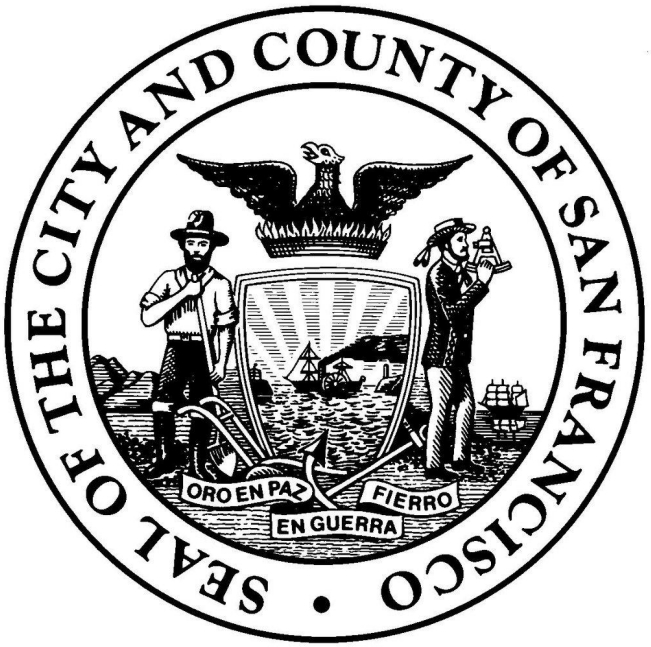
San Francisco Sugary Drinks Distributor Tax Advisory Committee

MARCH 2019 REPORT

small tax BIG BENEFITS
SF SUGARY DRINKS TAX



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Dear San Francisco,

It's only been a few years since the general public has heard the alarm sounded by our country's public health community: sugary drinks are the primary contributor of sugar to the American diet, and unhealthy amounts of it are making us sick. Liquid sugar is particularly harmful. Every year, the beverage industry spends millions on advertising to make sure we keep buying and drinking their products. Research has shown they intentionally target low income communities and communities of color. Existing policy is on their side; subsidies exist to make sugary beverages as cheap or cheaper than bottled water and these companies get tax breaks when advertising to youth. In 2016, San Francisco voters took a stand against soda industry tactics by passing a tax on the distribution of their products, known as the Sugary Drinks Distributor Tax (SDDT) or "soda tax." San Francisco took a stand against an industry that has spent over $70 million fighting local soda taxes since 2009, and about $10 million in San Francisco alone during the 2016 Soda Tax campaign. They want to make sure we keep buying their products and they will do everything to protect their profits. There are ways cities can reduce our consumption of sugary drinks, in order to reduce obesity, type 2 diabetes, dental caries and other illness that impact low-income communities and people of color disproportionately in the United States. A "soda tax" is an important tool in this work because it encourages reduced consumption and because it collects resources that San Francisco can invest in communities where consumption is greatest to help reduce consumption of sugary drinks and mitigate the impacts of that consumption.

This tax is new, and the SDDT Advisory Committee is new. As Co-Chairs of this inaugural Committee cohort, we've worked with our colleagues to establish committee processes and structures in ways that will sustain this work into the future. As scientists, health professionals, advocates and parents, our Committee has worked to find the nexus between science, data and community interest. As Co-Chairs born and raised in San Francisco's Mission, Excelsior and Bayview Hunters Point communities, we have worked to keep the focus on the communities most targeted by soda industry marketing, most burdened by the health impacts associated with consumption, and most in need of investment.

In the coming year, we will enjoy the continued service of some Committee members, the energy of new members, and the much awaited deployment of resources across CIty departments and community-based organizations. And we will continue to strengthen our infrastructure for supporting work to provide healthy food, physical activity, clean

water and health education to San Francisco. We will invest more in evaluation and media, to measure the impact of this tax and our investments of it, and to tell the story. We will work to ensure accountability to San Francisco-- like seeking ways to measure where and how impacted community members are employed to implement the strategies we propose here, and whether that employment provides a liveable wage.

While we appreciate the support and the trust the City's Mayor, Board of Supervisors and communities have entrusted in us, it's very important the public stay engaged to make sure the community voice is heard, and to make sure our recommendations and the City's investments hold true to the science, the data, and — especially — to San Francisco communities most impacted by sugary drinks.

We are pleased to present to you our Annual Report of the Sugary Drinks Distributor Tax Advisory Committee (SDDTAC) for 2019. Here you will find the latest data on San Franciscans' health conditions, sugary drinks consumption, food security and other factors that relate to the impacts related to sugary drinks consumption in our City. You will see some of the latest research our Committee has reviewed, and you'll see much of the input we've gathered from San Franciscans-- especially those SF populations we know to be consuming these unhealthy products more than others.

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

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

TABLE OF CONTENTS

I. BACKGROUND

SUGARY DRINKS DISTRIBUTOR TAX LEGISLATION

In November of 2016, the voters of San Francisco approved the passage of Proposition V. Proposition V established a 1 cent per ounce fee on the initial distribution of a bottled sugar-sweetened beverage, syrup, or powder, within the City and County of San Francisco.

The Sugary Drinks Distributor Tax (SDDT) is a general excise tax on the privilege of conducting business within the City and County of San Francisco. It is not a sales tax or use tax or other excise tax on the sale, consumption, or use of sugar-sweetened beverages. The funds collected from this tax are to be deposited in the General Fund.

The legislation defines a sugary drink, or sugary-sweetened beverage (SSB), as follows:

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

The passage of Proposition V established two pieces of law: the Sugary Drinks Distributor Tax in Business and Tax Regulations Code and the Sugary Drinks Distributor Tax Advisory Committee (referred to in this report as "Committee") in the CIty's Administrative Code. The ordinance stated that the Advisory Committee shall consist of 16 voting members, who are appointed by either the Board of Supervisors or certain City departments. The powers and duties of the Committee are to make recommendations to the Mayor and the Board of Supervisors on the effectiveness of the Sugary Drinks Distributor Tax and to submit a report that evaluates the impact of the Sugary Drinks Distributor Tax on beverage prices, consumer purchasing behavior, and public health. The Committee is to also provide recommendations regarding the potential establishment and/or funding of programs to reduce the consumption of sugar-sweetened beverages in San Francisco.

In May 2018, the SF Department of Public Health was requested to assume staffing of the SDDTAC. The Mayor's Office formalized the change in administrative oversight of the Committee from the City Administrator's Office to Department of Public Health through a transfer of function of the Executive Branch pursuant to Sec. 4.132 of the City Charter.

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

REPORT REQUIREMENTS AND PROCESS

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

Within 10 days after the submission of the report, the Department of Public Health (per change referenced above) shall submit to the Board of Supervisors a proposed resolution for the Board to receive the report.

RELATIONSHIP BETWEEN SUGARY DRINK CONSUMPTION, HEALTH, AND HEALTH EQUITY

A large body of evidence exists indicating that sugary drink consumption increases risk for cavities, overweight/obesity, type 2 diabetes, hypertension and heart disease.[1-5] Although sugary drinks can contain hundreds of calories in a serving, they do not signal "fullness" to the brain and thus facilitate overconsumption.[6] Sugary drinks are the leading source of sugar in the American diet, contributing 36% of the added sugar Americans consume.[7]

Numerous organizations and agencies, including the American Heart Association, American Diabetes Association, American Academy of Pediatrics, Institute of Medicine of the National Academies, American Medical Association, and the Centers for Disease Control, recommend limiting intake of added sugar and sugary drinks to improve health. Studies show that sugary drinks flood the liver with high amounts of sugar in a short amount of time and that this "sugar rush" over time leads to fat deposits and metabolic disturbances that are associated with the development of type 2 diabetes, cardiovascular disease, and other serious health

problems.[8] Of note, every additional sugary drink consumed daily can increase a child's risk for obesity by 60%[9] and the risk of developing type 2 diabetes by 26%.[10]

Diseases connected to sugary drinks are also found to disproportionately impact ethnic minority and low-income communities – the very communities that are found to consume higher amounts of sugary drinks. Diabetes hospitalizations are approximately three times as high in low-income communities as compared with higher income communities. African American death rates from diabetes are two times higher than San Francisco's overall rate. In San Francisco, approximately 46% of adults are estimated to be obese or overweight, including 66% of Latinx and 73% of African Americans. With respect to oral health, the data indicate that Asian and Pacific Islander children suffer from cavities at a higher rate than other populations; but Latinx and African American children also have a higher prevalence than the average for cavities.

The Sugary Drinks Distributor Tax is intended to discourage the distribution and consumption of sugary drinks in San Francisco by taxing their distribution. Mexico, where an average of 163 liters of sugary drinks are consumed per person each year, enacted an excise tax on sugary drinks in 2014, with the result that the purchase of taxed sugary drinks declined by 12% generally and by 17% among low-income Mexicans by December 2014. The Mexico data indicate that, when people cut back on sugary drinks, to a significant extent they choose lower-caloric or non-caloric alternatives. Studies have projected that a 10% reduction in sugary drink consumption in Mexico would result in about 189,300 fewer incident type 2 diabetes cases, 20,400 fewer incident strokes and myocardial infarctions, and 18,900 fewer deaths occurring from 2013 to 2022. This modeling predicts the sugary drinks tax could save Mexico $983 million international dollars.[11] Following the implementation of Berkeley, California's sugary drink tax, the first in the nation, there was a 50% decline in sugary drink consumption among diverse adults over the first 3 years of the tax.[12] Modeling suggests that a national sugary drink tax that reduced consumption by just 20% would avert 101,000 disability-adjusted life-years; gain 871,000 quality-adjusted life-years; and result in $23.6 billion in healthcare cost savings over just 5 years. The tax is further estimated to generate $12.5 billion in annual revenue. This body of research demonstrates that taxation can provide a powerful incentive for individuals to reduce their consumption of sugary drinks, which in turn can reduce the burden of chronic disease.

ADVISORY COMMITTEE

The Committee shall consist of the following 16 voting members:

- **Seats 1, 2, and 3** shall be held by representatives of nonprofit organizations that advocate for health equity in communities that are disproportionately impacted by diseases related to the consumption of Sugar-Sweetened Beverages, as defined in Business and Tax Regulations Code Section 552, appointed by the Board of Supervisors.
- **Seats 4 and 5** shall be held by individuals who are employed at medical institutions in San Francisco and who have experience in the diagnosis or treatment of, or in research or education about, chronic and other diseases linked to the consumption of Sugar-Sweetened Beverages, appointed by the Board of Supervisors.
- **Seat 6** shall be held by a person who is under 19 years old at the time of appointment and who may be a member of the Youth Commission, nominated by the Youth Commission and appointed by the Board of Supervisors. If the person is under legal voting age and unable to be an elector for that reason, the person may hold this seat, but upon reaching legal voting age, the person shall relinquish the seat unless he or she becomes an elector, in which case the person shall retain the seat.
- **Seat 7** shall be held by a person appointed by the Director of the Office of Economic and Workforce Development or any successor office.
- **Seats 8 and 9** shall be held by persons appointed by the Board of Education of the San Francisco Unified School District. If at any time the Board of Education declines to appoint a member to Seat 8 or 9 and leaves the seat vacant for 60 days or longer, the Board of Supervisors may appoint a member of the public to fill the seat until such time as the Board of Education appoints a member.
- **Seat 10** shall be held by an employee of the Department of Public Health who has experience or expertise in the field of chronic disease prevention or treatment, appointed by the Director of Health.
- **Seat 11** shall be held by a person with experience or expertise in the field of oral health, appointed by the Director of Health.
- **Seat 12** shall be held by a person with experience or expertise in the field of food security or access, appointed by the Director of Health.

- **Seat 13** shall be held by an employee of the Department of Children, Youth & Their Families, appointed by the Director of that Department.
- **Seat 14** shall be held by an employee of the Recreation and Park Department, appointed by the General Manager of that Department.
- **Seat 15** shall be held by a parent or guardian of a student enrolled in the San Francisco Unified School District at the time of appointment, nominated by the San Francisco Unified School District's Parent Advisory Council, and appointed by the Board of Supervisors. If at any time the Parent Advisory Council declines to nominate a member to a vacant seat for 60 days or longer, the Board of Supervisors may appoint a member of the public to fill the seat until the seat becomes vacant again.
- **Seat 16** shall be held by a person with experience or expertise in services and programs for children ages five and under, appointed by the Board of Supervisors.

Sugary Drinks Distributor Tax Advisory Committee, 2018-19

Seat 1	BOS Appointment - Health Equity- Latino/Chicano/Indigena	Vanessa Bohm
Seat 2	BOS Appointment - Health Equity – Asian/Pacific Islander	Kent Woo. Resigned effective January 2019
Seat 3	BOS Appointment - Health Equity – Black/African American	Joi Jackson-Morgan
Seat 4	BOS Appointment - Research/Medical Institutions	Roberto Ariel Vargas
Seat 5	BOS Appointment - Research/Medical Institutions	Jonathan Butler
Seat 6	BOS Appointment - Youth Commission Seat	Areeya Chananudech Resigned effective August 2018
Seat 7	Office of Economic and Workforce Development Appointment	Jorge Rivas
Seat 8	Board of Education Appointment - San Francisco Unified School District	Saeeda Hafiz
Seat 9	Board of Education Appointment - San Francisco Unified School District	Libby Albert Replaced by Alexandra Emmott January 2019
Seat 10	Department of Public Health Appointment - SF Department of Health – Chronic Disease	Rita Nguyen
Seat 11	Department of Public Health Appointment - Oral Health	Irene Hilton
Seat 12	Department of Public Health Appointment - Food Access/Security	Ryan Thayer replaced by Shelley Dyer January 2019
Seat 13	Department of Children Youth and Their Families Appointment	Michelle Kim
Seat 14	Recreation and Parks Department - Appointment	Linda Barnard
Seat 15	BOS Appointment - SFUSD Parent Advisory Council	Janna N. Cordeiro
Seat 16	BOS Appointment - Children 0-5 Years Old	Lyra Ng, resigned effective December 2018

SDDT REVENUE & REVENUE PROJECTIONS

The City and County of San Francisco operates on a July - June fiscal year (FY). Each year the Mayor and Board of Supervisors pass a rolling, two-year budget, with the second year becoming the first year of the next budget cycle; similarly, the SDDTAC makes rolling, two-year recommendations.

SDDT Revenues

Tax collection began January 1, 2018, and thus for FY 17-18 $7,649,971 was collected between January 1 - June 30, 2018 and $7,649,971 was collected June-Dec 2018, the first half of FY 18-19. According to the Office of the Treasurer and Tax Collector (TTX), a total of $12,300,100 was collected for the 2018 calendar year.

2018 SDDT REVENUE

FY 2017- 2018	
Jan - Mar 2018	$2,949,608
Apr-June 2018	$4,700,363
Subtotal	$7,649,971
FY 2018-2019	
Jul-Sept 2018	$4,233,035
Oct-Dec 2018	$417,093
Subtotal	$4,650,128
2018 Calendar Year Total	**$12,300,100**

Revenue Projections

In 2018, the Controller's Office projected that in the upcoming five fiscal years (through FY 2023-24), the SDDT is expected to raise $15 million annually.

After voter-mandated set asides (about 22%), the available amount of SDDT revenue is $11.6 million. The Board of Supervisors appropriated $1.2 million of the $11.6 million in ongoing "Healthy Addbacks" during the FY 17-18 budget process. The Committee makes recommendations on the remaining $10.4 million.

II. IMPACT OF THE SUGARY DRINKS DISTRIBUTOR TAX

The 2019 Annual Report is organized into two sections: 1) Impact of the Sugary Drinks Distributor Tax and 2) Committee Recommendations which details the Committee's recommendations for tax expenditure.

The Impact section is broken down into the following subsections:

- Use of Funds
- Impact on Beverage Prices and Consumer Purchasing Behavior
- Impact on Public Health

Because tax collection began in January 2019, there are limited data and infrastructure to fully evaluate the use of funds and its impact on public health. Thus, similar to the inaugural 2018 report, the 2019 report seeks to present a baseline description of health behavior and health outcome domains that the Committee was most interested in affecting. In particular, the Committee has expressed a commitment to supporting primary and secondary prevention to counteract the health impact of sugary beverage consumption. Thus there is more of a focus on nutrition and physical activity in this current report. The major changes between the 2018 and 2019 report are as follows:

- Addition of data on beverage prices which is newly available
- Addition of data on nutrition, food insecurity, and physical activity
- Shortened summary of the current state of diet-sensitive chronic disease since there has not been new data in this realm since the March 2018 report. See Appendix D for more detailed data regarding this

In general, existing data sources for 1) beverage prices, 2) consumer purchasing behavior, and 3) public health (particularly diet-sensitive chronic disease which the Committee is particularly interested in given the impact of sugary beverages on these conditions) are not robust. It can be difficult to recognize inequities across race, ethnicity, income, and geography or changes in nutrition, food security, physical activity, or burden of diet-sensitive chronic disease. Thus, tracking the measures included in the Impact Section of this report likely will not be able to reflect the full impact of the SDDT over time with the exception of more robust data sources such as the youth soda consumption data collected by San Francisco Unified School District in partnership with UC Berkeley and the Nutrition Policy Institute. Given the need for more robust data and data infrastructure to better understand and track the impact of the SDDT on beverage prices, consumer purchasing behavior, and the health of communities most vulnerable to sugary beverages, the Committee recommends investment in data infrastructure and evaluation.

