A local farmer arranges seasonal fruit at the Heart of the City Farmers Market.

San Francisco Sugary Drinks Distributor Tax Advisory Committee

2026 Annual Report

March 1, 2026

Mayor Lurie, San Francisco Board of Supervisors, and San Francisco residents,

The San Francisco Sugary Drinks Distributor Tax Advisory Committee (SDDTAC) remains committed to the will of the voters in making funding recommendations to the Mayor and Board of Supervisors that prioritize community programs, activities, and initiatives that provide direct services, preventative care, and education and outreach aimed at priority populations and neighborhoods targeted by the sugary drinks industry. Our recommendations are rooted in scientific evidence, research, and community input. We support community-led work to decrease the consumption of sugary drinks, increase access to water, and provide access to healthy eating and active living.

The SDDTAC recommends **$11,372,000** of generated SDDT-revenue to the Mayor and Board of Supervisors. The SDDTAC's FY 26-27 and FY 27-28 budget recommendations focus on Whole Health, Whole Community - a comprehensive, equity- centered approach to chronic disease prevention and management. These recommendations prioritize evidence-based, culturally responsive, and scalable interventions that address both the prevention and management of type 2 diabetes and heart disease, advance oral health, promote water consumption and healthy food access.

For Fiscal Years 2026-2028, SDDTAC introduces a new approach to the budget recommendations: the **North Star, a two-year plan** that upholds SDDTAC values and the will of the voters by allocating all funds as originally intended, and the **Bridge Plan, a one-year plan**, designed to address the City's budget deficit while striving to protect community priorities. This approach is not a concession, but a thoughtful compromise, acknowledging fiscal realities while remaining aligned with community needs and priorities.

In FY 25-26, contrary to the SDDTAC's recommendations, Mayor Lurie redirected more than half of the Sugary Drinks Distributor Tax (SDDT) revenue to the Human Services Agency (HSA) to support its Citywide Food Access Programs. While the urgency of addressing food insecurity is significant, the reallocation resulted in reduced funding for community-based prevention efforts.

The removal of these critical services negatively impacted community health at a time when access to food, education, and direct services are

vulnerable to cuts at the federal level, compounding the negative impacts on communities that are already experiencing the greatest health disparities. The SDDT remains the only funding specific to chronic disease prevention. Many San Francisco residents rely on SDDT-funded community-based organizations and programs to deliver the services needed to prevent disease and improve oral health.

Details of the committee's recommendations and supporting evidence can be found in the annual report attached to this letter. We ensure that recommendations for the SDDT-revenue is accountable, impactful, and aligned with key values for decreasing sugary drink consumption, increasing water consumption, and supporting healthy eating and active living, and that these recommendations benefit San Francisco communities most impacted by chronic disease while honoring the intent of the tax set forth by voters of Proposition V.

We strongly encourage Mayor Lurie and the Board of Supervisors to follow the annual budget recommendations with strong consideration for the Bridge Plan from the Sugary Drinks Distributor Tax Advisory Committee.

Thank you.

Abby Cabrera, MPH
Sugary Drinks Distributor Tax Advisory Committee Co-Chairs

Laura Urban

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Sugary Drinks Distributor Tax Advisory Committee

Members

San Francisco voters established the 16-member SDDTAC to make recommendations to the Mayor and the Board of Supervisors on the effectiveness of the soda tax. The SDDTAC is designed to intentionally reflect San Francisco's diverse communities with community and agency seats, balancing grassroots and institutional voices. Members' lived experiences provide crucial insight, enabling the committee to make informed, targeted decisions that support those most affected by sugary drinks. Review the legislation establishing the Committee for detailed descriptions of each seat (Article XXXIII: Sugary Drinks Distributor Tax Advisory Committee).

Sugary Drinks Distributor Tax Advisory Committee, 2025-2026

Seat	Description	Appointing Authority	Member
1	Health Equity	Board of Supervisor (BOS)	Chester Williams
2	Health Equity	BOS	Gabriela Castellanos Rumbo
3	Health Equity	BOS	Melinda Burrus/VACANT
4	Research/Medical Institution	BOS	Abby Cabrera (Co-Chair)
5	Research/Medical Institution	BOS	Jamey Schmidt
6	Youth	BOS	Shoon Mon
7	Office of Economic & Workforce Development (OEWD)	OEWD Director	Alesandra Lozano
8	San Francisco Unified School District (SFUSD)	Board of Education	Saeeda Hafiz
9	SFUSD	Board of Education	Jennifer Lebarre
10	Chronic Disease	Department of Public Health (DPH) Director	Tiffany Kenison
11	Oral Health	DPH Director	Linda Kuo
12	Food Access/Security	DPH Director	Omar Flores
13	Department of Children Youth & Their Families (DCYF)	DCYF Director	Michelle Kim
14	Recreation & Parks Department (RPD)	RPD Director	Linda Barnard
15	SFUSD Parent	BOS	Prasanthi Patel
16	Children 0-5 Years Old	BOS	Laura Urban (Co-Chair)

Subcommittees

The Committee meets monthly with the Department of Public Health (DPH) serving as backbone staff. All members of the SDDTAC participate in at least one of three standing subcommittees:

1. **Data & Evidence Subcommittee:** reviews, analyzes, and disseminates data within the context of our San Francisco communities to help inform and support the work of the SDDTAC.
2. **Community Input Subcommittee:** ensures that meaningful community engagement opportunities are fully integrated throughout the work of the Committee, so that impacted populations can inform the decisions of the SDDTAC.
3. **Infrastructure Subcommittee:** ensures needed staffing and resources are in place to support the functioning, administrative, and evaluation needs of the SDDTAC.

Each year, the Committee is tasked with making two-year budget recommendations to coincide with the City's two-year budget cycle. The Committee expects new information will emerge during the course of the 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 FY26-27 and FY27-28. The Committee will re-evaluate its FY27-28 recommendations at the end of 2026 and may make changes, if deemed appropriate, for its final FY27-28 recommendations at the end of 2026.

Given the Committee's legislative mandate to evaluate the impact of the SDDT and ensure accountability for public dollars, the Committee continues to recommend that revenue generated from the SDDT be clearly identified so that City departments know when their funding comes from SDDT revenue. This transparency makes it possible for the Committee to fulfill its legislative mandate by documenting the impact of the SDDT in San Francisco.

