Area	9	8	$0	0%	0%	0%	0%
Citizen's Committee on Community Development	9	8	$ 27,755,465	63%	50%	50%	63%
Citizens General Obligation Bond Oversight Committee	**9**	**6**	**$0**	**50%**	**0%**	**17%**	**100%**
City Hall Preservation Advisory Commission	5	5	$0	0%	0%	0%	20%
Civil Service Commission	**5**	**5**	**$ 1,286,033**	**60%**	**20%**	**40%**	**100%**
Commission on Community Investment and Infrastructure	7	6	$0	17%	17%	33%	50%
Commission on the Aging Advisory Council	22	14	$0	21%	0%	0%	21%
Commission on the Environment	**7**	**7**	**$0**	**57%**	**29%**	**43%**	**86%**
Commission on the Status of Women	**7**	**7**	**$ 9,089,928**	**100%**	**86%**	**86%**	**100%**
Committee on Information Technology	17	17	$ 22,934,703	12%	0%	6%	18%

Figure 26: Policy Body Demographics, 2021, Continued

Policy Body*	Total Seats	Filled Seats	FY20-21 Budget	Women	Women of Color	People of Color	Survey Response Rate
Elections Commission	**7**	**5**	**$ 69,000**	**60%**	**20%**	**40%**	**100%**
Entertainment Commission	**7**	**7**	**$0**	**29%**	**14%**	**43%**	**100%**
Ethics Commission	**5**	**4**	**$ 6,500,000**	**25%**	**25%**	**25%**	**25%**
Film Commission	**11**	**11**	**$0**	**45%**	**27%**	**45%**	**100%**
Fire Commission	**5**	**5**	**$ 414,360,096**	**40%**	**20%**	**60%**	**100%**
Health Commission	**7**	**7**	**$ 2,700,000,000**	**71%**	**43%**	**71%**	**100%**
Health Service Board	**7**	**7**	**$ 16,500,000**	**14%**	**14%**	**14%**	**43%**
Historic Preservation Commission	**7**	**7**	**$0**	**29%**	**14%**	**14%**	**71%**
Historic Preservation Fund Committee	7	7	$0	0%	0%	0%	0%
Housing Authority Commission	7	5	$ 55,800,000	20%	20%	20%	20%
Human Rights Commission	**11**	**9**	**$ 13,618,732**	**0%**	**0%**	**0%**	**0%**
Human Services Commission	**5**	**5**	**$ 604,412,630**	**20%**	**0%**	**60%**	**100%**
Immigrant Rights Commission	15	14	$0	43%	36%	50%	57%
Juvenile Probation Commission	**7**	**6**	**$0**	**50%**	**33%**	**67%**	**83%**
Library Commission	**7**	**7**	**$ 341,000,000**	**71%**	**43%**	**71%**	**100%**
Local Agency Formation Commission	**7**	**4**	**$ 427,685**	**50%**	**50%**	**50%**	**50%**
Local Homeless Coordinating Board	9	7	$ 54,000,000	0%	0%	0%	0%
Long Term Care Coordinating Council	40	35	$0	9%	3%	6%	14%
Mental Health Board	17	9	$0	0%	0%	0%	0%
MTA Board of Directors and Parking Authority Commission	**7**	**6**	**$ 1,258,700,000**	**33%**	**33%**	**50%**	**50%**