USE OF FUNDS

Funded Projects FY 2017-18

As was reported in the Committee's 2018 Annual Report, because the Committee had not been seated in time to develop recommendations, the Mayor and Board of Supervisors allocated the majority of the expected revenue for the second half of FY 17-18, January - June 2018 which was $5.5 million. The table below indicates the agencies and programs that received funding.

Program	Department	Description	FY 17-18
Health and Wellness	Department of Public Health	Black/African American Wellness and Peer Leadership (BAAWPL) program, healthy eating & active living programming, active transportation and pedestrian safety program, and Sunday streets program.	$2.3M
Peace Parks	Recreation and Parks Dept	Pilot funding for Peace Parks initiative.	$500K
Home Delivered Meals	Human Services Agency	Increased funding for nutritional supports for low-income, disabled, and senior residents.	$500K

Addbacks Funded with SDDT in FY 17-18 When the Board of Supervisors makes changes to the Mayor's budget, some of these changes are "addbacks" denoting the Board's decision to add funds back for a particular service. In 2017, the Board designated $2.2M toward addbacks, $1.2M of which will continue into subsequent fiscal years, **programs receiving one time funding are indicated in bold.**			
Family Violence Services	**Dept on the Status of Women**	**Direct services, training and assistance to improve San Francisco child abuse prevention and intervention services building upon existing Family Resource Centers Initiative**	**$500K**
Food Security - Congregate Lunch Meals	Human Services Agency	Address current waitlist: Daily, hot, nutritious meals for seniors/adults with disabilities	$220K
Food Security - Healthy Food Purchasing Supplement	Department of Public Health	Maintain current service levels: Vouchers and education to increase consumption and access to nutritious foods by increasing the ability of low income residents to purchase fruits and vegetables at neighborhood vendors and farmers' markets in collaboration with DPH healthy Retail Program.	$50K
Food Security - Home-Delivered Meals (HDM)	Human Services Agency	Address current waitlist: Delivery of nutritious meals, a daily safety-check/friendly interaction to homebound seniors/adults with disabilities who cannot shop or prepare meals themselves. Many providers offer home assessments/ nutrition education/counseling.	$477K
Healthy Corner Store Retail	Office of Economic and Workforce Development	Promoting corner stores and markets to sell healthy Products as opposed to sugary beverages, etc.	$60K
Medical Assisting and Hospitality Training	**Office of Economic and Workforce Development**	**Funding to support Medical Assisting and Hospitality Training**	**$150K**
Women's Health Rights in the Workplace Policy Coordinator	**Department of Public Health**	**New women's health in the workplace outreach coordinator to conduct outreach to businesses and provide trainings on women's health issues**	**$80K**
Upgrading services for a food pantry in Ingleside/Ocean Avenue	**Dept of Aging and Adult Services**	**Renovation and upgrades for a food pantry that serves residents on Ocean Avenue and Ingleside neighborhood**	**$25K**
Day laborer mental health support in the Mission	**Department of Public Health**	**Bilingual Spanish speaking Peer Health Navigator to conduct psycho-social training and individualized support sessions with Day Laborers in the Mission**	**$65K**
I Am Bayview Marketing Campaign	**Office of Economic and Workforce Development**	**Marketing campaign for Bayview merchant corridor**	**$20K**
Mental health services	**Mayor's Office of Housing**	**Mental health and trauma counseling services at Vis Valley elementary**	**$50K**

Resilient Bayview	**Mayor's Office of Neighborhood Services**	**Enhancement of existing programming, including free training for residents and non-profits**	**$25K**
Senior Fitness	Human Services Agency	Senior fitness programming at IT Bookman and George Davis	$200K
Third Street Economic Development	**Office of Economic and Workforce Development**	**Development and marketing of Third Street corridor**	**$75K**
Congregate Meal Program	Human Services Agency	Congregate Meal Program A	$75K
Congregate Meal Program	Human Services Agency	Congregate Meal Program B	$75K
Small Business Support	**Office of Economic and Workforce Development**	**1.5 FTE to serve Outer Mission and Broad Randolph business development**	**$115K**
			$5.5M

In keeping with its mandate to evaluate the impact of the tax, the Committee surveyed City departments receiving SDDT funds to document the impact of the $5.5 million from FY 17-18. See Appendix E for the department responses. In summary, of the $5.5 million, one quarter (26%) supported food security and food access; another quarter (25%) supported wellness services for Black/African Americans; approximately 15% supported senior fitness classes and Sunday Streets events; 11% supported mental health and violence prevention; 7% supported workforce and economic development; 10% supported staff for healthy eating, active living and active transportation programs; and 6% supported community based healthy eating and active living mini grants.

As a result of the passage of the SDDT, San Franciscans have directly benefited in a variety of ways, particularly low-income communities of color. Below are a few highlights.

Food security and healthy eating

- Over 80,000 EatSF produce vouchers were distributed to more than 4,400 unduplicated households helping low-income San Franciscans eat more fruits and vegetables.

    - This included 800 low-income pregnant women in partnership with the San Francisco Special Supplemental Nutrition Program for Women, Infant, and Children (WIC) and 2,100 households receiving SSI (Supplemental Security Income).
        - Food security rates among EatSF WIC participants increased 15%.
    - Non-WIC EatSF participants increased their fruit and vegetable intake by 0.7+ daily servings – enough for immediate health impacts.
    - 6-12 months after participants stopped receiving vouchers, 83% of participants still reported eating less junk food and 98% reported improved confidence in purchasing healthy food on a budget
- 525 more homebound seniors and adults with disabilities who cannot shop or prepare meals themselves received 203,000 nutritious, home delivered meals as well as a daily visit from the person delivering the meal.
- Low-income, disabled, and senior residents were served 48,000 additional hot, nutritious meals at congregate meal sites, reducing the waitlist for congregate meals by 145 new clients.
- Over 1,200 additional bags of food were made available through the expansion of food pantry services.
- Two corner stores received equipment and technical assistance supporting the addition of fresh produce to their shelves.

Physical activity

- Over 900 seniors accessed free physical activity at two low-income senior centers.
- Hundreds of families attended nine Sunday Streets events throughout San Francisco. Sunday Streets opens streets to people so they can play and engage in physical activity, community connection and support neighborhood merchants. Sunday Streets events are primarily hosted in neighborhoods with less open space, higher rates of chronic disease, and lower incomes.

Community building in support of wellness

- Peace Parks provided activities that promote physical, mental, and economic health to approximately 600 people per month in Bayview Hunters Point, Potrero Hill, and Sunnydale. This included sports and dance activities, a Teen Outdoor Experience

program, and workshops on anti-bullying, gender respect, job training, workforce development, and housing. Six families received housing through the program at Youngblood Coleman, and participants reported feeling safer and that a sense of togetherness had evolved as result of Peace Parks programming.

- The Black African/American Wellness Peer Leadership (BAAWPL) Program provided funding dedicated to Black/African American health through two community based organizations providing direct services and support. BAAWPL supported 2,000 Black/African American clients with programming to: promote nutrition and physical activity, support stress reduction, and decrease social isolation.

In keeping with the SDDTAC recommendations for FY 17-18, $200,000 was designated to support the implementation of the SDDT which included:

- Gathering community input to inform the Committee's work and recommendations for expenditures. This took the form of 10 focus groups hosted throughout San Francisco (see Appendix F);
- Developing a preliminary communications plan to help merchants and the public understand the tax; and
- Purchasing beverage sales data to document the potential impact of the tax on sugary drink consumption; the first analyses of these new data will be available in Fall 2019.

Funded Projects FY 2018-19

This report is published three-quarters through FY 18-19, which is the first full fiscal year that SDDT revenue is available. The City and County of San Francisco FY 18-19 budget was approved in August 2018, and funds were available to departments in September 2018. Since the majority of the funds for the FY 17-18 SDDT revenue were used for one-time expenditures or to supplement existing programs, departments that received funds for new programs focused on developing systems and processes for disbursing the new SDDT funds.

San Francisco Department of Public Health (DPH) allocated some SDDT funds to better understand community needs as it relates to healthy eating and active living. With support of a consultant, DPH conducted focus groups in six neighborhoods: Chinatown, Western Addition, Mission, Bayview Hunters Point, OMI, and Tenderloin, reaching over 100 people (see Appendix F). Another 400 people responded to an online survey or answered surveys at backpack giveaway events in Western Addition and Bayview Hunters Point (see Appendix G). Input collected through these mixed methods will inform the community grants Request for

Proposal (RFP), while also honoring the community engagement values of the Committee. Throughout the development of the Committee recommendations, members consistently stressed the importance of serving the populations that are targeted by the beverage industry and that drink the most sugary drinks. In response, DPH leadership indicated that any SDDT RFP it issues should be accessible to smaller organizations. The City's current structures do not make it easy for grassroots community and faith based organizations, which often have relationships with the very populations the Committee and DPH intend the funding to serve, to access these funding opportunities. To that end, DPH is spending time to ensure new processes and structures are in place to make it possible for a wide range of organizations to be eligible to apply for SDDT funds.

For FY 18-21, the SF Department of Public Health has contracted with Harder + Company to more systematically evaluate the impact of the work funded by the SDDT. Harder will work with City agencies and community organizations that receive general fund revenues tagged as SDDT funds to evaluate the work. The Committee's March 2020 Report, with evaluation and epidemiologist support, will be able to provide more in depth information about the reach and impact of programs receiving SDDT funds.

SF DPH is also working with a nationally renowned team of researchers at UC San Francisco, UC Berkeley and Stanford University that comprise the EVIDENCE Team (EValuating Interventions in Diabetogenic Environments through Natural and Controlled Experiments) to assess the impact of the SDDT on beverage prices, consumer purchasing behavior, and public health. Funding, analyses, staff and other resources are being pooled in a collective effort to quantify the impact of the SDDT.

IMPACT ON BEVERAGE PRICES AND CONSUMER PURCHASING BEHAVIOR

ABOUT THE DATA SOURCES

Beverage Pricing Data

In 2017 and in 2018, the UC Berkeley Madsen Research group collected and analyzed drink pricing data from 39 stores in San Francisco, 30 stores in Richmond, and 44 stores in San Jose. Across all cities, 11.5% were chain convenience stores, 39.8% were corner stores, 5.3% were discount supermarkets, 6.2% were drugstores, 6.2% were independent supermarkets, 8.9% were liquor stores, 13.3% were chain supermarkets, and 8.9% were superstores. Data were collected for the top-selling beverages in the United States and San Francisco

Bay Area, including single-serving (eg 16, 20 oz, etc) sodas, sports drinks, energy drinks, sweetened coffee/tea, fruit drinks, water, 100% orange juice, and low-fat milk; larger sodas (e.g. 2 liters); soda multipacks (e.g. 12 packs of 12 oz cans); and diet versions of beverages. Data collectors gathered prices either by directly recording visible price tags or by asking store staff when price tags were not available. In cases where prices could not be provided by store staff, beverages were purchased, and prices recorded from receipts.

Price was assessed using a longitudinal design, contrasting changes in pre-tax (May-June 2017) versus post-tax (May-June 2018) beverage prices in San Francisco. The price change in San Francisco was compared to price changes in Richmond and San Jose, where no beverage tax has been implemented, over the same time period to control for non-tax factors that might affect prices. Mean prices for each beverage (in cents per ounce) were used to estimate category-level (i.e. regular soda, diet soda, sports drinks, etc.) and SSB-level (i.e. SSB and non-SSB) price changes. Category-level price changes were weighted by the popularity of each component beverage in terms of the number of units of that beverage sold in 2017 compared to the total number of units sold across all study beverages, using data from Nielsen. SSB-level price changes were weighted by the popularity, in terms of units sold, of each component category across all beverages in Nielsen for 2017. All models were adjusted for household median income of the store census tract and store type and modeled using a difference-in-differences regression to reduce any distortion from inflation or other economic factors.

Beverage Consumption Data

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

The California Health Interview Survey (CHIS) is an annual telephone survey that uses a random-digit-dial technique to landlines and cell-phones and asks respondents to answer health related questions. CHIS only asks about soda consumption and does not include

other sugary drinks. In San Francisco, CHIS samples about 400 adults, which provides data for the county, but does not allow to stratify across different demographic categories.

Additional beverage consumption data sources and analyses will be available in Fall 2019.

Beverage Prices

Between May/June 2017 and May/June 2018, single serving sugary drinks averaged a 1.04 cent per ounce increase (95% confidence interval: 0.72 –1.36) and large sized sugary drinks (e.g. 1-2L bottles and multipacks) averaged 0.93 cent per ounce increase (95% CI: 0.62–1.24). Energy (1.88 cents/oz, 95% CI: 0.97–2.79) and coffee (1.86 cents/oz, 95% CI: 0.67–3.05) single serving sugary drinks increased the most. The lowest increases among sugary drinks were seen for flavored waters (0.85 cents/oz, 95% CI: 0.34, 1.35), fruit drinks (1.04 cents/oz, 95% CI: 0.47–1.61), teas (1.00 cents/oz, 95% CI: 0.30–1.70), and large size sodas (0.87 cents/oz, 95% CI: 0.58–1.16). The price of non-sugary drinks did not increase with the exception of diet soda; the price of single serving, large size, and multi packs of diet sodas increased by 0.62 cents/oz (95% CI: 0.22–1.02), 0.37 cents/oz (95% CI: 0.10–0.63), and 0.68 cents/oz (95% CI: 0.26–1.09), respectively.

Consumer Purchasing Behavior

SUGARY DRINK CONSUMPTION

The U.S. Department of Health and Human Services, the U.S. Department of Agriculture, and the World Health Organization have recommended that Americans consume no more than 10% of their daily calories in the form of added sugar. Yet standard single serving sizes of sugary drinks provide all (in a 20-ounce serving of many sugary drinks) or nearly all (in a 12-ounce serving) of the recommended maximum daily added sugar amount for most adults, and generally exceed the recommended maximum daily added sugar amount for children.[13]

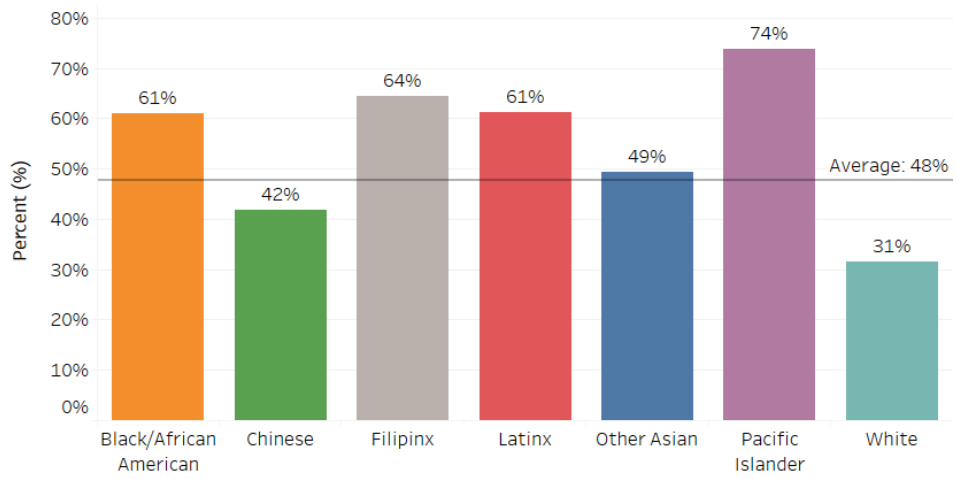
San Francisco data suggest that sugary drink consumption is highest among youth (middle school more than high school), young adults (age 18-29), and ethnic minorities, particularly Pacific Islanders, Filipinx, Latinx, and African American populations. Males also consume more soda than females.[14-15]

Youth Sugary Drink Consumption

Both the YRBS and SFUSD data suggest middle school students consume more sugary drinks than high school students. Consistent with national trends, students of ethnic minority backgrounds are more likely to have consumed sugary drinks in the prior week than white students. Nationally, among youth, sugary drink intake is higher among boys, adolescents, Black/African Americans, or youth living in low-income families.[16]

In San Francisco, 74% of Pacific Islander, 64% of Filipinx, 61% of Latinx, and 61% of African Americans reported consuming a sugary drink in the prior day which is more than the overall average middle school student, of which nearly half (48%) reported consuming a sugary drink in the prior day. 31% of White middle school students reported drinking a sugary drink the prior day. [17]

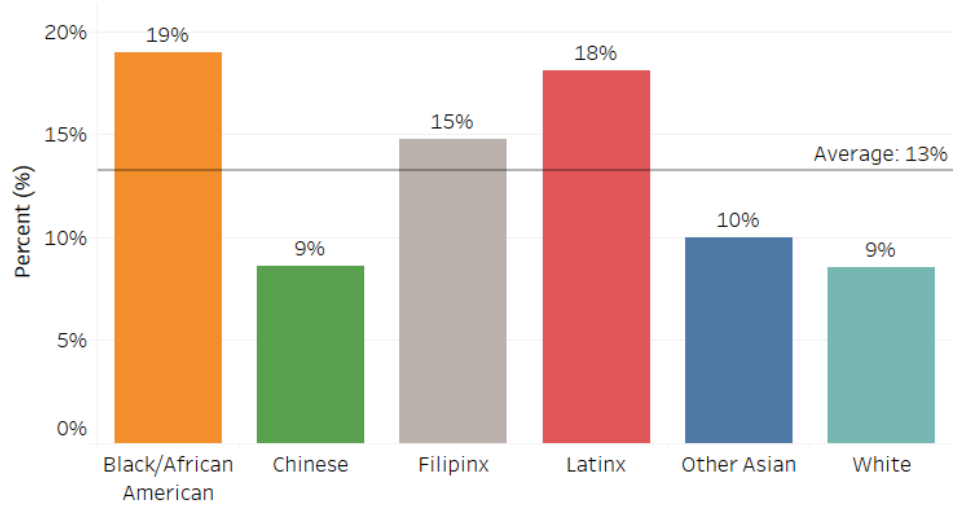
Percent of Middle School Students Who Drank at Least One Sugary Drink Yesterday, by Race/Ethnicity, San Francisco, 2017



Data Source: Youth Risk Behavioral Surveillance System (YRBSS), Centers of Disease Control and Prevention (CDC), 2017.