The Committee voted on December 17, 2026, to make the funding recommendations for FY26-27 and FY27-28 as described in the recommendations section.

Commission Streamlining Task Force

Proposition E, approved by the voters in November 2024, created the Commission Streamlining Task Force (CSTF) to recommend changes to City boards and commissions. In October 2025, CTSF initially proposed eliminating the SDDTAC. At the October 15th hearing, community members submitted nearly 40 letters of support and waited hours to provide public comment. This strong response led CSTF to reverse its decision and unanimously vote to remove the sunset provision of the SDDTAC. The CSTF released its final

recommendations and report to the Mayor and Board of Supervisors on February 1, 2026. The City Attorney is required to draft legislation reflecting the Task Force's final recommendations by March 1, 2026, followed by a Board of Supervisor's hearing by April 1, 2026. Any changes to the SDDTAC requiring Charter amendments must then be placed on the November 2026 ballot for voter approval.

Subcommittee Reports

Data and Evidence Subcommittee

The Data and Evidence Subcommittee's mission is to review, analyze, and share data within the context of our San Francisco communities to help inform and support the work of the SDDTAC. This group plays a critical role in ensuring that decisions and strategies are grounded in evidence and responsive to community needs.

Building on this mission and advocacy work, the subcommittee's responsibilities and accomplishments reflect its commitment to using data and evidence to guide recommendations, policy, and community impact.

Functions of the Data and Evidence Subcommittee

- Interpret and distill scientific evidence by reviewing and sharing research, local data, community health needs assessments, and evaluation findings that support the work of the SDDTAC's recommendations
- Center health equity by applying the Health Equity Framework to assess health outcomes influenced by people and their environment
- Support interpretation of the effect of the SDDT on sugary beverage pricing, purchasing patterns, and population health outcomes
- Monitor and translate emerging science, public health guidelines, and policy to translate implications for San Franciscans
- Engage subject-matter experts for ongoing learning to stay current on emerging science to translate evidence into supporting SDDTAC recommendations
- Elevate oral health impacts and prevention strategies
- Advise, review, and approve data and evaluation reports before presentation to the full SDDTAC

Highlights of Data and Evidence's Work in 2025

In 2025, the Data and Evidence Subcommittee demonstrated its commitment to data-informed strategies through several key accomplishments. One of the most significant efforts was the development and implementation of a successful public comment and letter-writing campaign for the October 15, 2025 Commission Streamlining Task Force

(CSTF) hearing. Through careful planning and collaboration, members crafted strategic talking points to highlight the impacts of SDDT-funded work and the efforts of the SDDTA C and mobilized community support, resulting in nearly 40 letters from a wide range of stakeholders and impactful public testimony. These efforts led the Task Force to reverse its recommendation to eliminate the SDDTAC and to remove the sunset clause from the legislation, securing the Committee's long-term role. While the CST will finalize these changes in its report to the Board of Supervisors in February 2026, the amendments will ultimately require approval by San Francisco voters in Fall 2026.

The subcommittee also played a pivotal role in shaping the Committee's ongoing and future strategy by developing and delivering a comprehensive presentation on chronic disease health disparities to the full SDDTAC. This presentation aligned with the Department of Public Health's priority to eliminate long-term health disparities and served as the foundation for the Committee's new approach to budget recommendations for FY 2026–27 and FY 2027–28.

Throughout the year, the Data and Evidence Subcommittee maintained active engagement through in-person and virtual meetings, fostering collaboration and ensuring that decisions were informed by the latest data and evidence. These accomplishments underscore the subcommittee's leadership in advancing equity-focused strategies and set the stage for continued progress toward healthier communities in San Francisco.

Future Considerations for the Data & Evidence Subcommittee

As the Data and Evidence Subcommittee looks to the future, two key priorities will guide its work. First, the subcommittee would like to partner with SFDPH and other scientists and experts to develop and establish agreed-upon outcome measures for upstream prevention strategies. These measures will help ensure that prevention efforts are clearly defined, measurable, and aligned with broader public health goals.

Second, the subcommittee seeks to create opportunities to share San Francisco's best practices on SDDT data-driven efforts for chronic disease prevention. This will include leveraging platforms such as community forums, blog posts, research articles, case studies, and presentations to inform and inspire the broader sugary drinks movement. By sharing lessons learned and successful strategies, the subcommittee aims to strengthen collective efforts to reduce health disparities and promote healthier communities.

The Data and Evidence Subcommittee will continue to play an important role in ensuring that the SDDTAC's recommendations are grounded in robust data and evidence. In the coming year, the subcommittee will focus on strengthening partnerships with policymakers, DPH leadership, and public health experts to advance equity-driven

strategies with measurable outcomes. By tracking long-term outcomes and aligning efforts with DPH priorities to eliminate long-term health disparities, the subcommittee aims to support sustainable solutions to promote healthy eating, active living, and improved health outcomes for San Francisco's most impacted communities.

Data and Evidence Subcommittee Membership

The following SDDTAC members served on the Data and Evidence Subcommittee during the development of this report:

- Abby Cabrera (Seat 4: Research/Medical Institution)
- Jamey Schmidt (Seat 5: Research/Medical Institution)
- Saeeda Hafiz (Seat 8: SFUSD)
- Tiffany Kenison (Seat 10: DPH Chronic Disease)
- Linda Kuo (Seat 11: DPH Oral Health)
- Laura Urban (Seat 16: Children 0-5 Years Old), Data & Evidence Subcommittee Chair

Meeting Schedule

The Data and Evidence Subcommittee met monthly with a total of 12 meetings between March 2025 and February 2026:

1. March 12, 2025
2. April 9, 2025
3. May 14, 2025
4. June 11, 2025
5. July 9, 2025
6. August 13, 2025
7. September 10, 2025
8. October 10, 2025
9. November 12, 2025
10. December 12, 2025
11. January 14, 2026
12. February 11, 2026

Community Input Subcommittee

The Community Input Subcommittee ensures that meaningful community engagement is woven throughout every aspect of SDDTAC's work. Its mission is to fully integrate meaningful community engagement opportunities throughout the work of the SDDTAC, so that impacted communities can help shape the SDDTAC's decisions.