Figure 26: Policy Body Demographics, 2021, Continued

Policy Body*	Total Seats	Filled Seats	FY20-21 Budget	Women	Women of Color	People of Color	Survey Response Rate
Municipal Green Building Task Force	21	21	$0	43%	24%	29%	67%
Municipal Transportation Agency Citizens' Advisory Council	15	13	$0	15%	8%	8%	15%
Office of Early Care and Education Citizens' Advisory Committee	9	9	$0	67%	33%	44%	78%
Paratransit Coordinating Council	40	25	$0	0%	0%	0%	0%
Park, Recreation, and Open Space Advisory Committee	23	19	$0	26%	11%	11%	53%
Planning Commission	**7**	**7**	**$ 62,194,821**	**57%**	**29%**	**43%**	**71%**
Police Commission	**7**	**5**	**$0**	**20%**	**20%**	**80%**	**100%**
Port Commission	**5**	**5**	**$ 125,700,000**	**60%**	**40%**	**40%**	**60%**
Public Utilities Citizen's Advisory Committee	17	14	$0	21%	0%	14%	43%
Public Utilities Commission	**5**	**5**	**$ 1,433,954,907**	**20%**	**20%**	**20%**	**60%**
Public Utilities Rate Fairness Board	**7**	**4**	**$0**	**25%**	**0%**	**25%**	**75%**
Recreation and Park Commission	**7**	**7**	**$ 231,600,000**	**29%**	**14%**	**29%**	**43%**
Reentry Council	7	5	$0	0%	0%	0%	0%
Rent Board Commission	**10**	**10**	**$ 9,381,302**	**10%**	**0%**	**30%**	**60%**
Residential Users Appeal Board	**3**	**2**	**$ 900**	**0%**	**0%**	**0%**	**50%**
Retire Health Care Trust Fund Board	**5**	**5**	**$ 70,000**	**0%**	**0%**	**0%**	**0%**
Retirement System Board	**7**	**7**	**$ 90,000,000**	**14%**	**14%**	**29%**	**57%**
Small Business Commission	**7**	**7**	**$ 3,505,244**	**14%**	**0%**	**14%**	**43%**
SoMa Community Planning Advisory Committee	11	7	$0	0%	0%	0%	0%

Figure 26: Policy Body Demographics, 2021, Continued

Policy Body*	Total Seats	Filled Seats	FY20-21 Budget	Women	Women of Color	People of Color	Survey Response Rate
SoMa Community Stabilization Fund Community Advisory Committee	14	10	$0	0%	0%	10%	10%
Southeast Community Facility Commission	7	7	$0	0%	0%	0%	0%
Sunshine Ordinance Task Force	**11**	**9**	**$0**	**56%**	**44%**	**44%**	**89%**
Sweatfree Procurement Advisory Group	11	6	$0	0%	0%	0%	0%
Transgender Advisory Committee	14	14	$0	0%	0%	21%	36%
Treasure Island Development Authority	**7**	**6**	**$0**	**17%**	**17%**	**33%**	**50%**
Urban Forestry Council	15	14	$0	0%	0%	0%	0%
Veterans Affairs Commission	17	16	$ 150,000	0%	0%	0%	0%
War Memorial Board of Trustees	**11**	**11**	**$ 18,500,000**	**27%**	**18%**	**18%**	**45%**
Workforce Investment Board	**30**	**27**	**$0**	**0%**	**0%**	**0%**	**0%**
Youth Commission	17	17	$0	41%	35%	71%	88%

**Policy Bodies in bold are Commission and Boards, while unbolded bodies are Advisory Bodies.*

Figure 27: San Francisco Population Estimates by Race/Ethnicity and Gender, 2017*

Race/Ethnicity	Total		Female		Male	
	Estimate	Percent	Estimate	Percent	Estimate	Percent
San Francisco County, California	864,263	-	423,630	49%	440,633	51%
White, non-Hispanic or Latino	353,000	38%	161,381	17%	191,619	20%
Asian	295,347	31%	158,762	17%	136,585	15%
Hispanic or Latinx	131,949	14%	62,646	7%	69,303	7%
Some Other Race	64,800	7%	30,174	3%	34,626	4%
Black or African American	45,654	5%	22,311	2.4%	23,343	2.5%
Two or More Races	43,664	5%	21,110	2.2%	22,554	2.4%
Native Hawaiian and Pacific Islander	3,226	0.3%	1,576	0.2%	1,650	0.2%
Native American and Alaska Native	3,306	0.4%	1,589	0.2%	1,717	0.2%

San Francisco Population estimates come from the 2017 and 2018 American Community Survey 5-Year Estimates.

**Due to unavailable updated data on San Francisco population, the data used to represent the San Francisco population is from the 2019 Gender Analysis Report.*

Acknowledgments

The San Francisco Department on the Status of Women would like to thank the various policy body members, commission secretaries, and city staff who graciously assisted in collecting demographic data and providing information about their respective policy bodies. In particular, the Department would like to thank interns Charly De Nocker and Brooklynn McPherson for the data collection and analysis of this report.

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