Similar ethnic disparities are seen in high school, with 19% of African American, 18% of Latinx, and 15% of Filipinx high school students reporting drinking at least one sugary drink daily in the prior 7 days compared to 9% of White and Chinese students.

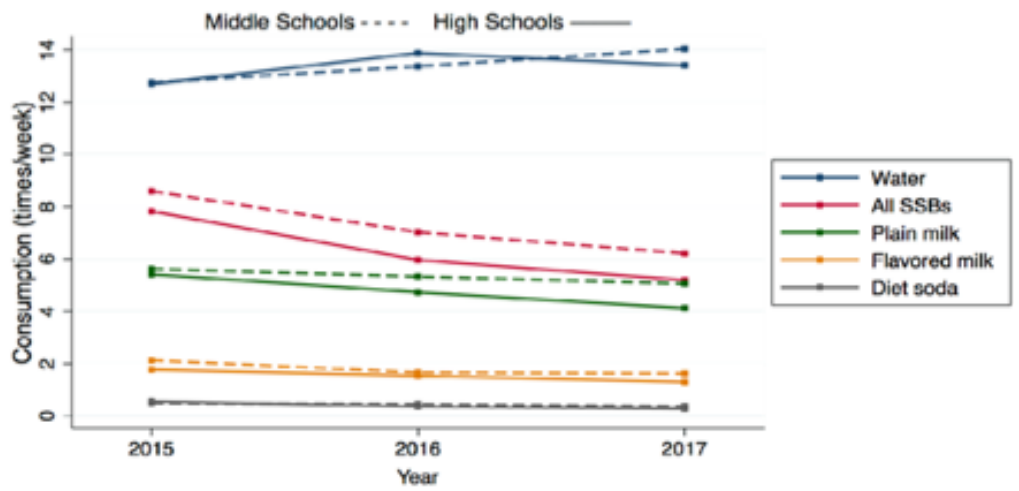
Percent of High School Students Who Drank at Least One Sugary Drink Daily in the Past 7 Days, by Race/Ethnicity, San Francisco, 2017



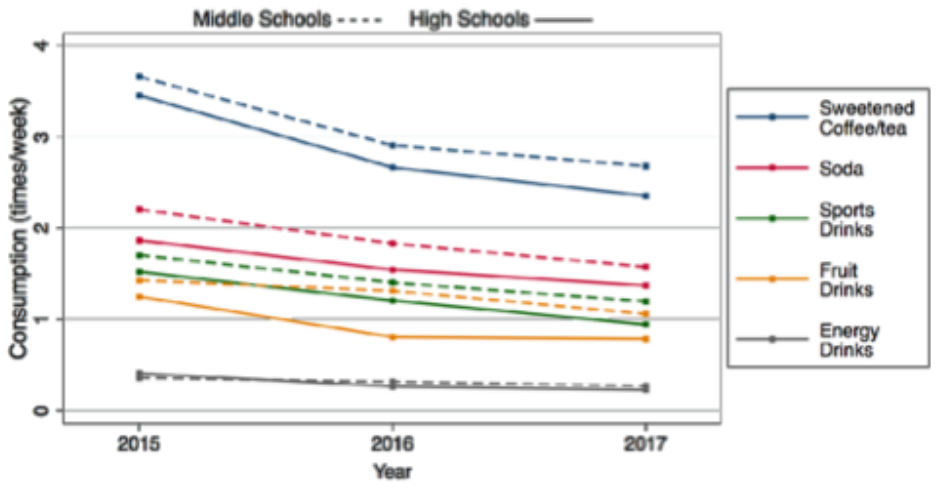
Data Source: Youth Risk Behavioral Surveillance System (YRBSS), Centers of Disease Control and Prevention (CDC), 2017.

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

Changes in Beverage Consumption Among SFUSD Middle and High School Students, 2015—2017



Changes in Sugary Drink Consumption Among SFUSD Middle and High School Students, 2015—2017



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

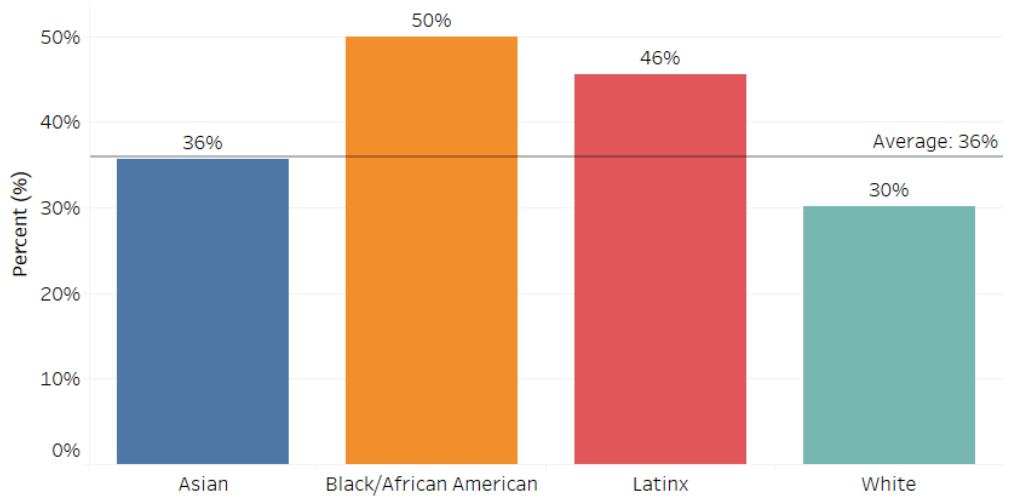
Adult Sugary Drink Consumption

With respect to sugary drink sales, Nielsen data indicate that sodas account for the largest proportion of weekly sugary drink sales at about 5 oz/capita. In San Francisco, approximately 36% of adults report drinking soda at least once per week which is comparable to all surveyed Californians, of which approximately 40% report drinking at least one soda per week. This survey question only accounts for soda which is one type of sugary drink.

Consumption is highest among younger San Francisco adults; nearly 50% of adults between 18 and 29 years report consuming soda at least once per week and 13% report consuming soda more than 4 times per week.

Male adults tend to be more likely to consume soda than female adults (44% of males versus 26% of females report drinking at least one soda per week). Similar to trends seen in the youth data, San Francisco Black/African American (50%) and Latinx adults (46%) consume more soda than their Asian (36%) and White counterparts (30%).

Percent of Adults Who Drank at Least One Soda per Week, by Race/Ethnicity, San Francsico, 2013—2016

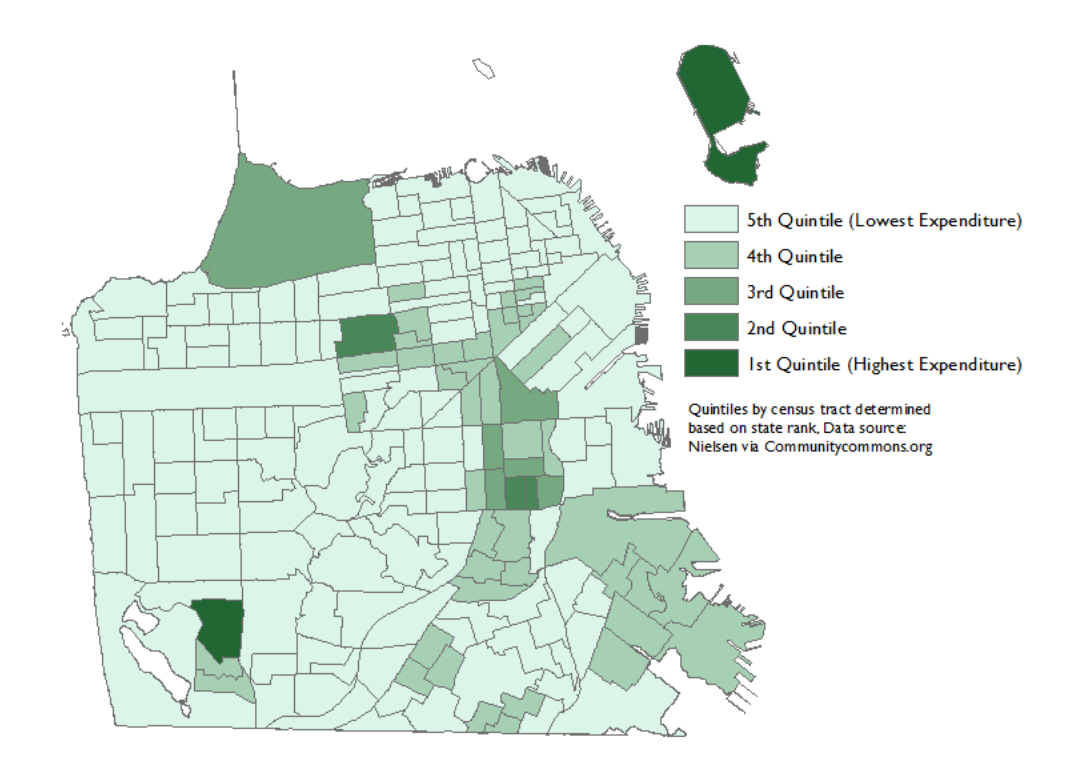


Data Source: California Health Interview Survey (CHIS), UCLA Center for Health Policy Research, 2013-2016.

SUGARY DRINK SALES AND EXPENDITURES

Data indicate that sodas account for the largest proportion of sugary drinks, with sales two times higher than fruit drinks. Soda expenditures, relative to total at home food expenditures, varies by neighborhood. Residents in Bayview Hunters Point, Mission, Tenderloin, SOMA, Treasure Island, West Addition in Lakeshore spend a greater proportion of their food-at-home expenditures on soda. Neighborhoods with high soda expenditures are the same as those with higher proportions of persons of color--Black/African American and Latinx, and where higher amounts of sugar drinks are consumed.

Soda Expenditures, Percentage of Food-at-Home Expenditures, 2014



Using funds from the Sugary Drinks Distributor Tax (SDDT), the SDDT Advisory Committee purchased retail sales data. The results of the analysis of this data will be available in Fall 2019.

IMPACT ON PUBLIC HEALTH

As mentioned previously, because tax collection began in January 2018, there has not been adequate data generated or infrastructure developed to collect and analyze relevant data to fully evaluate the impact of the Sugary Drinks Distributor Tax on public health. Thus, similar to the inaugural 2018 report, the 2019 report seeks to present a baseline description of health behaviors and health outcome domains that the Committee was most interested in affecting. It is also worth reiterating that, in general, existing data sources on health behaviors and diet-sensitive chronic diseases, which the Committee is particularly interested in, are not robust. It can be difficult to recognize inequities across race, ethnicity, income, and geography or changes in nutrition, food security, physical activity, or burden of diet-sensitive chronic disease over time. Thus, tracking the measures included in the Impact Section of this report likely will not be able to reflect the full public health impact of the SDDT over time.

ABOUT THE DATA

Community Health Needs Assessment (CHNA)

This report seeks to describe the current state of health and health behaviors in San Francisco as it relates to diet-sensitive chronic diseases that may be affected by sugary drink consumption. This report draws heavily from the 2019 CHNA which is a comprehensive report on the status of health in San Francisco. The CHNA was created as a collaborative process involving community residents, community-based organizations, healthcare partners, academic partners, and the Department of Public Health. The Community Health Assessment and Impact Unit of the San Francisco Department of Public Health conducted the data analysis for the report (see: http://www.sfhip.org/community-health-data.html).

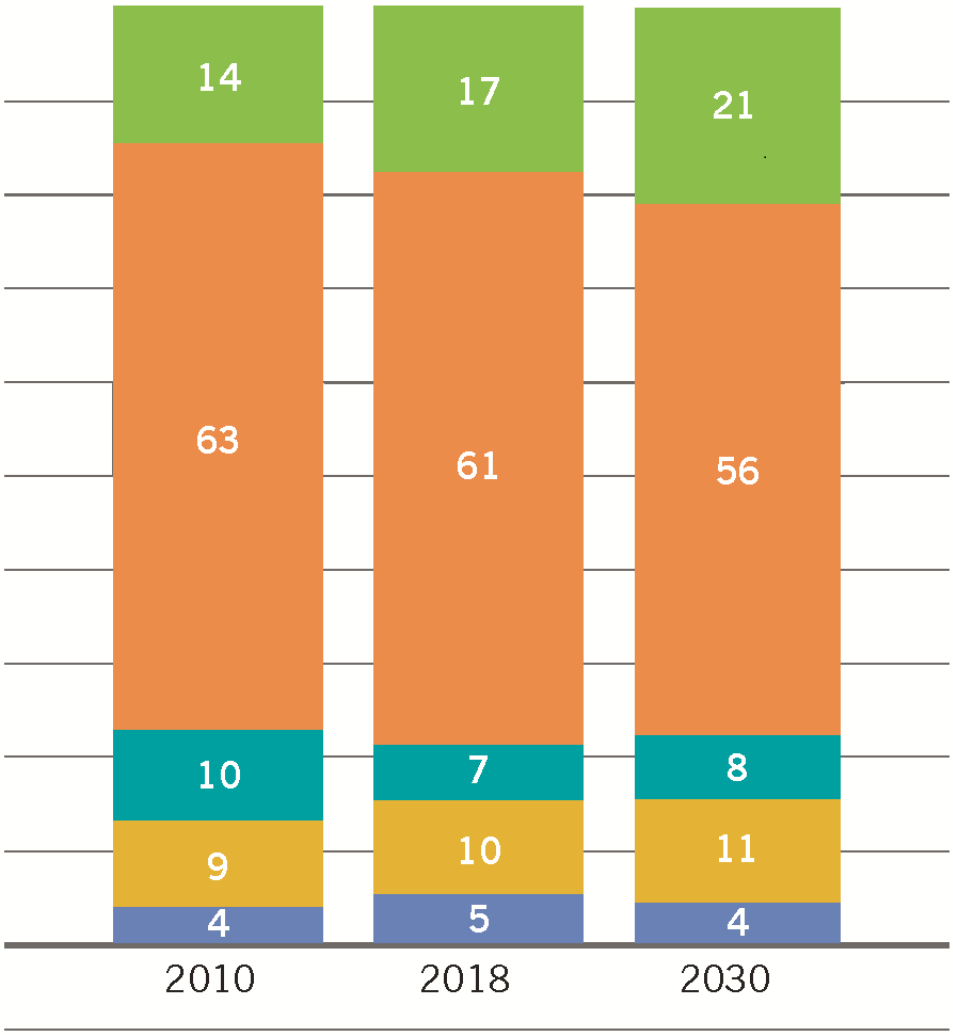
Food Security

The food security section draws heavily from the San Francisco Food Security Task Force's 2018 Assessment of Food Security which compiled data from federal, state and locally funded food programs in order to develop recommendations for policies and systems to support gaps in San Francisco's food needs (see: https://www.sfdph.org/foodsecurity/).

San Francisco Demographics

Understanding the demographics of San Francisco is crucial to the Committee's intent to improve the health of San Franciscan communities with strategic investments. There are approximately 850,300 residents in San Francisco with distributions by age and ethnicities shown in the figures below. Visitacion Valley, Bayview Hunters Point, Outer Mission, and Excelsior all have the highest proportion of households containing youth; all have over 35% of households with youth. 58% of San Francisco's population is non-White and the ethnic diversity score is increasing. This score estimates the probability that any two people chosen at random from a given study area (e.g., neighborhood) are of different races or ethnicities. Communities with a high percentage of Black/African American residents include Bayview Hunters Point, Western Addition, and Treasure Island, ranging from 20-27% Black/African American residents. Dense Latinx communities are found in the neighborhoods that border Mission Street. In most neighborhoods, Asian residents comprise more that 20% of the population apart from central neighborhoods like, Castro, Mission, Glen Park, and Noe Valley. Neighborhoods that have predominantly White residents include central and northern neighborhoods. Twenty-four percent of San Francisco residents 5 years and older have limited English proficiency – 57% of those persons speak Chinese and 21% speak Spanish.