Members of this Subcommittee bring a unique combination of lived experience and professional expertise working with diverse communities disproportionately burdened by nutrition-sensitive health inequities. Their deep understanding of cultural, social, and economic factors positions them to guide SDDTAC in developing outreach strategies that are not only inclusive but effective in reaching those who have historically been left out of decision-making processes.

At the heart of this Subcommittee's work is a core principle: addressing the disproportionate health burdens faced by communities of color and low-income communities. By centering equity, the Subcommittee aims for these communities to actively participate in shaping how soda tax revenues are invested to improve health outcomes.

Equally important is the Subcommittee's commitment to transparency and accessibility. Recognizing that complex processes can create barriers to engagement, the Subcommittee advocates for clear and culturally relevant communication about how recommendations are made and how funds are allocated. This approach builds trust and accountability, reinforcing the Committee's commitment to equity and community empowerment.

Highlights of the Community Input Subcommittee's Work in 2025

In 2025, the Community Input Subcommittee actively worked to strengthen community engagement and awareness around the Sugary Drinks Distributor Tax and its advisory committee. The youth seat representative played a key role in outreach by connecting with the SFUSD Student Health Advisory Board and consistently checks in with the Lowell High School Wellness to inform them of the work of the SDDTAC. Additionally, the youth representative regularly reported SDDTAC updates and announcements at monthly Youth Commission meetings, ensuring young voices remained informed and opportunities to be involved.

To support consistent messaging for community-based organizations and community members, the subcommittee collaborated with backbone staff to create a standardized presentation template. This resource is used to explain the role of the SDDTAC, highlight opportunities for organizational and community member involvement, and outline the SDDTAC budget recommendations process for FY 26-27 and FY 27-28. Members also engaged directly with community groups, including presenting at the MoMagic community meeting to share details about the accelerated budget timeline for FY 26-27 and FY 27-28 budget recommendations and gather feedback and support.

Recognizing the importance of visibility for SDDT grantees, the subcommittee curated videos that community-based organizations could use to promote their SDDT-funded work and utilize for future funding opportunities. Subcommittee members further amplified community voices by sharing information through their networks and participating by providing public comment at the Commission Streamlining Taskforce hearing, advocating for the sustainability and continued impact of the SDDTAC.

Future Considerations for the Community Input Subcommittee

Looking ahead to 2026-2027, the Community Input Subcommittee remains committed to fostering a strong bidirectional flow of information between communities most impacted by the harms of sugary drinks and the SDDTAC. The subcommittee's priorities for the coming year include: **outreach and recruitment, strengthening partnerships, policy**

engagement, cross-sector alignment, and communications and outreach. The subcommittee's work for the upcoming year includes outreach and recruitment for the vacant health equity seat; building relationships with SFUSD parent groups, coalitions, etc that are aligned with SDDT values and efforts; engagement with In Advance policy workgroup to ensure that community input is included as part of In Advance's efforts around sugary drink policies; continued efforts to ensure SDDT alignment with the work of the Mayor's Office food security roundtable and the Human Services Agency; and continued discussions on SDDT communications/marketing to support ongoing and consistent messaging and outreach on SDDT efforts and priorities to engage community and increase awareness.

Community Input Subcommittee Membership

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

- Chester Williams (Seat 1: Health Equity)
- Gabriela Castellanos Rumbo (Seat 2: Health Equity)
- Melinda Burrus (Seat 3: Health Equity) Subcommittee Co-Chair, *Resigned December 2025*
- Shoon Mon (Seat 6: Youth Seat)
- Jennifer Lebarre (Seat 9: San Francisco Unified School District)
- Omar Flores (Seat 12: Food Access/Food Security)
- Prasanthi Patel (Seat 15: SFUSD Parent) Community Input Subcommittee Co-Chair; Chair as of January 2026

Meeting Schedule

The Community Input Subcommittee met 9 times between March 2025 and February 2025:

1. *March 2025 - Meeting Cancelled*
2. April 8, 2025
3. May 13, 2025
4. June 10, 2025
5. *July 2025 – Summer Hiatus*
6. August 12, 2025
7. September 9, 2025
8. October 14, 2025
9. *November 2025 – Meeting Cancelled*
10. December 9, 2025
11. January 13, 2026
12. February 18, 2026

Infrastructure Subcommittee

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

Function of the Infrastructure Subcommittee

To contextualize the Committee's work within City Department systems and processes, ensuring that the SDDTAC's recommendations are not siloed but are integrated into the City's broader public health and equity strategies.

The Infrastructure Subcommittee is composed mainly of members appointed from City Departments, bringing essential institutional knowledge and expertise to the Committee's work. This Subcommittee ensures that SDDTAC's priorities and recommendations are aligned with City systems and processes, creating a bridge between the Committee's goals and the operational realities of local government. By leveraging their understanding of departmental structures and procedures, members help integrate SDDTAC's work into broader public health and equity strategies, ensuring that its impact extends beyond the Committee itself.

Highlights of Infrastructure Subcommittee's Work in 2025

In 2025, the Infrastructure Subcommittee focused on the potential extension of SDDTAC beyond its current sunset date of 2028. To inform these conversations, the Subcommittee invited InAdvance, a policy and advocacy organization, to present potential sugary drink policy pathways and share insights from other jurisdictions. These discussions provided essential context for evaluating future policy directions and sustainability strategies and led to a presentation to the full SDDTAC.

The Subcommittee also guided the refresh of SDDTAC's Strategic Plan, ensuring that the Committee's priorities remain aligned with evolving public health goals and community needs. This process involved a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis and discussing themes that emerged and identifying strategic goals to strengthen the Committee's ability to address health inequities related to sugary drink consumption. This strategic planning work will continue into 2026.

Future Considerations for the Infrastructure Subcommittee

Looking ahead, the Infrastructure Subcommittee will continue monitoring developments in other jurisdictions with soda tax ordinances to identify best practices and emerging trends. The implications of Proposition E and related policy bodies will also require close attention, as these could influence the Committee's authority and scope of work. Another priority will

be re-examining the structure of SDDTAC and its Subcommittees to determine whether the current configuration continues to meet operational and strategic needs. These considerations will help ensure that the Committee remains adaptive, effective, and integrated within the City's public health framework.