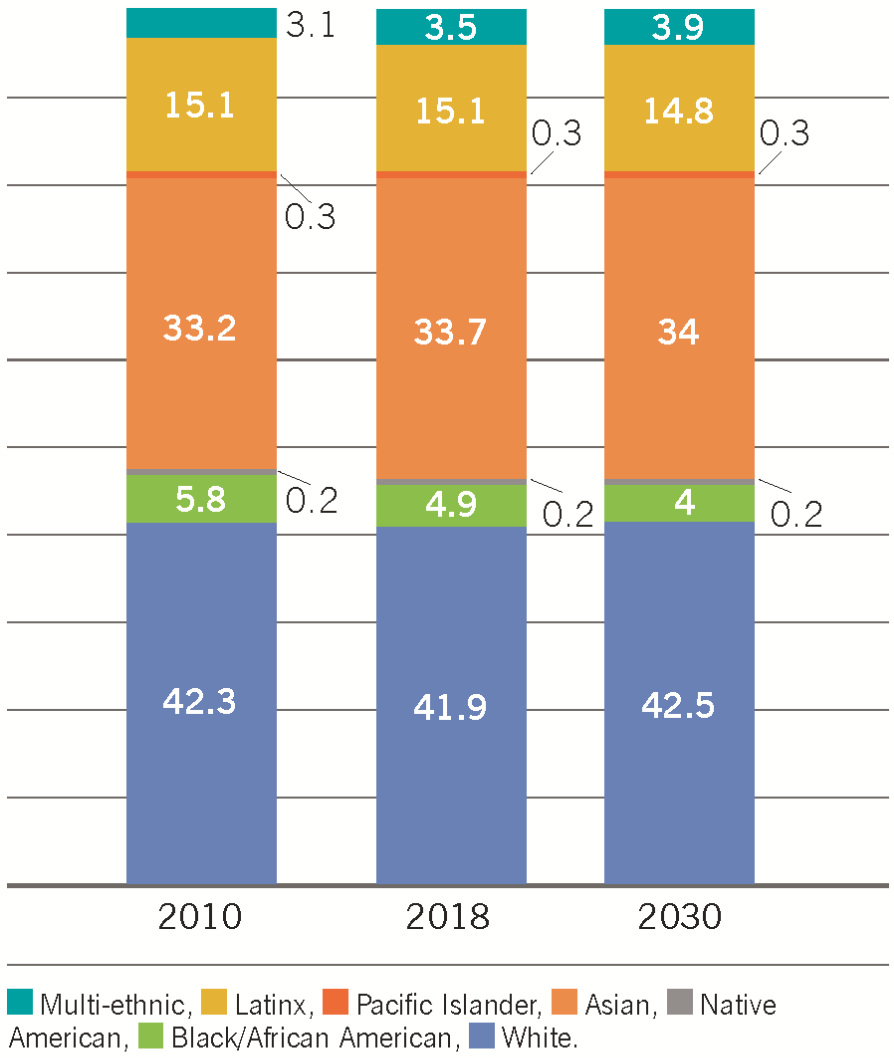
Percent of Population by Age Group, San Francisco



Groups by age range in years: Seniors (65+), Working Adults (25–64), College Age (18–25), School Age (5–17), Preschool Age (0–4).

Data Source: State of California Department of Finance. Report p-2: County Population Projections (2010-2060) by Age. Sacramento, California, 2018.

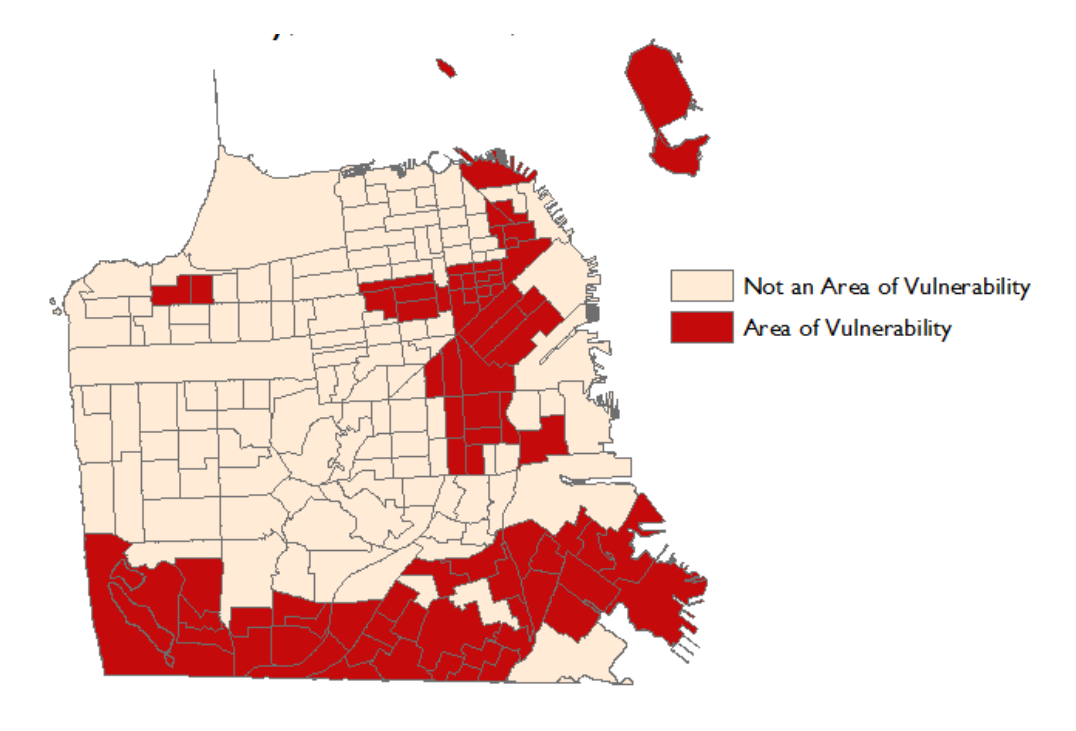
Percent of Population by Ethnic Group, San Francisco



Data Source: State of California Department of Finance. Report p-2: County Population Projections (2010-2060) by Age. Sacramento, California, 2018.

Treasure Island, the northeastern part of San Francisco, and the southern parts of San Francisco have higher density of socioeconomically disadvantaged populations which is identified as measured by the Area of Vulnerability (AOV) index.[18] The population of these Areas of Vulnerability total approximately 321,000 individuals, or 38% of San Francisco's population. These areas have higher diversity scores and also have higher percentages of youth and seniors.

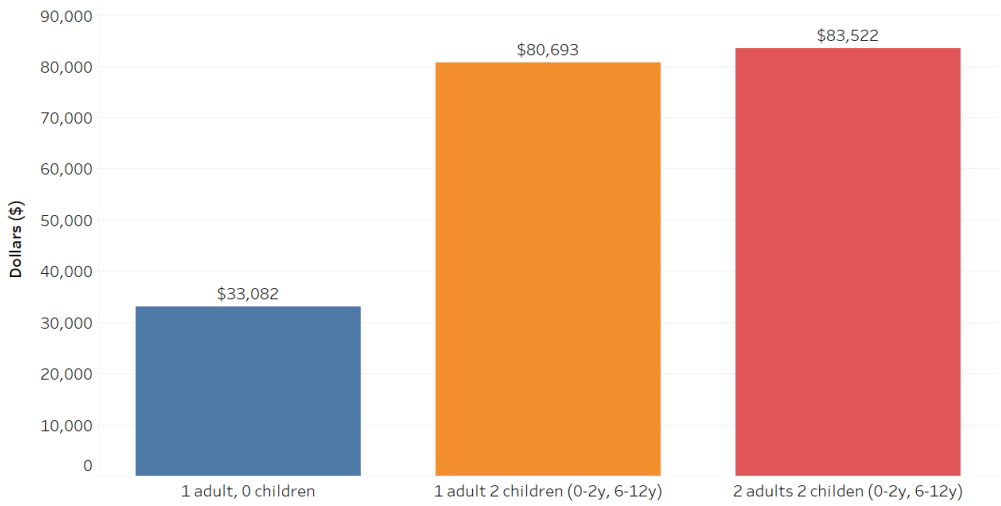
Area of Vulnerability, San Francisco, 2012—2016



In terms of economic environment, San Francisco is unique in the Bay Area and in the country for its degree of income inequality which in itself is strongly and independently associated with decreased life expectancy and higher mortality.[19] In 2016, the median household income in San Francisco was $103,801, ranking 14th among all US counties with a population of 65,000 or more.[20] However, the increasing cost of living along with inequitable economic opportunity means that many in San Francisco are struggling to meet their basic needs. Whereas the federal poverty level (FPL) is a widely used indicator of poverty and is often used to determine eligibility for public services, the high cost of living in San Francisco means that a significant number of individuals are not making enough to meet basic needs and yet do not qualify for social services designed to support those basic needs. The Family Economic Self-Sufficiency Standard (SSS) measures how much income is needed for a family to adequately meet its minimal basic needs, taking into account the county's cost of living. In San Francisco, the self-sufficient standard for 2 adults, 1 infant, and 1 school aged child was $83,522 compared to the federal poverty guideline of $23,850. Thus a family of four has to earn 300-400% federal poverty level to meet basic needs in San Francisco. However, social

services like CalFresh (SNAP, formerly known as food stamps) are generally available only to those with less than 200% FPL (and in some cases <130% FPL) and MediCal is available to adults who are less than 138% FPL. San Francisco's $15.00 minimum wage equates to $31,200 annually working full time which remains significantly less than what is needed to live in San Francisco with children.

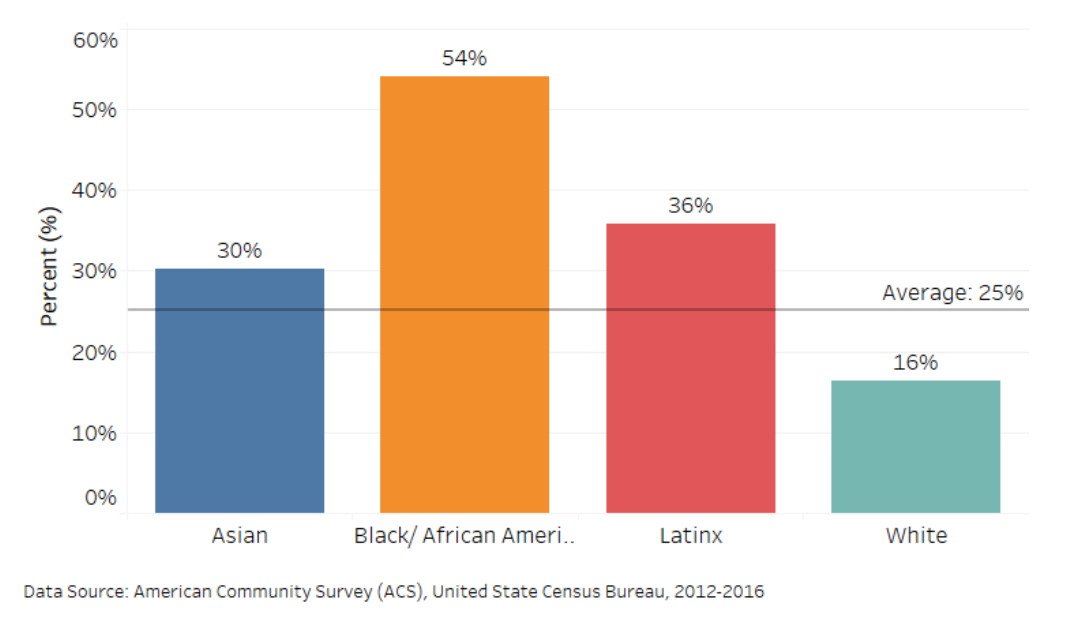
Self-sufficiency Income by Family Type, San Francisco, 2014



Data Source: Insight Center for Community Economic Development, 2014.

Though we do not have good data on the proportion of San Franciscans who are living below the Self Sufficiency Standard (which is approximately 300-400% FPL), data on populations below 200% FPL in San Francisco paints a dire picture particularly for communities of color: 54% of Black/African American residents, 36% of Latinx residents, and 30% of Asian residents are living at less than 200% FPL compared to 16% of White residents. Overall, approximately 1 in 4 San Franciscans are living at less than 200% FPL, well below what is needed to have basic needs met.

Percent of Population Living Below 200% Federal Poverty Level by Race/Ethnicity, San Francisco, 2012—2016



In this context, the Committee recognizes the need to support basic needs such as food security in order to support the health of low income communities of color whose health is particularly vulnerable to negative influences such as sugary beverage consumption. Investment in affordable food access and food security is also a consistent request the Committee has heard from community members through a variety of forums.

Current State of Food Security, Food & Drink Environment, and Nutrition in San Francisco

Food Security

Food security is the ability, at all times, to obtain and consume enough nutritious food to support an active, healthy life. Food insecurity exists when the ability to obtain and prepare nutritious food is uncertain or not possible. Food insecurity can have far reaching impact throughout the life course that helps establish and perpetuate health disparities; fetal development in utero is impacted by maternal food security and that impact on early development can increase unborn babies' lifetime risk of obesity and diabetes. Children who

are food insecure are more likely to have behavioral issues and worse school performance as well as more hospitalizations – all of which can limit socioeconomic advancement and lay the foundations for developing chronic disease as adults. In adults, food insecurity increases the risk of multiple chronic conditions including type 2 diabetes, heart disease, and hypertension, and exacerbates existing physical and mental health conditions. The San Francisco Food Security Task Force (FSTF), frames food security as an issue of:

1. Food Resources: the ability to secure sufficient financial resources to purchase enough nutritious food to support a healthy diet on a consistent basis
2. Food Access: the ability to obtain affordable, nutritious, and culturally appropriate foods safely and conveniently
3. Food Consumption: the ability to prepare and store healthy meals, and the knowledge of basic nutrition, food safety, and cooking

"Food access" and also "affordable food" are priority concerns for community that is consistently heard in multiple forums including the DPH Town Halls, focus groups, online surveys, public testimony, and is the most commonly requested service from 211. For the purposes of this report, the Committee interprets "food access" and "affordable food" as the more encompassing term of food security. Food security is measured at the household level through the use of standard survey questions. The food security status of each household lies somewhere along a continuum extending from high food security to very low food security.

The City does not currently have data infrastructure to fully assess food security in San Francisco. However, we do know that a primary driver of food security is inadequate resources to purchase food. In this regard, data on poverty rates and the Self Sufficiency Standard (see Demographics above) reveal that 54% of Black/African American residents, 36% of Latinx residents, and 30% of Asian residents are living at less than 200% FPL compared to 16% of White residents. Overall, approximately 25%, or 1 in 4 San Franciscans, are living at less than 200% FPL. Data from the 2015-16 CHIS revealed that 50% of San Franciscans surveyed who earned less than 200% FPL were food insecure, which increased from 44% in 2013-14. Additionally, we have some data on the food security status of some specific vulnerable groups including:

- **Pregnant women:** Data from the Maternal and Infant Health Assessment (MIHA) survey indicate that approximately one quarter of all pregnant women in San Francisco are food insecure, including 26.5% Latinx and 19.5% Black/African American women.

Food Insecurity Among Pregnant Women in San Francisco

26.5% among Latinx women

19.5% among Black/African American women

6.6% among Asian and Pacific Islander women

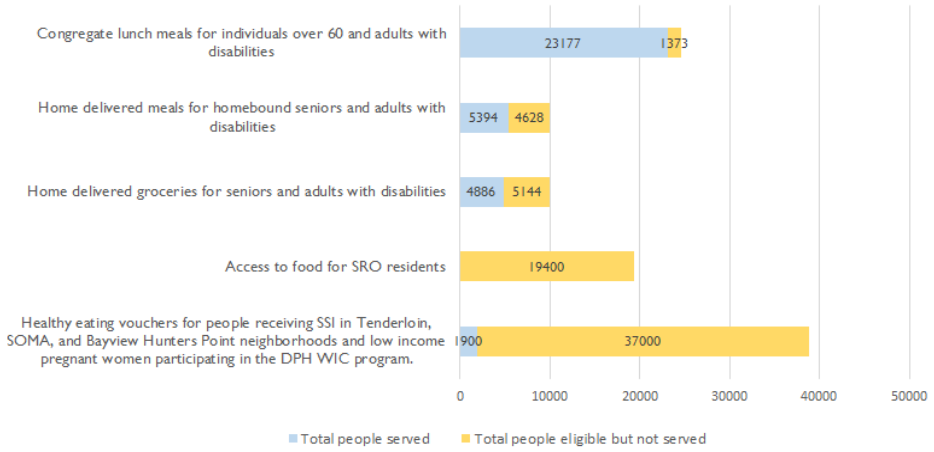
Almost no White women in San Francisco report food insecurity during pregnancy.

- **Low income families with young children:** Data from a sample of 803 low-income families in San Francisco participating in the Special Supplemental Program for Women, Infants and Children (WIC) program revealed that 53-60% of these families were food insecure.
- **Immigrants:** National research indicates that the risk for food insecurity among households with immigrants is higher than households with members who are all US born,[21] and immigrant families with young children experience disparities in their ability to afford food.[22] Although food insecurity rates among immigrants living in San Francisco are not available, 37% of children in San Francisco living in households headed by two immigrant parents live below 200% of FPL, compared to only 6% of children living with two US born parents.[23]
- **People without homes:** During the 2017 San Francisco homeless survey, 52% of respondents indicated that they had experienced a food shortage in the past four weeks. It is estimated that 7,500 people without homes live in San Francisco.

- **Residents of Single Room Occupancy Hotels:** Approximately 500 SRO hotels in San Francisco provide housing for over 19,000 people. Most were constructed in the years immediately following the 1906 earthquake and have limited or no cooking facilities. In a study of over 600 adult residents of single-room occupancy (SRO) hotels in San Francisco conducted by the FSTF, 84% reported food insecurity even with high utilization of community food resources.
- **Transitional aged youth and college students:** There is growing awareness of high rates of food insecurity among youth and young adults in San Francisco. According to the 2016 National College Health Assessment data for San Francisco State University, 35% of students surveyed were food insecure. A recent assessment of 1,088 students at City College of San Francisco found that 41% were food insecure.
- **Seniors and people with disabilities:** An estimated one-third of low-income seniors in San Francisco are reportedly unable to afford enough food.[24] In San Francisco, program data from the Department of Aging and Adult Services indicate that 78% of the adults with disabilities (18-59 years) seeking home delivered meal and congregate meals were food insecure.[25]

Despite the high level of need for food support among many communities in San Francisco, the food safety net is both impacted and not fully utilized. In 2016, 65.6% of eligible San Franciscans were enrolled in CalFresh, compared to a national average of 85% eligible enrollment. In contrast, congregate and home-delivered meal programs and many food pantries often have waiting lists of individuals who are in need of food support.