Additionally, the Infrastructure Subcommittee will continue to lead the strategic planning refresh and ensure that the completed versions of the strategic plan are incorporated into future work plans.

Infrastructure Subcommittee Membership

The following SDDTAC members served on the Infrastructure Subcommittee during the development of this report:

- Tiffany Kenison (Seat 10 - Department of Public Health, Chronic Disease) *April 2025*
- Michelle Kim (Seat 13, Department of Children, Youth & Their Families), Infrastructure Subcommittee Chair
- Linda Barnard (Seat 14, Recreation and Parks Department)
- Melinda Burrus (Seat 2, Health Equity) Resigned as of *December 2025*
- Alesandra Lozano (Seat 7, Office of Economic & Workforce Development)

Meeting Schedule

The Infrastructure Subcommittee met monthly, with a total of 11 meetings between April 2024 and February 2025:

1. April 14, 2025
2. May 12, 2025
3. June 9, 2025
4. July 7, 2025
5. August 11, 2025
6. September 22, 2025
7. October 20, 2025
8. November 10, 2025
9. December 8, 2025
10. January 12, 2026
11. February 9, 2026

Sugary Drinks Distributor Tax 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 Committee makes rolling, two-year recommendations.

The Controller's office projects expected SDDT revenue, shown in the "Projected" column in the table below. The Treasurer and Tax Collector collect the SDDT revenue and the

Controller's office reports the revenues as indicated in the "Actual" column below. Since its implementation on January 1, 2018, the Sugary Drinks Distributor Tax (SDDT) has generated approximately $101 million in revenue for the City and County of San Francisco.

The amount available to the Committee to recommend is determined after voter-mandated set asides (about 22%). In November 2023, the Controller's Office projected revenue for the Committee to make recommendations at $11,372,000 for both FY26-27 and FY27-28.

Table of Projected vs. Actual SDDT Revenue

Fiscal Year	Projected SDDT Revenue	Actual SDDT Revenue
2017-2018	$8,000,000	$7,911,731*
2018-2019	$16,000,000	$16,097,908
2019-2020	$16,000,000	$13,181,608
2020-2021	$16,000,000	$10,435,241
2021-2022	$12,200,000	$11,973,028
2022-2023	$13,700,000	$12,870,055
2023-2024	$13,700,000	$11,625,512
2024-2025	$13,700,000	$11,372,268
2025-2026	$11,600,000	$6,033,555**
2026-2027	$11,600,000	--
2027-2028	$11,600,000	--
TOTAL		**$101,500,906**

*Actual figure represents 6 months: Jan-Jun 2018
**This figure represents 8 months: July 2025 - Feb 23, 2026

Sugary Drinks Distributor Tax Advisory Committee Budget Recommendations

The SDDTAC's FY 26-27 and FY 27-28 budget recommendations focus on **Whole Health, Whole Community**—a comprehensive, equity-centered approach to chronic disease prevention and management of type 2 diabetes, heart disease, and tooth decay. These recommendations prioritize evidence-based, culturally responsive, and scalable

interventions that address both the prevention and management of type 2 diabetes and heart disease, advance oral health, promote water consumption and healthy food access.

According to the 2024 San Francisco Community Health Assessment, five of the top 10 leading causes of death in San Francisco are preventable, nutrition-sensitive chronic diseases. This includes cardiovascular diseases and diabetes—conditions that disproportionately impact Black, Indigenous, and People of Color (BIPOC) and low-income communities. Aligned with the San Francisco Department of Public Health's (SFDPH) commitment to Getting to Zero on long-term health disparities, the proposed investments support integrated strategies through a direct service community-based grants program that:

- Expands access to preventive care and chronic disease management services through integrated community-based screenings and strong referral pathways to culturally competent services.
- Promotes healthy eating and active living by investing in partnerships that increase access to affordable, nutritious foods and by connecting residents to moderate to vigorous physical activity programs that are accessible, culturally relevant, and community-led.
- Supports culturally tailored health education and outreach led by community health workers (CHWs) who provide trusted, linguistically appropriate health education, chronic disease prevention messaging, and navigation to services and resources.
- Strengthens community capacity by funding organizations that center community voice and leadership, and that are equipped to deliver sustainable, equity-driven health promotion initiatives rooted in the lived experiences of priority populations.
- Increases access to safe, appealing drinking water through hydration station installations, reusable water bottles for all incoming SFUSD students, and education campaigns that promote water as the beverage of choice.

In addition to the community-based grants program, SDDTAC recommends funding to support:

- School-based oral health programs that provide screenings and dental sealant applications;
- Culturally relevant oral health care education and linkage to services in high-need neighborhoods (Chinatown, Mission, District 10);
- Healthy school meals and school partnerships that improve nutrition environments and support lifelong healthy eating habits;

- Food access initiatives, such as Market Match and healthy food purchasing supplements, that increase affordability and access to fresh, nutritious foods for low-income residents.
- Healthy food access and nutrition education for children 0-5, school-aged, and transitional-aged youth.

Accelerated Timeline and Strategic Approach

After meeting with DPH leadership in September 2025 and anticipating another challenging budget year, the SDDTAC recognized that its traditional timeline—finalizing recommendations by March 1—would be too late, as City budgets were already being drafted. The SDDTAC accelerated their process by three months and developed a new approach: the North Star (approved on November 19, 2025), which upholds SDDTAC values and the will of voters by allocating all funds as originally intended, and the Bridge Plan (approved on December 17, 2025), which accounts for the City's budget deficit while striving to protect community priorities.

North Star (Two-Year Plan)

- Represents the committee's ideal, values-driven approach: data-driven, evidence-based, and community-centered.
- Fully aligns with the intent of the tax and the will of San Francisco voters.
- Excludes allocations to the Human Services Agency (HSA) to maintain focus on health equity and chronic disease prevention.

Bridge Plan (One-Year Plan)

- Developed to navigate fiscal uncertainty while maintaining alignment with the tax's intent and SDDTAC values.
- Assumes reallocation of $7M of the $7.5M allocated to HSA in FY 25-26.
- Provides a strategic redistribution of remaining funds across priority areas to minimize disruption to community programs.
- Serves as a proactive strategy to safeguard community priorities during a period of financial uncertainty.

The following tables outline the proposed North Star and Bridge Plan allocations and program descriptions designed to advance our shared goals of a healthier San Francisco for all.

FY 26-27 and FY 27-28 Budget Recommendations

Total projected SDDT revenue for FY 26-27 and FY 27-28: $11,372,000.

Type 2 Diabetes and Heart Disease Prevention & Management

Mutually Reinforcing Strategies	North Star FY 26-27	North Star FY 27-28	Bridge Plan FY 26 - 27
Direct Service Community-Based Grants for community health worker-led education and navigation, linkages/referrals, screenings, and partnerships with healthy food hubs.	$4,726,605	$4,726,605	$320,000
Early Childhood Education/Nutrition (0-5 years old)	$250,000	$250,000	$200,000
Healthy School Meals and nutrition education	$1,400,000	$1,400,000	$1,000,000
Student-led action for healthy food and water consumption	$350,000	$350,000	$200,000
Healthy Food Access for Peace Parks Transitional Aged Youth	$300,000	$300,000	$100,000
Healthy Food Purchasing Supplements	$2,000,000	$2,000,000	$691,605
Healthy School Grants	$300,000	$300,000	$300,000
HSA Citywide Food Access Programs	$0	$0	$7,000,000
Healthy Retail	$0	$0	$0
Total type 2 diabetes and heart disease prevention & management	**$9,326,605**	**$9,326,605**	**$9,811,605**

Oral Health & Water for Community Wellbeing

Mutually Reinforcing Strategies	North Star FY 26-27	North Star FY 27-28	Bridge Plan FY 26-27
School-based **oral health screenings and sealant applications**	$415,000	$415,000	$415,000
Culturally relevant oral health care education and linkage to services in **Chinatown, Mission, and D10**.	$720,000	$720,000	$415,000
Water access in school and community settings for promotion, education, and water bottles.	$300,000	$300,000	$120,000
Total Oral Health & Water for Community Wellbeing	**$1,435,000**	**$1,435,000**	**$950,000**

Staffing and Total

	North Star FY 26-27	North Star FY 27-28	Bridge Plan FY 26-27
Total SDDT Staffing	**$610,395**	**$610,395**	**$610,395**

Total	**$11,372,000**	**$11,372,000**	**$11,372,000**

Budget Descriptions and Recommendations by Category

North Star Plan (Two-Year)

The tables below outline the SDDTAC's funding recommendations by category, along with corresponding budget descriptions. The Controller's Office has forecasted SDDT revenue of **$11,372,000** for both FY 26-27 and FY 27-28. The "Percentage" column shows the share of the total projected revenue allocated to each category.

Type 2 Diabetes & Heart Disease Prevention and Management

Direct service community-based grants

Expands access to preventive care and chronic disease management services through integrated community-based screenings (e.g., blood pressure, blood glucose, and oral health), strong referral pathways to culturally competent services, promoting healthy eating active living, access to safe and appealing drinking water, and strengthening community access and capacity to address the prevention and management of type 2 diabetes and heart disease.

Early childhood nutrition/education (0-5)

Supports childcare educators in implementing research-based best practices in nutrition and physical activity for children from birth to age 5 through the Healthy Apple Program.

Healthy school meals and nutrition education

Healthy school meals and school partnerships to improve nutrition environments, increase nutrition education, and support lifelong healthy eating habits.

Student-led action for healthy food and water consumption

Supports student-led initiatives to promote healthy food and water consumption among peers and funds SFUSD staff to coordinate SDDT-funded wellness efforts across SFUSD.

Healthy food access for Peace Parks (transitional-aged youth)

Healthy meals and snacks for the Recreation and Parks Department Peace Parks program that provides transitional-aged youth opportunities to engage in healthy recreational activities, building community wellness, and preventing violence in District 10 neighborhoods.

Healthy food purchasing supplements

Increases affordability and access to fresh, nutritious foods for low-income residents.

Healthy School Grants

Supports CBO and school partnerships that engage students through moderate/vigorous physical activity and encourage life-long healthy eating/active living habits.

HSA Citywide Food Access Programs

Equitable food access and distribution to priority populations through the citywide food access program

Healthy Retail

Supports small businesses to increase healthy food access in high-risk, impacted communities and neighborhoods by supporting business operations, promoting community engagement, and improving the retail environment. While Healthy Retail has been recommended and funded in the past, the SDDTAC chose to prioritize other programs and initiatives that provide scalable intervention, and this decision was supported by the Office of Economic and Workforce Development.

Type 2 Diabetes & Heart Disease Prevention and Management	**FY 26-27**	**%**	**FY 27-28**	**%**	**Dept Rx**
Direct Service Community-Based Grants	$4,726,605	41.6%	$4,726,605	41.6%	DPH/CHEP
Early Childhood Nutrition/Education	$250,000	2.2%	$250,000	2.2%	DPH
Healthy School Meals and Nutrition Education	$1,400,000	12.3%	$1,400,000	12.3%	DCYF
Student-led action for healthy food and water consumption	$350,000	3.1%	$350,000	3.1%	DCYF
Healthy Food Access for Peace Parks Transitional Aged Youth	$300,000	2.6%	$300,000	2.6%	RPD
Healthy Food Purchasing Supplements	$2,000,000	17.9%	$2,000,000	17.9%	DPH/CHEP
Healthy School Grants	$300,000	2.6%	$300,000	2.6%	DPH
Healthy Retail	$0	0%	$0	0%	OEWD
Total Type 2 Diabetes & Heart Disease Prevention and Management	**$9,326,605**	**82%**	**$9,326,605**	**82%**	

Oral Health & Water for Community Wellbeing

School-based oral health screenings and sealant applications

Provision of school-based oral health screenings and dental sealant applications and funds DPH staff to implement and coordinate oral health care for school-based youth.

Oral health care coordination and services

Culturally relevant oral health care education and linkage to services in high-need neighborhoods (Chinatown, Mission, and District 10).

Water access in school and community settings for promotion, education, and water bottles.

Increases access to safe, appealing drinking water through hydration station installations, reusable water bottles for all incoming SFUSD students, and education campaigns that promote water as the beverage of choice.