Number of Food Insecure Individuals Who Were Eligible for Meal Programs or Eating Vouchers in San Francisco in 2017—2018 by Whether or Not They Were Served



Data Source: San Francisco Food Security Task Force FY 2017-18 & FY 2019-20 Funding Request. https//www.sfdph.org/dph/files/mtgsGrps/FoodSecTaskFrc/docs/FSTE-Budget-Request-FY-18-19.pdf Accessed 8-24-18

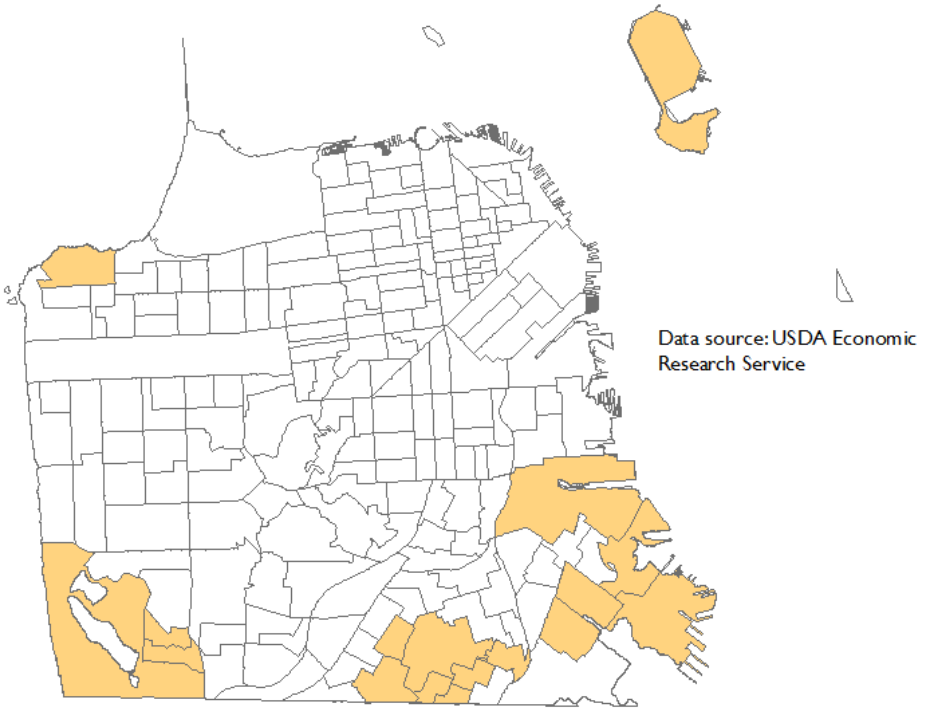
For a more detailed report on food security in San Francisco, please see the 2018 Food Security Task Force Report at www.sfdph.org/foodsecurity.

Food Environment

Although research supports the primary role of income in healthy eating,[26] the food retail environment is an important component of equity and the equitable distribution of resources. In several areas throughout San Francisco, there are concentrations of corner/convenience stores paired with a paucity of full service grocery stores, most often found in low-income neighborhoods. Fresh produce and a variety of healthier food items can then be more inconvenient for low-income residents to access, requiring increased travel time and expenses. Whether or not a food retail environment facilitates food security and promotes health is dependent on a number of factors beyond the type of food retail establishments available in a given neighborhood (i.e. corner/convenience store, fast-food restaurant, grocery store, etc.). These include: the convenience, quality, affordability, and cultural acceptability of healthy foods offered within the food retail store; the transportation infrastructure that affects accessibility; the acceptance of federal nutrition programs and

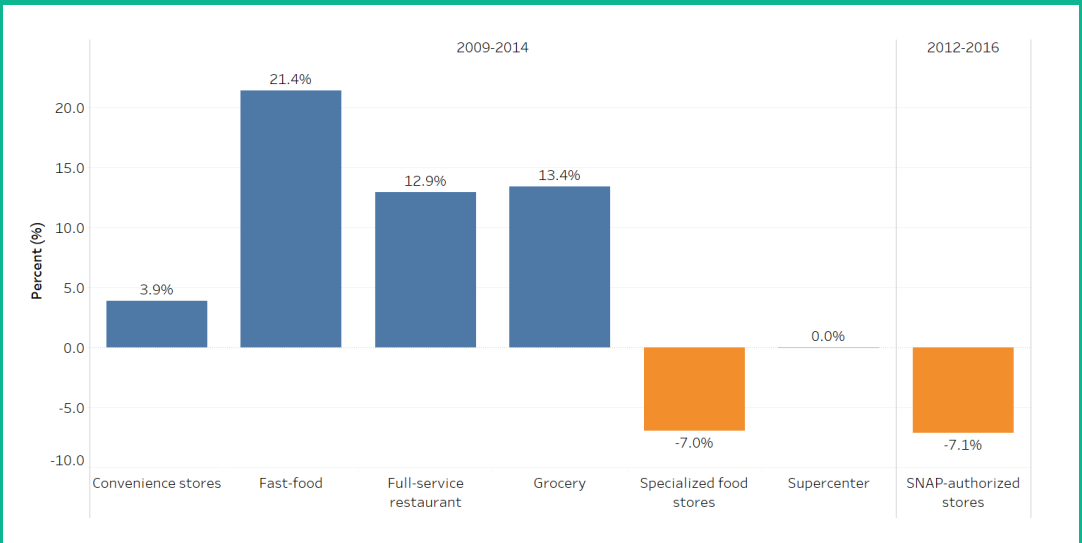
local food purchasing supplements; the accessibility of online ordering options; and the food sourcing practices of the food retail establishment (i.e. production, distribution, and procurement of foods from local farms). According to the USDA, Southeast San Francisco and Treasure Island were designated as low-income areas with low food access.

Southeast San Francisco and Treasure Island were Designated as Low Income Areas With Low Food Access by the USDA



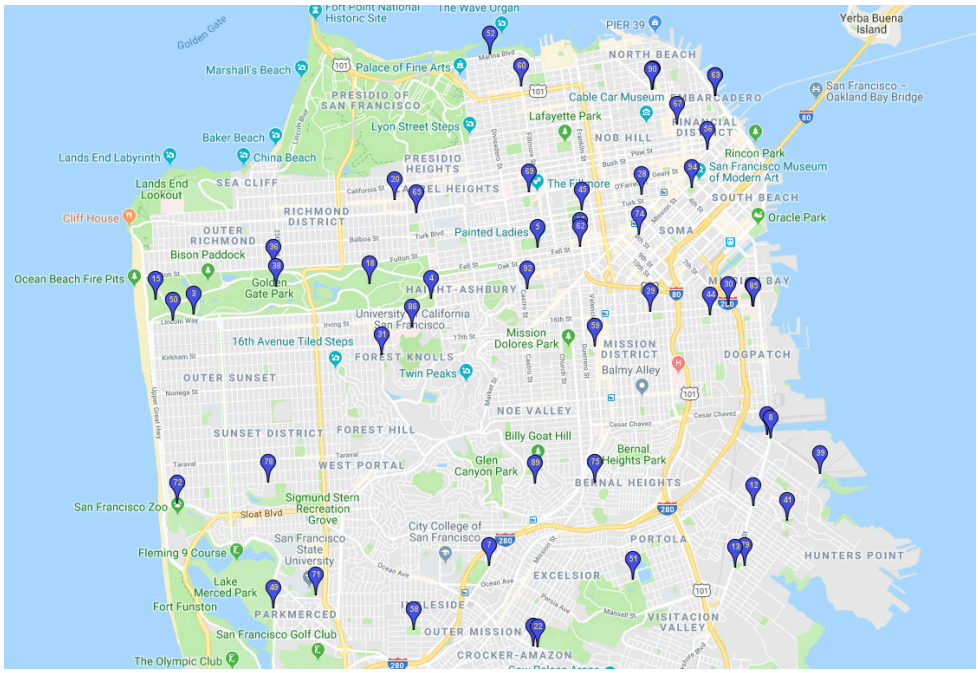
Consistent with nationwide norms to spend less time cooking and eat more meals away from home, access to ready-to-eat meals at fast food stores and full service restaurants increased in San Francisco between 2009 and 2014. The number of fast food restaurants increased by 21% from 761 to 924. The number of full service restaurants increased by 13% from 1676 to 1893. In 2014, there were 1.1 fast food restaurants and 2.2 full service restaurants for every 1,000 people in San Francisco. Meanwhile, the number of vendors authorized to accept SNAP (Supplemental Nutrition Assistance Program, formerly referred to as food stamps) decreased by 7%. In 2016, 0.55 stores per 1,000 people accepted SNAP.

Change in the Types of Food Retail or Stores Available in San Francisco, 2009—2016



As San Francisco communities increasingly recognize the health harms of sugary drinks and the beverage industry tactics to maintain consumption, San Franciscans will increasingly turn to water as the preferred beverage. Infrastructure for water access, including hydration stations, water fountains, and refillable water bottles, must exist to support the community's desire for healthy, accessible drinking options. Hydration stations, distinct from drinking fountains, are stations designed to fill water bottles. Currently, they are not abundantly available nor equitably distributed throughout San Francisco. Thus the Committee has recommended funding to support hydration stations and refillable water bottles to promote tap water consumption and decrease sugary drink consumption.

Currently Installed Water Hydration Stations in San Francisco, March 2019



Nutrition

Breastfeeding

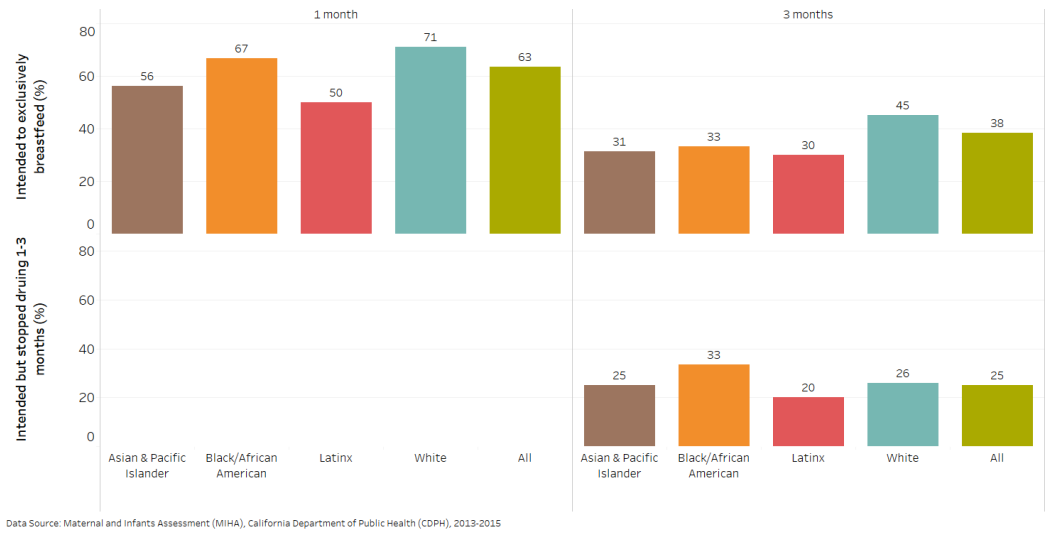
Breast milk is the optimal source of nutrition for most infants and is associated with health benefits for both the mother and infant. Mothers who do not breastfeed are at higher risk of several diet-sensitive chronic diseases such as diabetes mellitus, hyperlipidemia, hypertension, heart disease, and obesity as well as breast and ovarian cancer.[27] Breastfeeding is consistently associated with a modest reduction in the risk of later overweight and obesity in childhood and adulthood.[28] Thus good, optimal nutrition in the early months of life can set the stage for health outcomes in adulthood. Breastfeeding also reduces risk of pediatric infections and death in the first year of life, promotes infant brain development and is associated with improved intelligence by about 2 IQ points.[29]

Breastfeeding has dose-dependent effects, such that both the duration and exclusivity of breastfeeding are associated with positive health benefits.[30] Annually, in the US, billions of dollars could be saved by reducing hypertension and heart attacks, and more than 4,000 infant deaths could be prevented, if 90% of U.S. mothers were able to breastfeed for one year after every birth.[31]

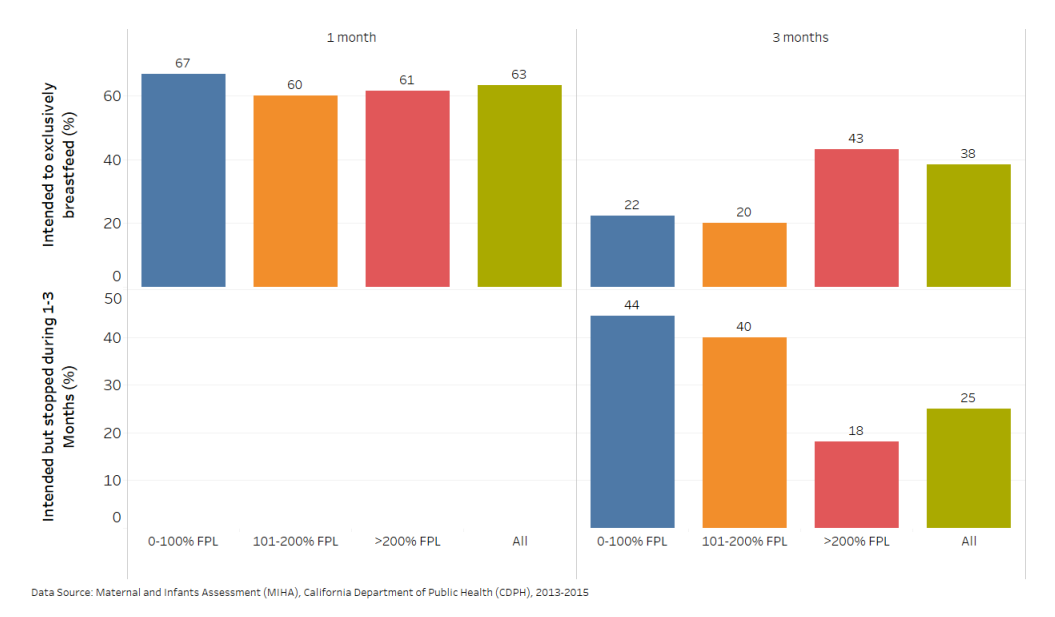
In San Francisco, rates of exclusive breastfeeding at 1 month and 3 months varied by mother's age, race-ethnicity, education, income level, and parity. Less than one in three Asian/Pacific Islander, Black/African American, and Latinx women exclusively breastfed at 3 months, compared to 50% of White women. The proportion of women with a college degree who exclusively breastfed at 3 months was about triple that of women with less than a high school degree and double that of women with some college coursework but no completed degree. Almost half of women with an income over 200% of the Federal Poverty Level exclusively breastfed their infant at 3 months, compared to about 15% of women with lower income.

Among women who intended to exclusively breastfeed before birth, the rate of exclusive breastfeeding at 1 month did not differ markedly between groups. Rates were not significantly higher for White vs. Black/African American women, higher income vs lower income, or women with private vs public health insurance. However, after 1 month, rates of exclusive breastfeeding dropped significantly faster for younger, non-White, and lower income groups than for older, White, and higher income groups. The proportion of women with an income below 100% of the Federal Poverty Level, who intended to exclusively breastfeed before birth and did so for the 1st month, decreased by 67% between 1 and 3 months postpartum. The corresponding decrease among women with an income above 200% of the Federal Poverty Level was 30%.

Exclusive Breastfeeding at 1 and 3 Months by Race/Ethnicity, San Francisco, 2013—2015



Exclusive Breastfeeding at 1 and 3 Months by Income Level, San Francisco, 2013—2015



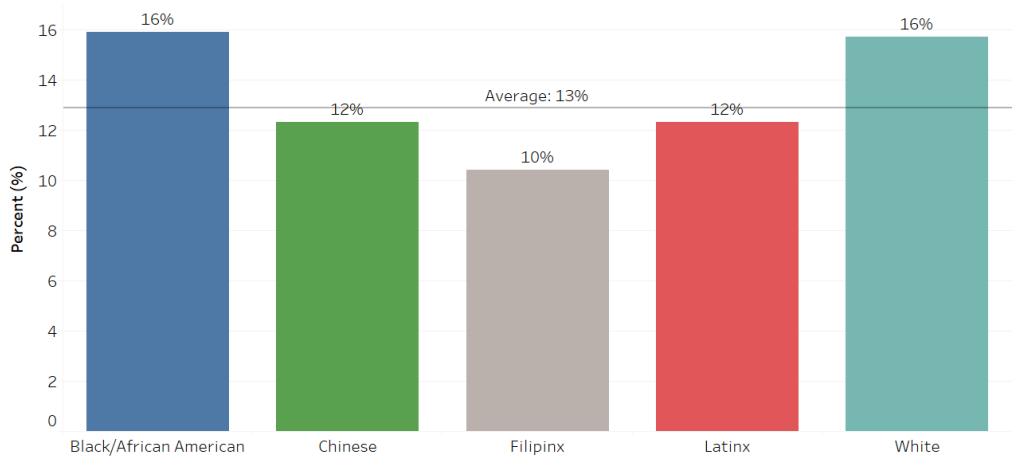
Produce Consumption

Promoting health and reducing chronic disease risk through the consumption of healthful food and drink is a national priority. Good nutrition is critical for growth, development, physical and cognitive function, reproduction, mental health, immunity, and long-term health. An estimated 45% of all heart disease, stroke, and type 2 diabetes deaths are associated with poor nutritional intake of 10 dietary factors (low intake of vegetables, fruits, seafood, whole grains, nuts/seeds, polyunsaturated fats and high intake of sodium, red meats, processed meats, sugary beverages).