Oral Health & Water for Community Wellbeing	**FY 26-27**	**%**	**FY 27-28**	**%**	**Dept Rx**
School-based oral health screenings and sealant applications	$415,000	3.7%	$415,000	3.7%	DPH
Oral health care coordination and services	$720,000	6.3%	$720,000	6.3%	DPH
Water access in school and community settings	$300,000	2.6%	$300,000	2.6%	DPH
Total Oral Health & Water for Community Wellbeing	$1,435,000	12.6%	$1,435,000	12.6%	

Sugary Drinks Distributor Tax (SDDT) Staffing

SDDT supports three positions: (1) a program manager to provide backbone support for the SDDTAC, including staffing meetings in compliance with Sunshine/Brown Acts, coordinating city agencies and CBOs, guiding strategy, managing reports, and overseeing media and nominations; (2) staff to manage community-based grants by overseeing contractors, leading the CBO RFP process, providing technical assistance, and supporting evaluation efforts; and (3) an epidemiologist to conduct research and evaluation, including data analysis for annual reports, managing data purchases, and implementing the SDDT evaluation plan.

SDDT Staffing	**FY 26-27**	**%**	**FY 27-28**	**%**	**Dept Rx**
SDDT staffing	$610,395	5.4%	$610,395	5.4%	DPH
Total SDDT Staffing	$610,395	5.4%	$610,395	5.4%	

SDDTAC Budget Descriptions and Recommendations by Category: Bridge Plan (One-Year)

The tables below outline the SDDTAC's one-year bridge plan funding recommendations by category, along with corresponding budget descriptions. The Controller's Office has forecasted SDDT revenue of **$11,372,000** for both FY 26-27 and FY 27-28. The "Percentage" column shows the share of the total projected revenue allocated to each category.

Type 2 Diabetes & Heart Disease Prevention and Management

Direct service community-based grants

Expands access to preventive care and chronic disease management services through integrated community-based screenings (e.g., blood pressure, blood glucose, and oral health), strong referral pathways to culturally competent services, promoting healthy eating active living, access to safe and appealing drinking water, and strengthening community access and capacity to address the prevention and management of type 2 diabetes and heart disease.

Early childhood nutrition/education (0-5)

Supports childcare educators in implementing research-based best practices in nutrition and physical activity for children from birth to age 5 through the Healthy Apple Program.

Healthy school meals and nutrition education

Healthy school meals and school partnerships to improve nutrition environments, increase nutrition education, and support lifelong healthy eating habits.

Student-led action for healthy food and water consumption

Supports student-led initiatives to promote healthy food and water consumption among peers and funds SFUSD staff to coordinate SDDT-funded wellness efforts across SFUSD.

Healthy food access for Peace Parks (transitional-aged youth)

Healthy meals and snacks for the Recreation and Parks Department Peace Parks program that provides transitional-aged youth opportunities to engage in healthy recreational activities, building community wellness, and preventing violence in District 10 neighborhoods.

Healthy food purchasing supplements

Increases affordability and access to fresh, nutritious foods for low-income residents.

Healthy School Grants

Supports CBO and school partnerships that engage students through moderate/vigorous physical activity and encourage life-long healthy eating/active living habits.

Healthy Retail

Supports small businesses to increase healthy food access in high-risk, impacted communities and neighborhoods by supporting business operations, promoting community engagement, and improving the retail environment. While Healthy Retail has been recommended and funded in the past, the SDDTAC chose to prioritize other programs and initiatives that provide scalable intervention, and this decision was supported by the Office of Economic and Workforce Development.

Type 2 Diabetes & Heart Disease Prevention and Management	Bridge Plan FY 26-27	%	Dept Rx
Direct Service Community-Based Grants	$320,000	2.8%	DPH/CHEP
Early Childhood Nutrition/Education	$200,000	1.8%	DPH
Healthy School Meals and Nutrition Education	$1,000,000	8.8%	DCYF
Student-led Action for Healthy Food and Water Consumption	$200,000	1.8%	DCYF
Healthy Food Access for Peace Parks Transitional Aged Youth	$100,000	0.9%	RPD
Healthy Food Purchasing Supplements	$691,605	6.1%	DPH/CHEP
Healthy School Grants	$300,000	2.6%	DPH
Healthy Retail	$0	0%	OEWD
Total Type 2 Diabetes & Heart Disease Prevention and Management	$2,811,605	24.7%	

Human Services Agency

Citywide Food Access Programs

$7M to provide equitable food access and distribution to priority populations through the citywide food access program

Equitable Food Access and Distribution	Bridge Plan FY 26-27	%	Dept Rx
HSA citywide food access programs	$7,000,000	61.6%	HSA
Total Equitable Food Access and Distribution	$7,000,000	61.6%	

Oral Health & Water for Community Wellbeing

School-based oral health screenings and sealant applications

Provision of school-based oral health screenings and dental sealant applications and funds DPH staff to implement and coordinate oral health care for school-based youth.

Oral health care coordination and services

Culturally relevant oral health care education and linkage to services in high-need neighborhoods (Chinatown, Mission, and District 10).

Water access in school and community settings for promotion, education, and water bottles.

Increases access to safe, appealing drinking water through hydration station installations, reusable water bottles for all incoming SFUSD students, and education campaigns that promote water as the beverage of choice.

Sugary Drinks Distributor Tax (SDDT) Staffing

SDDT supports three positions: (1) a program manager to provide backbone support for the SDDTAC, including staffing meetings in compliance with Sunshine/Brown Acts, coordinating city agencies and CBOs, guiding strategy, managing reports, and overseeing media and nominations; (2) staff to manage community-based grants by overseeing contractors, leading the CBO RFP process, providing technical assistance, and supporting evaluation efforts; and (3) an epidemiologist to conduct research and evaluation, including data analysis for annual reports, managing data purchases, and implementing the SDDT evaluation plan.

SDDT Staffing	Bridge Plan FY 26-27	%	Dept Rx
SDDT staffing	$610,395	5.4%	DPH
Total SDDT Staffing	$610,395	5.4%	

Impact on Beverage Prices, Consumer Purchasing Behavior & Public Health

Reducing consumption of sugary drinks is a key goal of the tax; increasing prices through a distributor tax was one strategy to do so. And that approach is working. A study published in the JAMA Health Forum[1] in January 2024, found that retail prices of sugary beverages rose by 33% in the two years following the implementation of a local excise tax on sugary drinks in Philadelphia, Oakland, Seattle, San Francisco, and Boulder. The study also found a 33% reduction in purchases and determined there was not an increase in cross-border purchases (when people cross into a different jurisdiction without the tax).