Local consumption of fruit and vegetables is below recommendations for the majority of children and teens and for at least 1 in 7 adults. In 2012-2016, almost two thirds of San Francisco teens reported eating less than 5 servings of fruits and vegetables daily according to the California Health Interview Survey (CHIS).[34] The Behavioral Risk Factor Surveillance System (BRFSS) asks similar questions about adult vegetable consumption which revealed that 14% of San Francisco respondents reported eating vegetables less than one time per day.[32]

Among high school students, the odds of reporting 5 or more servings of fruit and vegetables per day does not vary by race-ethnicity (See Figure 2). In 2013-2017, 16% of Black/African American and White students and 12% of Chinese and Latinx students reported eating 5 or more servings of fruit and vegetables per day.

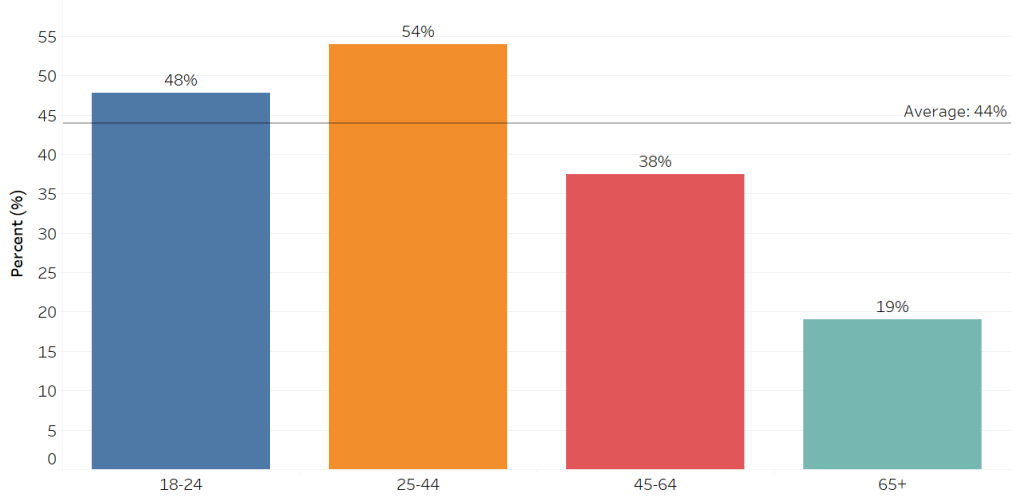
Percent of High School Students Reporting 5+ Servings of Fruits/ Vegetables per Day by Race/Ethnicity, San Francisco, 2013—2017



Data Source: Youth Risk Behavior Surveillance System (YRBSS), Center for Disease Control and Prevention (CDC), 2013-2017

In contrast, consumption of fast food is in excess of recommendations. Over the past five years, 44% of San Franciscans reported eating fast food at least weekly. Younger adults and males were over two times more likely to report eating a fast food meal in the past 7 days[33]. In 2014-2016, 54% of adults between the ages 25 to 44 years reported eating fast food at least weekly compared to 19% of adults aged 65 or older. Half of the men who responded to the California Health Interview Survey reported eating fast food weekly, compared to 37% of the women surveyed.[34]

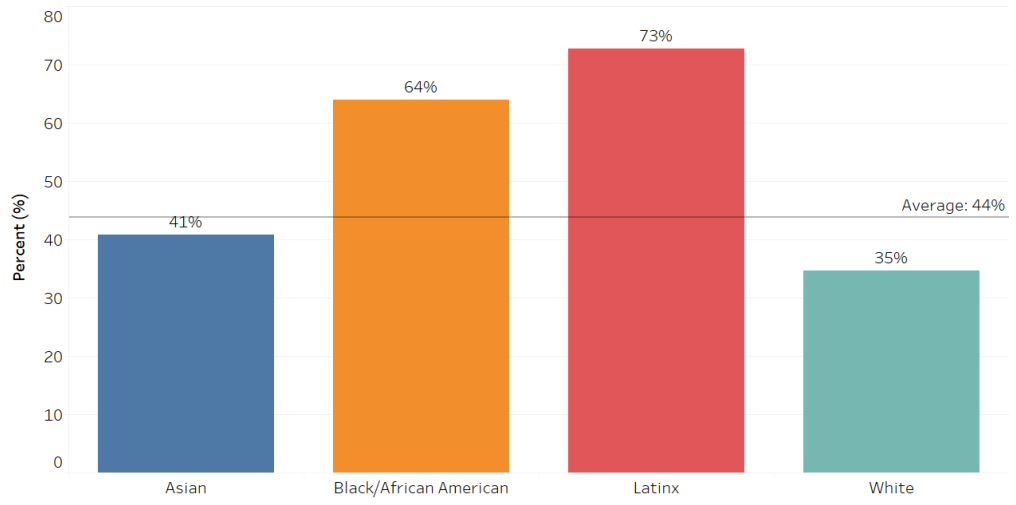
Percent of Adults Who Reported Eating Fast Food Weekly by Age Group, San Francisco, 2014—2016



Data Source: California Health Interview Survey (CHIS), UCLA Center for Health Policy Research, 2014-2016.

Among adults, the odds of reporting fast food varies by race-ethnicity. Two times more Latinx adults reported eating fast food at least weekly than White adults.

Percent of Adults Who Reported Eating Fast Food Weekly by Race/Ethnicity, San Francisco, 2014—2016



Data Source: California Health Interview Survey (CHIS), UCLA Center for Health Policy Research, 2014-2016.

Current State of Physical Activity and Built Environment

Physical activity is defined as any bodily movement that requires energy expenditure. The Centers for Disease Control and Prevention (CDC) recommends that children and adolescents, age 5 to 17 years, should do at least 60 minutes of moderate-to-vigorous physical activity daily, while adults, age 18 years and above, should do at least 150 minutes of moderate-intensity physical activity, 75 minutes of vigorous-intensity physical activity, or an equivalent combination of moderate and vigorous activity throughout the week.[35] The National Association for Sport and Physical Education set physical activity guidelines for infants to children 5 years old at a minimum of 120 min of daily in the form of 60 min of structured activity and 60 minutes of unstructured activity.[36]

Regular physical activity can help people live longer, healthier lives. According to WHO, physical inactivity has been identified as the fourth-leading risk factor (after hypertension, tobacco use, and high blood sugar) for mortality, causing an estimated 3.2 million deaths globally.[37] Physical activity protects against many chronic health conditions including obesity, cardiovascular disease, type 2 diabetes, metabolic syndrome, and cancer (breast and colon). Through the release of serotonin, exercise can help reduce stress, anxiety, and depression.[38]

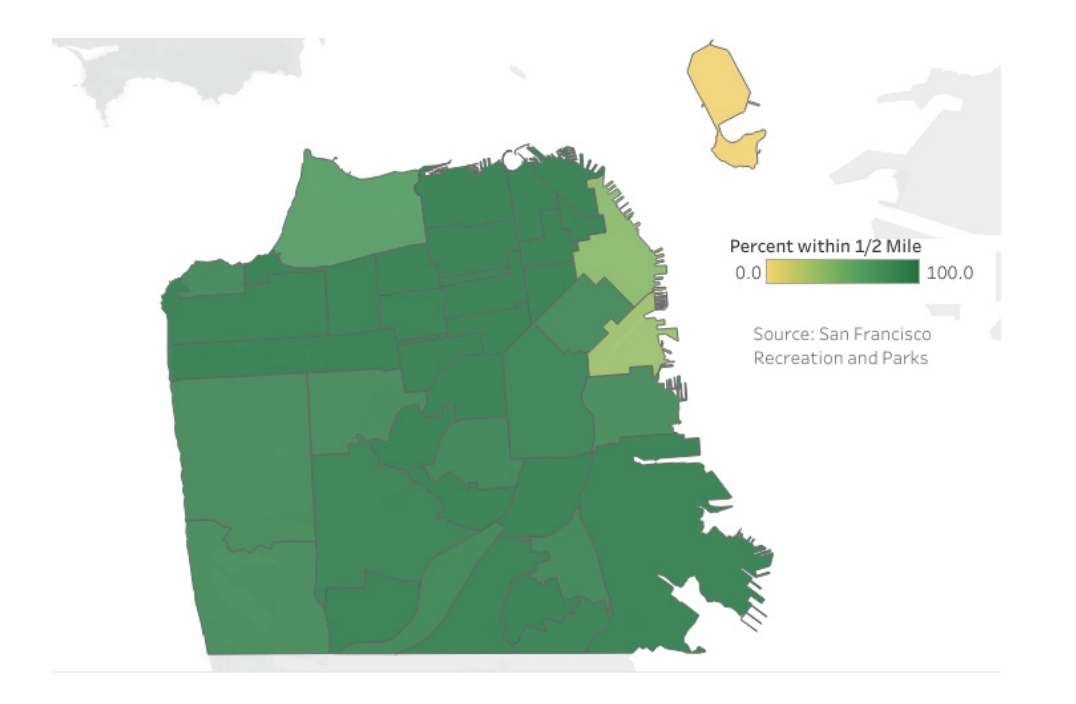
Beyond physical and mental health, physical activity has been found to be vital to the success of students. It supports learning by improving concentration and cognitive functioning, and has been shown to have a positive influence on students' academic performance.[39] California uses the FitnessGram® to assess physical fitness of 5th, 7th and 9th graders. On average, California students who achieve more fitness standards perform better on standardized tests.[40]

Despite health advantages of physical activity, a 2009 summary by the Robert Wood Johnson Active Living Research Program revealed that less than 50 percent of children and adolescents as well as less than 10 percent of adults in the U.S. achieve public health recommended goals of 30 to 60 minutes per day of moderate to vigorous physical activity on five or more days per week.[41]

The environments in which we live can have significant impact on our level of physical activity. Institutional policies and practices, living conditions, especially physical and social environments, and individual factors interact to promote or inhibit physical activity.[42-44] Land use and transportation policies determine the location and design of infrastructure and activities.[45] Neighborhood features such as parks, sidewalks, bicycle trails, recreational facilities, nearby shops, and public transportation stops promote leisurely physical activity, sports, and active transportation.[46, 47]

Although 95% of San Francisco's population lives within one half mile of a public recreation facility (defined as athletic fields, meeting spaces/activity centers, performance spaces, and recreational centers/pools run by the San Francisco Recreation and Park Department), Treasure Island currently has no recreation facilities, and only 32% of Mission Bay and 41% of Financial District/South Beach residents are within one half mile of a facility. Potrero Hill and western neighborhoods (including Sunset/Parkside, Inner Sunset, and Lakeshore) also have 10% or more of residents living more than a half mile away from a recreation facility.

Percent of Residents that Live Within a 1/2 Mile of a Public Recreation Facility, by Analysis Neighborhood, 2017



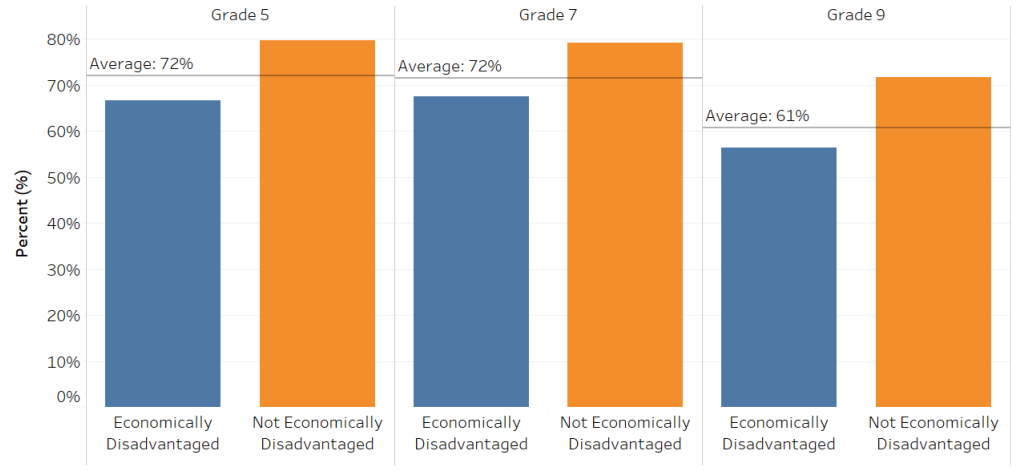
However, existence of infrastructure alone is insufficient. Barriers to use of facilities and physical activity include costs, poor access to facilities, and perceived unsafe environments.[48-50] Institutional policies, including those in the workplace and school and childcare, also affect health. Policies including transportation vouchers, on-location gyms, safe routes to school, recess, physical education, and after-hours availability of the school yard for play can boost physical activity among children and adults.[51] Additionally, social support is instrumental in starting and maintaining a physically active lifestyle. Persons who receive encouragement, support or companionship from family and friends are more likely to form positive views of physical activity and to begin and continue being physically active.[44, 45, 49, 52] At the individual level, interest in and ability to do physical activity vary. Individuals may have physical or emotional blocks to doing physical activity. Examples include a lack of skills or confidence; a functional limitation associated with a disability, a chronic disease, or increased age; habits such as cigarette smoking or drinking alcohol; as well as a dislike for physical activity.[44, 53, 54] Additional personal barriers which are commonly cited are competing priorities, limited discretionary time and/or money, lack of childcare, and a lack of culturally-appropriate activities.

Walking or biking for utilitarian trips, sometimes referred to as active transportation, is an opportunity to incorporate routine physical activity into daily living. In San Francisco, 50% of adults age 18 and older reporting walking for transportation or leisure for at least 150 minutes in one week in 2014 which is significantly higher than the 33% of adults statewide who walked for at least 150 minutes.[34]

According to the California State Board of Education's standardized FitnessGram® which tests students in grades 5, 7, and 9 on six measures of fitness, almost half of 5th, 7th and 9th grade SFUSD students are not physically fit - defined as being in five or six out of six Healthy Fitness Zones. Overall, San Francisco students perform worse than California students overall. Children from economically disadvantaged households perform worse than students from families who are not economically disadvantaged. While 60% of Asian and White 5th grade students score within five or six zones, less than 40% of Black/African American, Latinx, and less than 30% of Pacific Islander, Native American grade students do the same).

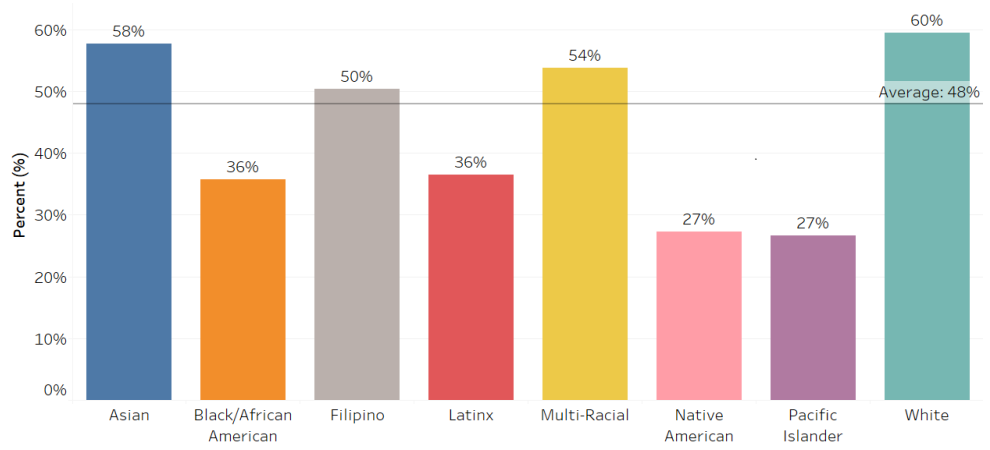
One of the most potent measures of physical fitness from the FitnessGram® test is aerobic capacity because of its relationship to cardiovascular and metabolic health. In San Francisco, about 70% of 5th and 7th graders meet the standard for aerobic capacity. About 60% of high school students meet the standard. When examined by income, the percentage of students identified as not economically disadvantaged who met the aerobic standard was more than 10 percentage points higher than those identified as economically disadvantaged. By ethnicity, around 80% of White and Asian students meet aerobic standards in 5th and 7th grade while only 50-65% of Black/African American and Latinx students do the same. In 9th grade those rates for White and Asian students drop to around 70%, while for Black/African American and Latinx students they drop to around 40%.