The SDDT 2025 Data Brief and Appendix was approved by the Committee on February 18, 2026 and can be found on the SDDTAC webpage. The SDDT 2025 Data Brief highlights the most recent data as of 2025 for three metrics: public health impacts (oral health), sugary drink consumption, food security, and sugary drink sales and pricing in San Francisco.

Impact of Sugary Drinks Distributor Tax

SF Department of Public Health (SFDPH)'s Community Health Equity and Promotion (CHEP) Branch Healthy Eating Active Living (HEAL) team and Center for Data Science (CDS) conducted an evaluation of the SDDT-funded work for FY 24-25. The teams worked together in the development of the evaluation plan and data collection through reporting templates and participant surveys. The impact of the SDDT is captured in the FY 24-25 evaluation report which can be found in the appendices or on the Soda Tax SF webpage.

The following are evaluation findings for SDDT funded programs in Fiscal Year 24–25, which includes July 1, 2024- June 30, 2025.

FINDING 1: SDDT revenue continues to be invested in priority populations and places most targeted by the beverage industry.

FINDING 2: SDDT investments continue to show improved healthy behaviors and attitudes related to drinking more water, drinking fewer sugary drinks, and increasing fruit and vegetable consumption and physical activity.

FINDING 3: SDDT investments continue to alleviate food insecurity through direct services and long-term system change strategies.

FINDING 4: SDDT investments strengthens connections and leadership in communities most impacted by health inequities leading to long term benefits.

The following recommendations focus on investments in evidence-based and data-informed strategies to strengthen the achievements of SDDT, promote sustainability, and ensure accountability for long-term, equitable impact.

1) Increase awareness about the negative impacts of sugary drinks and to reduce sugary drink consumption, especially among priority populations.

2) Promote tap water consumption through culturally responsive strategies.

3) Prioritize youth-focused strategies that reduce sugary drink consumption and promote tap water from early childhood through transition-age youth (TAY).

4) Invest in systems-level changes and comprehensive strategies to ensure equitable access and sustained benefits to community health and wellbeing.

5) Invest in leadership development and job opportunities that support stronger, more resilient neighborhoods with meaningful connections to local, state, or national decision-makers.

6) Strengthen and support SDDT evaluation efforts.

7) Ensure stable funding to support chronic disease prevention.

The evaluation reports includes more information about funded organizations and their programs (SDDT Funded Initiatives) as well as the complete FY 24–25 Evaluation Report.

Background

In November 2016, San Francisco voters passed Proposition V. Proposition V established a one penny 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 (also referred to as soda 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 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 Committee. 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. See Commission Streamlining Task Force section.

Report Requirements

By March 1 of each year, the Committee must submit a report to the Board of Supervisors and the Mayor. The report should evaluate the impact of the Sugary Drinks Distributor Tax on beverage prices, consumer purchasing behavior, and public health. It should also include recommendations on creating or funding programs to reduce the consumption of sugary drinks in San Francisco.

Relationship Between Sugary Drink Consumption, Health, Health Equity and Taxes

A large body of evidence exists indicating that sugary drink consumption increases risk for cavities, type 2 diabetes, hypertension and heart disease. [7-11] Although sugary drinks can contain hundreds of calories in a serving, they do not signal "fullness" to the brain and thus facilitate overconsumption.[12] Sugary drinks account for nearly half of the total added sugars in a typical American diet. About half of adults and over 60% of kids consume a sugary drink

A note regarding use of obesity as a measure of health.

Evolving research indicates that focusing on overweight/ obesity furthers stigma and can exacerbate or contribute to poor health. Whereas the Healthy Eating Active Living Team in San Francisco Department of Public Health (SFDPH)'s Community Health Equity and Promotion Branch have focused on preventing chronic disease and promoting nutrition and physical activity as opposed to obesity prevention; their recommendation is to shift from using obesity as a measure in this work and focus instead on other health conditions impacted by SSB consumption. The Canadian Medical Association Journal provides additional context to this recommendation: "Although obesity has been shown to contribute to certain types of health problems, anti-fat stigma is also a threat to health. Anti-fat stigma adds both psychological and physiologic stress to people who are considered excessively fat, which some experts argue partially accounts for health disparities by weight.[2,3] Anti-fat stigma is underpinned by common assumptions that fatness is highly malleable and under individual control, implying that people who are visibly fat have poor self-control, are unknowledgeable or are not invested in their health. Puhl and Heuer's 2009 review of over 200 studies (with experimental, survey, population based and qualitative designs) highlighted how common such stigmatizing assumptions are and the discrimination that follows in multiple sectors.[4] In a 2016 systematic review and meta analysis, Spahlholz and colleagues confirmed high rates of perceived weight-based discrimination in many life domains.[5] Stigmatization can be a daily occurrence; an analysis involving 50 overweight or obese women in the United States who filled out the Stigmatizing Situations Inventory over 298 days reported more than 1000 weight-stigmatizing events. Body mass index (BMI) was the strongest predictor.[6]

on any given day.[13-16] Sugary drinks are the leading source of sugar in the American diet, contributing 36% of the added sugar Americans consume.[17]

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.[18] Every additional sugary drink consumed daily can increase the risk of developing type 2 diabetes by 26%.[19]

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. 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. Additionally, in San Francisco, Asian kindergartners experienced the most pronounced changes, with the sharpest increase in untreated cavities observed in 2023, followed by the largest decrease in 2025, as reported in the 2025 SDDT Data Brief.

While many factors contribute to sugary drink consumption, including wide availability/access and affordability, the role of industry is relevant as well.