Percent of SFUSD Students Who Meet the Aerobic Capacity Fitness Standard by Income Level, 2016—2017



Data Source: California Department of Education FitnessGram, 2016-2017

Percent of SFUSD 5th Grade Students Meeting 5+ of 6 Statewide Fitness Standards by Race/Ethnicity, San Francisco, 2016—2017



Data Source: California Department of Education FitnessGram, 2016-2017

Mortality in San Francisco

A broad summary of the findings above about the current economic environment as well as the state of nutrition and physical activity in San Francisco generally show poorer outcomes among lower income communities and ethnic minorities, particularly Latinx and Black/African American communities. Most data sources do not allow for sub-analyses that show the health behaviors or outcomes for ethnic minority communities like Pacific Islander, Native Americans, and Filipinx who are known to face disparities in health outcomes and health behaviours similar to Latinx and Black/African American communities. Looking downstream at the ultimate health consequences of these factors and many other determinants of health, it is both unfortunate and not surprising that Black/African Americans and Pacific Islanders have the lowest life expectancy in San Francisco, with an average life expectancy of 72 and 76 years, respectively, compared to the average life expectancy of 83 years. Latinx and Asians both have longer life expectancies than Whites.[55]

Life Expectancy at Birth by Race/Ethnicity and Gender, San Francisco, 2015—2017

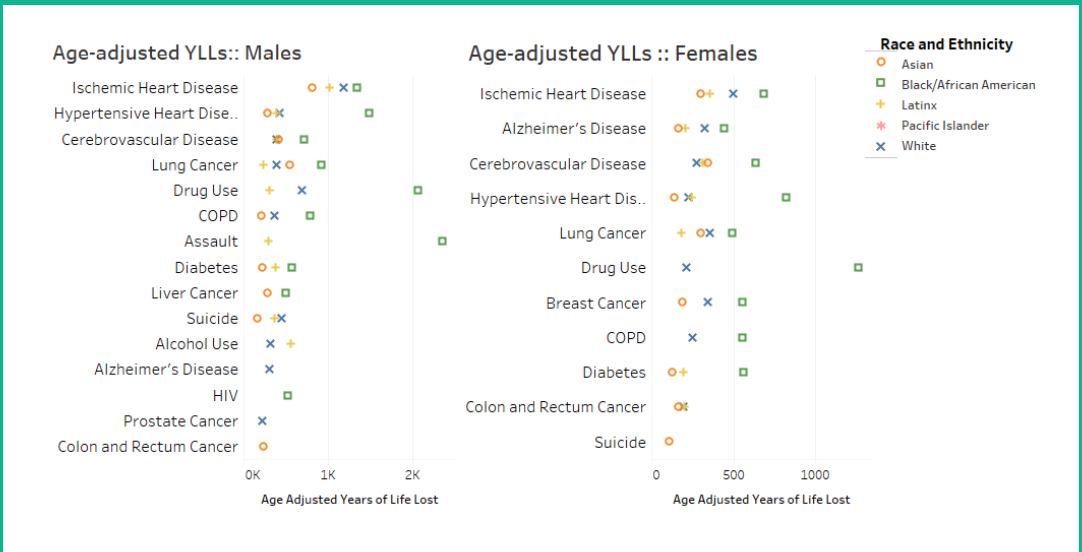
Race/Ethnicity	All	Female	Male
All	83	86	80
Asian	87	90	84
Black/African American	72	76	68
Latinx	85	88	83
Multi-Racial	96	97	94
Native American	75		
Pacific Islander	76	77	75
White	82	84	80

Data Source: Death Statistical Master Files, California Department of Public Health (CDPH), 2015-2017.

When looking at the burden of premature mortality, Years of Life Lost (YLL) weights each death by the years of remaining life expectancy at the time of death, based on a standard population. From this, we see the top contributors to Years of Life Lost are diet-sensitive chronic diseases like ischemic heart disease, cerebrovascular disease, hypertensive disease,

and diabetes which is consistent with the major causes of death. Across nearly all causes of death, Black/African Americans face disproportionately high Years of Life Lost relative to other race/ethnic groups.

Years of Life Lost



Diseases connected to sugary drinks are also found to disproportionately impact ethnic minority and low-income communities – the very communities that are found to consume higher amounts of sugary drinks. Diabetes hospitalizations are approximately three times as high in low-income communities as compared with higher income communities. Black/African American death rates from diabetes are two times higher than San Francisco's overall rate. In San Francisco, approximately 46% of adults are estimated to be obese or overweight, including 66% of Latinx and 73% of Black/African Americans. With respect to oral health, the data indicate that Asian and Pacific Islander children suffer from cavities at a higher rate than other populations; but Latinx and Black/African American children also have a higher prevalence than the average for cavities.

Further information on the Current Status of Diet-Sensitive Disease can be found in Appendix D. Most of the data presented in that section were presented in the 2018 Sugary Drinks Distributor Tax Report and remain largely unchanged since, for the most part, there have not been any new, updated data to incorporate into new analyses.

III. SUGARY DRINKS DISTRIBUTOR TAX ADVISORY COMMITTEE RECOMMENDATIONS

ADVISORY COMMITTEE PROCESS

Upon completion of its first report in March 2018, the Committee was not reconvened again until May 2018, this time with DPH serving as the backbone staff. From May through December, the Committee met monthly and added an extra meeting in February 2019 to complete its recommendations and this report.

In addition to the full monthly Committee meetings, many Committee members participated in one or two subcommittees. The three subcommittees continued their work from the previous year: Data and Evidence, Community Input, and Infrastructure. Each subcommittee gathered input from experts, stakeholders, community groups, and sugary drink tax advisors from other cities. The full Committee also heard community input at meetings and through DPH Town Halls, and each subcommittee was encouraged to incorporate public feedback in its recommendations. The Committee's recommendations were informed by scientific data and evidence; community input via community focus groups, town halls, and online surveys; and the learnings from other jurisdictions that have implemented similar taxes.

The Co-Chairs also conducted meetings with the Mayor's office and members of the Board of Supervisors to describe the process for developing recommendations and to describe their strategies in more depth. Additionally, they participated along with backbone staff in national conference calls with representatives of other jurisdictions that have passed sugary drink taxes.

As previously described in this report, the Committee is tasked with making two-year budget recommendations to coincide with the City's two-year budget cycle every year. The Committee expects new information will emerge during the course of the first year (from

funded organizations, ongoing community input, new data and evidence, etc.) that will inform potential changes to its second year budget recommendations. For example, this year the Committee is making recommendations for expenditures in FY 19-20 and FY 20-21. The Committee will re-evaluate its FY 20-21 recommendations at the end of 2019 and may make changes, if deemed appropriate, for its final FY 20-21 recommendations in early 2020.

The Sugary Drinks Distributor Tax Advisory Committee voted on February 20, 2019 to make the funding recommendations for FY 19-20 and FY 20-21 as described in the recommendations section.

Given the Committee's legislative mandate to evaluate the impact of the SDDT and Mayor London Breed's commitment to accountability ("Make every dollar count") of public dollars, the Committee recommends that revenue generated from the SDDT be indicated in such a way that City Departments know that they have received funding that was generated from SDDT revenue. Such notation makes it possible for the committee to fulfill its legislative mandate with respect to documenting the impact the SDDT is having in San Francisco.

Data and Evidence Subcommittee

The mission of the Data and Evidence Subcommittee is to review, analyze and share research within the context of our San Francisco communities to help inform and support the work of the Sugary Drinks Distributor Tax Advisory Committee.

The duties of the subcommittee are to:

- Collect and review research and data that would be helpful to the work of the committee;
- Help inform and support efforts to analyze the impact of the SDDT on sugary drink pricing, public health, and consumer purchasing behavior; and
- Help inform efforts to evaluate programs and work funded by SDDT.

The following members of the Committee were active members of the Data and Evidence Subcommittee during the development of this report:

Jonathan Butler	Seat 5: research/medical institution; Data and Evidence Subcommittee Chair
Joi Jackson-Morgan	Seat 3: Health equity Black/African American; SDDTAC Co-Chair
Roberto Vargas	Seat 4: research/medical institution; SDDTAC Co-Chair
Saeeda Hafiz	Seat 8: San Francisco Unified School District
Libby Albert	Seat 9: San Francisco Unified School District, resigned January 2019
Rita Nguyen	Seat 10: DPH chronic disease
Irene Hilton	Seat 11: DPH oral health
Lyra Ng	Seat 16: Children 0-5 years-old, resigned January 2019

The Data and Evidence Subcommittee met on a monthly basis with a total of nine meetings from September 2018–February 2019:

September 5, 2018
September 19, 2018
October 17, 2018
November 29, 2018
January 16, 2019
January 22, 2019*
February 4, 2019*
February 13, 2019
December 19, 2018

**Special meetings to prepare for extra Committee meetings*

Meetings are approximately 2 hours long and agenda items included: (1) developing the subcommittee's mission and duties; (2) creating a work plan that identifies subcommittee tasks in alignment with the goals of the Committee; (3) reviewing and discussing data collected by DPH; (4) reviewing and discussing DPH's focus group report; (5) reviewing the Committee's evaluation plans, needs, and funding; (6) presenting research on health

disparities and factors that contribute to health disparities; and (7) presenting FY19/20 and FY20/21 recommendations for strategic investments that are evidence-based and data-driven to the SDDTAC.

Additionally, select subcommittee members have: (1) hosted SFUSD student forum to develop and share student-designed strategies to be funded by the SDDT; (2) contacted Bay Area academic researchers to review the subcommittee's synthesis of data driven and evidence-based interventions and strategies to be considered by the full Committee; and (3) Invited speakers to present on relevant research to the Committee.

FUTURE CONSIDERATIONS FOR DATA AND EVIDENCE

The Data and Evidence Subcommittee recommends that the DPH data section of the annual report be prepared by each fall for the Data and Evidence Subcommittee to review and provide input that may inform the full Committee's recommendations.

The Data and Evidence Subcommittee remains committed to helping inform the SDDTAC recommendations with objectiveness and dedication to evidence-based scientific information in the context of community through the remaining time of the SDDTAC on behalf of all the residents of the City and County of San Francisco.

Community Input Subcommittee

The mission of the Community Input Subcommittee is to ensure that meaningful community engagement opportunities are fully integrated throughout the work of the SDDTAC, so that impacted populations can inform the decisions of the full committee. This subcommittee recognizes the disproportionate health burdens felt by communities of color and low-income communities and the need to have members of these communities actively participate in shaping funding recommendations for strategies, approaches and services that contribute to decreasing the consumption of sugary drinks for those most impacted, as well as all San Franciscans. This subcommittee also recognizes the necessity for the Committee to create mechanisms by which information about the recommendation process and the implementation of the SDDT can be communicated to members of the public, including disproportionately impacted communities. With this as our guiding perspective, the Community Input Subcommittee worked in partnership with the Department of Public Health (DPH), who provided backbone staffing for the Committee, to support and give feedback related to community engagement and outreach efforts.

The duties of this subcommittee are to:

- Evaluate the funding process and extent to which the intent of the original recommendations are implemented through community input;
- Make recommendations to full committee for any needed improvements to next round of recommendations/funding process based on community input;
- Ensure that implementing organizations are getting the support they need; as well those who may need support responding to calls for proposals;
- Solicit input from the community about SDDTAC recommendations and related processes;
- Advocate for community engagement activities such as Town Hall meetings;
- Recommend the addition of public engagement component be a part of the funding process:
- In collaboration with the Infrastructure Subcommittee, develop a process for some funded organizations to report out to the Committee and the public what they have done or what they intend to do; and
- Oversee strategic outreach to communities.

The following members of the Committee were active members of the Community Input Subcommittee during the development of this report:

Vanessa Bohm	Seat 1: Health equity – Latino/Chicano/Indigena; Community Input Subcommittee Co-Chair
Ryan Thayer	Seat 12: DPH Food Access/Security, resigned January 2019; Community Input Subcommittee Co-Chair
Kent Woo	Seat 2: Health equity - Asian/Pacific Islander
Joi Jackson-Morgan	Seat 3: Health equity - Black/African American; SDDTAC Co-Chair
Jonathan Butler	Seat 5: research/medical institution
Janna Cordeiro	Seat 15: SFUSD Parent Advisory Council
Shelley Dyer	Seat 12: DPH food access/food security*
Alexandra Emmott	Seat 9: San Francisco Unified School District**

**Shelley Dyer was appointed to replace Ryan Thayer. Shelley's first meeting of SDDTAC was January 16, 2019.*

***Alexandra Emmott was appointed to Seat 9 by SFUSD as of January 2019.*

Almost all of the subcommittee members participated in one or both the sugary drink tax campaigns in 2014 and 2016. All members of the subcommittee have extensive work experience with diverse communities disproportionately impacted by the consumption of sugary drinks and have expert knowledge on important issues and concerns affecting these communities. As a result, subcommittee members are well positioned to inform recommendations for community engagement and outreach efforts.

The Community Input Subcommittee has met 7 times between August 2018–February 2019:

August 24, 2018
September 21, 2018
November 16, 2018
November 30, 2018
January 11, 2019
January 31, 2019
February 15, 2019
February 13, 2019
December 19, 2018

Each meeting was approximately two hours in length. Agenda items included: (1) developing a subcommittee work plan in alignment with the SDDTAC overarching work plan; (2) discussing and providing feedback related to the 510Media campaign,DPH community engagement and outreach efforts; (3) reviewing and discussing FY 19-20 and FY 20-21 funding recommendations; and discussing and developing the subcommittee's report for the Committee's 2019 Annual Report. In addition, subcommittee members reported to and gathered community input from various community stakeholders to inform the Committee's work.

2018 COMMUNITY ENGAGEMENT ACTIVITIES

DPH staff partnered with Resource Development Associates to organize community engagement opportunities and outreach efforts from May through October 2018 in the form of 10 focus groups (Appendix F), surveys (Appendix G) and six town hall meetings (Appendix H). In addition, community input was gathered at monthly Committee meetings through public comment. While subcommittee members did not participate directly in focus groups

or the implementation of surveys, subcommittee members did have the opportunity to attend all town hall meetings to learn from the community, observe the process and provide feedback to DPH on the organization and implementation of the town hall meetings.

The feedback through the DPH-led community outreach showed that the community wanted to see more access to healthy foods, nutrition and water education, physical activity programming, etc. Participants also indicated a desire for more emphasis on health equity-related components such as access, cultural responsiveness, and age appropriateness.

CONSIDERATIONS FOR FUTURE COMMUNITY INPUT OPPORTUNITIES

Community engagement activities and outreach efforts to gather input from diverse communities, including those most impacted by the consumption of sugary drinks, were successful overall. In general, activities were held at locations and times that were convenient for community members, taking into account working individuals, youth and elderly populations, and language and accessibility needs. Through these activities, DPH was able to collect the comments and feedback by members of the public. DPH backbone staff presented data gathered at community engagement activities at the general meetings of the Committee. Please see DPH reports on community engagement efforts for an analysis of the community input data in Appendices F-H.

While the community engagement activities were successful in gathering important perspectives and feedback from the public representing diverse communities across San Francisco, the subcommittee suggests the following activities to inform future community engagement opportunities:

- Implement mechanisms or procedures to ensure a bi-directional flow of information between the Committee and the public, particularly from communities most impacted by the consumption of sugary drinks. Mechanisms should be established for the Committee to report back to the public the investment and impact of SDDT funding and for gathering input on the health and wellness needs, concerns and priorities of community members.
- Allocate adequate resources to fund effective community engagement strategies and activities, including but not limited to focus groups, surveys, presentations at coalition meetings, and town halls.
- Partner with community-based and faith-based organizations and coalitions, particularly those working directly with impacted communities, to effectively promote community engagement activities, gather input and ensure participation by diverse members of the community.

- Ensure input from youth via SFUSD, the Committee youth seat, etc. The subcommittee has included youth input by other means to date, in lieu of the youth seat being filled this year. Youth engagement in 2018 included: attending presentations by John O'Connell High School students on sugary drinks consumption and ideas for improvement of student health and wellness at SFUSD; youth participation in several town halls; and outreach within SFUSD; and A community convener model could be a promising approach for gathering community input in the future. Greater discussion is needed to assess the feasibility of implementing such a model.
- Identify mechanisms or procedures for both City Departments and community-based and faith-based funded programs and services to report back to community stakeholders about their impact, especially for those most impacted by the consumption of sugary drinks.
- Ongoing option for input through a standing survey link on the Committee's webpage.
- Reminding all Committee members that, as a basic premise of their Committee membership, they are responsible for representing their designated communities and/or sectors.
    - » Consider developing a regular/quarterly schedule for Committee members to collect and share input to/from communities.
    - » Committee members track/report information collected and provide at monthly meetings via evaluation form.
- Host Committee meetings in the community

The Community Input Subcommittee will work with DPH backbone staff to design a community engagement process and infrastructure, taking the above recommendations into consideration.

Infrastructure Subcommittee

The mission of the Infrastructure Subcommittee is to ensure needed staffing and resources are in place to support the functioning, administrative, and evaluation needs of the Committee and Subcommittees.

The duties of this subcommittee are to:

- Provide recommendations regarding the infrastructure resources needed to support implementation of the SDDT which includes infrastructure to:
    - » Provide administrative and operational support to the Committee and its Subcommittees
    - » Support coordination across City departments and funded agencies.

  - » Ensure community engagement so that Committee recommendations are developed and implemented in partnership with community
  - » Track the economic impact of the tax on small businesses and larger corporations
  - » Support evaluation of funded City agencies and programs
  - » Support the creation of an annual report
  - » Support CBOs and FBOs to respond to City RFPs related to SDDT funds
  - » Help merchants comply with the tax
- Ensure the full Committee is updated regularly on the progress of implementation and has opportunities to provide input as needed
- Provide guidance/recommendations in the Committee's media relationships/ communications, ensuring alignment and consistency of messaging
- Provide regional representation with other cities with sugary beverage taxes, regularly reporting back to Subcommittee and full Committee
- Contextualize the work of the Committee within City Department systems and processes

The following members of the Committee were active members of the Infrastructure Subcommittee during the development of this report:

Michelle Kim	Seat 13 - Department of Children, Youth & Their Families; Chair of Infrastructure Subcommittee
Linda Barnard	Seat 14, Recreation and Parks Department
Rita Nguyen	Seat 10 - Department of Public Health, Chronic Disease
Jorge Rivas	Seat 7, Office of Economic and Workforce Development
Roberto Vargas	Seat 4 - Research/Medical Institution: Committee Co-Chair Seat 9: San Francisco Unified School District, resigned January 2019

The subcommittee met 8 times August 2018-February 2019.

August 28, 2018
September 19, 2018
October 17, 2018
November 20, 2018
December 19, 2018
January 9, 2019
January 17, 2019
February 14, 2019
December 19, 2018

Meetings are approximately 1.5 hours long. Topics for these meetings consist of: (1) reevaluating the Infrastructure Subcommittee's mission and duties; (2) creating a work plan (in coordination with Committee's overarching work plan), and (3) creating a survey to receive updates from City departments about SDDT funding. In addition, the Infrastructure Subcommittee has also dedicated time to prepare for the March 2019 report by reviewing FY 19-20 and FY 20-21 funding recommendations.

Between Subcommittee meetings, the Chair and a few other Subcommittee members have spent additional time with RDA to help facilitate and prepare for Subcommittee meetings. Subcommittee members have spent additional time outside of the Infrastructure Subcommittee to check-in with DPH regarding infrastructure needs, participate in regional media campaign meetings with other cities with sugary drink taxes, draft survey questions for reporting updates from City departments, and provide input on branding and a media campaign geared toward retailers.

FUTURE CONSIDERATIONS FOR INFRASTRUCTURE SUBCOMMITTEE

In general, existing data sources for 1) beverage prices, 2) consumer purchasing behavior, and 3) public health (particularly diet-sensitive chronic disease which the Committee is particularly interested in given the impact of sugary beverages on these conditions) are not robust. It can be difficult to recognize changes in nutrition, food security, physical activity, and diet-sensitive chronic disease. Thus the Committee has made recommendations to support data and evaluation infrastructure to better understand the impact of the SDDT especially on the communities most affected by the impact of sugary beverages. Additionally the Infrastructure subcommittee will be recommending which SDDT funded agencies should present their work to the Committee.

ADVISORY COMMITTEE RECOMMENDATIONS

SDDTAC Principles

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

The City of San Francisco is not an exception but a reflection of these entrenched inequities and health disparities among low-income, communities of color and other discriminated groups. Data shows that within San Francisco these populations experience the highest rates of chronic diseases such as type 2 diabetes, obesity, heart disease and tooth decay. These same communities have the highest concentration of sugary beverage consumption and are disproportionately targeted by aggressive and exploitative marketing campaigns by the soda and sugary drinks industry. It is also the case that San Francisco is one of the cities in which the wealth gap between rich and poor is growing the fastest. The top 5% of the City's wealthiest make 16.6 times more than the middle class (middle 20 percent) and even greater in comparison to the City's poorest.[56]

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

For these reasons, the Committee prioritizes the majority of funds to be directed toward community-led initiatives. In this vein, the following strategies and approaches should be prioritized in the implementation of initiatives funded by the Sugary Drinks Distributor Tax:

- **Community-Led & Informed.** Funded activities should value and involve communities in determining how activities are shaped and implemented in advancing health outcomes. Community-led and informed activities incorporate vision and priorities created by the people who live in a particular geographic community, put local voices in the lead, build on local strengths, and collaborate across sectors in intentional and adaptable ways that build community power and works to address root causes of inequities. Community-based organizations and faith based organizations have concrete ties to community members, demonstrated experience working in target communities, and have staff and governance that reflect those they serve. Community-based programs and services are also community endorsed and evidence- or practice-based.

- **Culturally Relevant.** Funded activities should be shaped and informed by languages, cultural practices, traditional knowledge, perspectives, and expressions that reflect the communities and populations targeted by the activities, including being multi-cultural and multi-generational.

- **Peer-Led/Promotora Approach.** Funds should support activities that incorporate peer led and/or promotora (community health worker) led interventions. Peer/promotora led approaches value community members as vehicles for promoting and enhancing change among peers by educating and sharing information with those who share the same language, culture, ethnicity and life experiences as them. By doing so, peer educators/promotoras are able to remove barriers to information and services. They are natural advocates and committed to equity and social justice.

- **Implementation provides training and employment for target community members (Workforce Development).** Activities should support development opportunities that lead to increased employability and employment, including but not limited to local hiring, job readiness training, skill and capacity building, career path development, and entrepreneurial opportunities.

- **Collaborations & Partnerships.** Funding should support existing and new community-based partnerships and collaborations that leverage resources in order to increase capacity, effectiveness and impact of strategies, programs and services.

- **Leadership Development.** Funding should support activities that promote the development of skills and capacity of community members to become more effective leaders in their communities; enhance leadership skills to create and implement purposeful desired community change; and build capacity of community members to work effectively with a broad range of community issues

- **Accessible - Free & Low Cost Services.** Funding should support programs and activities that offer free and/or low-cost services to target populations to ensure accessibility and engagement with community members

- **Intersection of Strategies and Program Areas.** Funding should support activities that incorporate multiple strategies or program areas that represent holistic approaches addressing health disparities and inequities

- **Promotes long term policy, systems, or environmental change.** Funding should support policy, systems and environmental changes that go beyond programming and focus on the systems that create the structures in which we work, live, learn and play. Adopting a Policy, Systems & Environmental (PSE) change approach can help create sustainable, comprehensive measures to improve community health. PSE can enrich and expand the reach of current health preventive efforts and engage diverse stakeholders around the goal of improving health.

GUIDELINES FOR IMPLEMENTING SDDT FUNDS

Given the Principles above, the Committee identified the following priority populations to be served by SDDT funding:

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

  *Including but not limited to Black/African American, Asian, Latinx, Native American, and Pacific Islander populations as well as youth and young adults, particularly adolescent males.

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

In addition, to capture the spirit of the SDDT, the Committee made the following

recommendations regarding how funds from the SDDT should be spent. Expenditures should:

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

  Priority categories for the expenditures (in no particular order) are:

  - » Decreasing consumption of sugary drinks
  - » Increasing water consumption
  - » Oral health
  - » Healthy eating/food security
  - » Physical activity
  - » Other (e.g. research/community-based participatory research (CBPR), new innovations, etc.)

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

ADDITIONAL RECOMMENDATION

Given the Committee's legislative mandate to evaluate the impact of the SDDT and Mayor London Breed's commitment to accountability ("Make every dollar count") of public dollars, the Committee recommends that revenue generated from the SDDT be indicated in such a way that City Departments know that they have received funding that was generated from SDDT revenue. Such notation makes it possible for the committee to fulfill its legislative mandate with respect to documenting the impact the SDDT is having in San Francisco. City Agencies should also be notified that they will be expected to report back on how the funds were spent and the impact it had on San Franciscans.

SDDTAC BUDGET RECOMMENDATIONS FY19-20 AND 20-21 *(Budget descriptions follow)*

	FY19-20	FY20-21	%	Department
COMMUNITY-BASED GRANTS				
Health education, food security, physical activity	$3,260,000	$3,260,000		DPH/CHEP
CBOs working with SFUSD	$300,000	$300,000		DPH/CHEP
Media	$680,000	$680,000		DPH/CHEP
Community engagement	$50,000	$50,000		DPH/CHEP
TOTAL COMMUNITY BASED GRANTS	**$4,290,000**	**$4,290,000**	**41%**	
SAN FRANCISCO UNIFIED SCHOOL DISTRICT				
School Food, Nutrition Ed	$1,000,000	$1,000,000		SFUSD via DCYF
Student Led Action	$500,000	$500,000		SFUSD via DCYF
TOTAL SFUSD	**$1,500,000**	**$1,500,000**	**14%**	
FOOD ACCESS / SECURITY				
Healthy Food Purchasing Supplement	$1,000,000	$1,000,000		DPH/CHEP
Healthy Retail	$150,000	$150,000		OEWD
TOTAL FOOD ACCESS	**$1,150,000**	**$1,150,000**	**11%**	
ORAL HEALTH				
Community task forces	$450,000	$450,000		DPH/MCAH
School-based sealant application	$350,000	$350,000		DPH/SF Health Network
School-based education and case management	$200,000	$200,000		SFUSD via DCYF
TOTAL ORAL HEALTH	**$1,000,000**	**$1,000,000**	**10%**	
INFRASTRUCTURE				
DPH Infrastructure	$1,000,000	$1,000,000		DPH/CHEP
Strategic planning	$40,000	$ -		DPH/CHEP
Evaluation	$200,000	$200,000		DPH/CHEP
TOTAL INFRASTRUCTURE	**$1,240,000**	**$1,200,000**	**12%**	
WATER ACCESS				
Water Access - SFUSD	$ -	$340,000		PUC via RPD
Water Access - Public Spaces	$300,000	$ -		PUC via RPD
TOTAL WATER ACCESS	**$300,000**	**$340,000**	**3%**	
SF RECREATION & PARKS	**$520,000**	**$520,000**	**5%**	**RPD**
HOPE SF CHRONIC DISEASE EQUITY	**$400,000**	**$400,000**	**4%**	**DPH/Behavioral Health**
Total Proposed	**$10,400,000**	**$10,400,000**	**100%**	

BUDGET DESCRIPTIONS

COMMUNITY-BASED GRANTS	
Health education, food security, physical activity	City Departments should contract directly with CBOs through an RFP process managed through the Community Health Equity and Promotion (CHEP) Branch of the Department of Public Health. CBG should support community-based programs and services that address the health inequities of those most targeted by the beverage industry. Funding should go to Community Based Organizations (CBOs) and Faith Based Organizations (FBOs) for the following strategies: 1. Health Education activities including, chronic disease prevention, healthy eating and active living, tap water promotion, oral/dental health 2. Physical Activity opportunities, including: a) Dance and movement, sports, yoga, walking groups, biking, etc.; b) Efforts to influence changes to the built environment (ie sidewalks, streets, parks, buildings, etc) or safety of the built environment that facilitates increased physical activity and walking and biking for utilitarian trips, sometimes referred to as active transportation); and c) pursuit of institutional or local policies that facilitate physical activity and active transportation (such as adequate PE time and instructors, commuter benefits for active transportation, etc) 3. Healthy Eating/Food Security*, including: a) Community-based pantries, community-based hot meals, community kitchens and community home delivery services; b) Increased financial resources (i.e. wages, income, government nutrition supplements, vouchers, etc.); c) Changes to the built environment that facilitate food security; and d) Pursuit of institutional or local policies that facilitate food security. 4. Water Promotion, such as support for Spa Water Supplies, station maintenance/beautification, refillable water bottles to distribute to communities, water testing 5. Community Based Participatory Research
CBOs working with SFUSD	7% of all CBO funding (eg 7% of approximately $4.3 million) should go towards CBOs implementing programs/initiatives that take place in school settings. Funding to issue grants to CBOS should follow the guidelines above.

** Funding should support programs and services that increase financial resources to purchase healthy food; access to healthy fruits and vegetables while minimizing processed foods for high-risk communities; foods that are affordable and convenient; and programs that support the consumption of healthy foods including the ability to prepare and store meals and the knowledge of basic nutrition, food safety and cooking. Priority programs should incorporate a community-based food security perspective and have demonstrated increased ability of food insecure residents to purchase, access, and consume consumption of healthy, fresh, low-to-no cost and culturally appropriate foods, including but not limited to food vouchers/incentives, transportation and delivery and prepared foods.*

Media	To develop and implement a media campaign focused on the impact of the SDDT with an emphasis on grassroots, community-led storytelling. Community Based Participatory Principles will be utilized in the development of the storytelling campaign, with CBOs funded to co-develop the campaign with a contracted media agency. The funds should support both a local and regional media campaigns. The regional campaign should be in coordination with other jurisdictions with similar sugary beverage taxes to leverage resources and augment the intended goals of the SDDTAC. A portion of the local media campaigns must include a merchant education component. A smaller proportion of the funds (to be determined by the Department of Public Health and any contracted entities) may support media/communications campaigns that highlight the health harms of sugary beverage intake and encourage tap water consumption. DPH/CHEP will contract with media agency, and oversee the campaign progress, with guidance from the Community Input Subcommittee on the local and regional community-led storytelling campaigns and guidance from the Infrastructure Subcommittee on the merchant focused campaign.
Community engagement	Community engagement activities (ex. community conveners, focus groups, town halls, attending existing community meetings, etc.) to ensure that meaningful community engagement opportunities are fully integrated throughout the work of the SDDTAC, so that impacted populations can inform the decisions of the full committee.
SAN FRANCISCO UNIFIED SCHOOL DISTRICT	
School Food, Nutrition Ed	To improve the quality and appeal of school meals and support nutrition education to increase participation in school meal programs (for example: cooking and serving equipment, staff professional development, and innovative procurement and menu strategies to increase freshly prepared food). Funding will target schools with the largest populations of high-risk students that are disproportionately targeted by the sugary drinks industry.
Student Led Action	Support student led efforts to decrease consumption of sugary drinks and increase awareness of sugary drinks consumption among students, with focus on schools with the largest populations of high-risk students that are disproportionately targeted by the sugary drinks industry. SFUSD should provide to SDDTAC a proposal of how funding will be spent through student led action.
FOOD ACCESS	
Healthy Food Purchasing Supplement	Support programs that increase financial resources to purchase healthy food such as vouchers and food purchasing incentives. This investment is meant to support both the communities most impacted by the health consequences of sugary beverage consumption and to support the local economy including local merchants. These funds should be RFPed out to CBOs and FBOs according to the Community Based Grants guidelines.
Healthy Retail	Supporting small business to increase healthy food access in high risk and impacted communities and neighborhoods by: 1) supporting business operations; 2) promoting community engagement; and 3) improving the retail environment.

ORAL HEALTH	
Community task forces	Support development of community infrastructure such as oral health community task forces that incorporate diverse stakeholders for outreach, education, and interventions to address the oral health needs of children in high risk populations.
School-based sealant application	Support school-based and school-linked preventive oral health programs within SFUSD schools serving high risk target populations. This should also support SFUSD dedicated oral health staffing.
School-based education and case management	
INFRASTRUCTURE	
DPH Infrastructure	A. Personnel 1) Backbone staffing to support SDDTAC a. A program manager to provide backbone staffing to the SDDTAC, including: i) Staffing full committee and 3 subcommittees in compliance with Sunshine and Brown Acts; ii) Coordinating among city agencies and funded CBOs to promote collective impact; iii) Help guide vision and strategy of SDDTAC, support aligned activities; manage SDDTAC work and timeline; and iv) Working with evaluation team to establish shared measurement practices b. As necessary, manage citywide/soda tax impact media c. Develop/Compile and Manage completion of SDDTAC Annual Report d. Manage SDDTAC biennial nominations process 2) Staffing to support DPH SDDT implementation of community based grants a. Manage work of contractors, including: i) develop and implement CBO RFP process; ii) provide technical assistance for CBOs and merchants; iii) promote collective impact in coordination with SDDTAC backbone staff and City Agencies; and iv) work with evaluator and SDDTAC backbone staff to develop and implement evaluation plan and evaluation technical assistance. 3) Staffing to support research and evaluation of SDDT impact, including data purchases as necessary a. At least 1.0 FTE epidemiologist; b. Support data analysis for annual report; c. Manage data purchases; d. participate in development and implementation of SDDT evaluation B. Professional services including: i) technical assistance for funded CBO and FBO; ii) evaluation - to implement evaluation framework and evaluate funded city agencies, CBO and FBO, and process evaluations from applicants, and provide evaluation technical assistance; iii) city attorney to provide ongoing technical consultation C. Materials/Supplies for meetings and printing costs D. Training to support staff development E. Data for collection (pricing), analysis (Nielsen) and purchase (IRI)

Strategic planning	Strategic planning consultant to facilitate the SDDTAC in creating a strategic plan to guide the work. The development of this plan should be informed by multiple guiding principles to at least include: the 10 essential public health services, community input regarding its priorities and needs, lessons learned and best practices from other jurisdictions that have implemented similar taxes. The strategic planning process should address, among other aspects, the near and long term strategic goals of the SDDTAC; the role of CBOs, FBOs, and city agencies in achieving this vision; how the SDDTAC's goals fit within the context of city-wide coalitions with similarly aligned goals
Evaluation	Additional funds for evaluation may: a. support community based participatory research (ex. street intercept, merchant interview, focus groups) b. develop a system to collect data c. expand technical assistance d. conduct more qualitative evaluation that can help develop stories that describe impact of tax
WATER ACCESS	
Water Access - SFUSD	To install hydration stations at low income schools serving students with health disparities (ex. Bayview, Chinatown, Mission), to elevate the schools to the Silver or Gold standard for hydration stations (i.e. one on each floor, centrally located, and conduct water education). Funds may support purchase of Spa Water Supplies, station maintenance and beautification, refillable water bottles to distribute to students, water testing.
Water Access - Public Spaces	To install or upgrade existing hydration station(s) in public spaces that target high-risk populations that are disproportionately targeted by the sugary drink industry (community identified public spaces). This funding should support high-quality, visually appealing, stations that can serve as a highlighted example of the potential for hydration stations. This can include beautifying and optimizing current station(s) or creating new one(s).
SF RECREATION & PARKS	
To support staffing and supplies, including healthy food, for Peace Parks programs in target populations	
HOPE SF CHRONIC DISEASE EQUITY	
To fund services to public housing residents in the HopeSF sites. Public housing is a known risk factor for diet sensitive health disparities. The concentrated poverty and resource isolation intensify the impact of race and poverty. This funding will be used to support resident peers, trained as community health workers, to provide health education, chronic disease self-care programs, and linkages to care. Each of the 4 sites will have two full time peer community health workers who will provide a variety of programming. The funding supports both wages and some program expenses.	

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