A study by Rudd [20] documents how food and beverage companies disproportionately target Black and Hispanic consumers with TV ads promoting predominantly unhealthy products, despite having healthier options in their portfolios, such as plain water, low-sugar cereals, and fruits and vegetables. In 2021, Black youth and adults viewed 9% to 21% more food and beverage ads than their White peers, and companies increased their focus on advertising to Spanish-speaking viewers. The ads predominantly promoted unhealthy items like sugary drinks, candy, snacks, and cereals, which made up 73% of ad spending on Black-targeted and Spanish-language TV in 2021. This targeted advertising contributes to health inequities in communities of color, leading to higher rates of diet-related diseases, such as heart disease and diabetes. Additionally, there were no ads for fruits or vegetables on these platforms. Marketing campaigns, including those on social media, often feature hip-hop and Latino music celebrities and cause-related initiatives aimed at

youth and communities of color, but these campaigns almost exclusively promote unhealthy products. Other studies further confirm that beverage and retail marketing efforts target Black/African American and Latinx communities, particularly children, contributing to higher consumption of sugary drinks compared to non-Latinx White Americans, with lower-income households with young children purchasing more sweetened drinks than wealthier ones.

The Sugary Drinks Distributor Tax is intended to make sugary drinks more expensive through the supply chain and ultimately drive down sales and consumption of sugary drinks. A study conducted in San Francisco by the Public Health Institute's Prevention Policy Group showed the tax is working as intended: consumption of SSBs declined markedly (34%) in San Francisco in the first two years after implementation of the tax.[21] Key findings from the study note a 34.1% drop in consumption of sugary drinks in the San Francisco sample at two years post-tax, versus a 16.5% drop in San José, which did not institute a tax.

- In San Francisco, the probability of consuming more than 6 ounces per day decreased by 4.3% in the first year and by 13.6% in the two years post-tax. In San José, this decrease was 1% in the first year and less than 1% at two years post-tax.
- There was a significant difference in change over time (13.2%) in high consumption of SSBs between the two cities two years after the tax started.
- High SSB consumption decreased 23.6% among San Francisco respondents who were living below 200% of the federal poverty level, while increasing in San José, yielding another significant difference in change over time between the cities.

The study sampled different racial and ethnic groups from zip codes in San Jose and San Francisco, with a higher density of Black and Latino residents and racial/ethnic groups with higher SSB consumption in California. This analysis paints a robust picture of the positive health impact of soda tax policies and suggests that even a modest size tax can be effective in reducing high SSB consumption and mitigating the risk of harm. These findings support the preliminary analysis of sales data which indicated that the soda tax is successful in decreasing consumption: purchases of sugar-sweetened beverages at supermarkets in San Francisco decreased by more than 50% in the two years following the implementation of the tax. [22]

Mexico, where an average of 163 liters of sugary drinks is consumed per person each year, enacted an excise tax on sugary drinks in January 2014, resulting in a decline in the purchase of taxed sugary drinks 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.[23]

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.[24] 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 supports the notion that taxation provides a powerful incentive for individuals to reduce their consumption of sugary drinks, which in turn can reduce the burden of chronic disease.

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Appendix

Appendix A: 2025 SDDT Data Brief

Appendix B: 2025 SDDT Data Brief Appendix

Appendix C: FY 24-25 SDDT Evaluation Report

Appendix A: 2025 SDDT Data Brief

2025 Sugary Drinks Distributor Tax (SDDT) Data Brief

About this Data Brief

This data brief is prepared by the Healthy Eating Active Living (HEAL) Team in the Community Health Equity and Promotion (CHEP) Branch and the Center for Data Science (CDS) of the Population Health Division of the San Francisco Department of Public Health to meet Article XXXIII of the SF Administrative Code requirements.

Data sources are not updated annually, and changes in public health outcomes occur over time. An annual brief will highlight key metrics outlined in the legislation, with a comprehensive report every five years. The next full data report will be produced in 2028.

The 2025 data brief uses publicly available data from prior years, as more current data was not available at the time this brief was released. The data sources included in this brief have a one-to-three-year lag between data collection and when the most recent year of data are available for public release. Despite these limitations, the brief provides valuable insights into trends and patterns related to the health impact of sugary drinks.

Introduction

Scientific evidence links the overconsumption of sugary drinks to chronic diseases like type 2 diabetes, heart disease, and tooth decay – health concerns that disproportionately affect low-income communities of color. In 2016, San Francisco voters passed the Sugary Drinks Distributor Tax (SDDT), also known as the soda tax, to reduce sugary drink consumption and help prevent nutrition-sensitive diseases. This brief highlights the most recent data as of 2024 for three metrics: public health impacts, sugary drink consumption and sugary drink sales in San Francisco.

The soda tax is part of a broader strategy to address long-term health outcomes by reducing sugary drink consumption. The current data show small positive changes, highlighting the need for larger investment in key strategies targeting communities most impacted by sugary drinks.

A note regarding obesity as a measure of health:

Research shows that using overweight and obesity as health indicators can perpetuate stigma and harm overall health.[1-4] In line with this evidence, the SDDT focuses on reducing sugary drink consumption and preventing related chronic diseases through nutrition and physical activity initiatives rather than framing efforts around obesity prevention. This brief does not report on obesity and highlights conditions strongly linked to sugary drinks, such as type 2 diabetes, heart disease, and tooth decay.

Sugary Drinks and Public Health Disparities in San Francisco

Sugary drinks contribute significantly to nutrition-sensitive health disparities in San Francisco, impacting chronic disease outcomes, oral health, and food security.

- The **mortality rate among Black or African American adults for most nutrition-sensitive diseases is roughly two to four times higher** than that of White or Asian adults in San Francisco.[5]
- **Asian kindergartners** experienced the **sharpest increase (10%) in untreated dental cavities in 2023, followed by the largest decrease (20%) in 2025**.[6]
- Among adults in San Francisco earning less than 200% of the Federal Poverty Line (FPL), **food insecurity decreased from 67% in 2022 to 37% in 2023; however, disparities persist across geography, race and income**. Among all adults regardless of poverty status, food insecurity is a major problem for neighborhoods like Chinatown (30%), Treasure Island (28%), and Tenderloin (25%) which face rates almost 6 times the prevalence seen in neighborhoods like Marina, Presidio, and Pacific Heights (5%).[7]

Sugary Drink Consumption Remains Highest Among Low-Income and Communities of Color in San Francisco

Sugary drink consumption varies significantly by race/ethnicity and income level, contributing to health disparities across the city.

- A greater proportion of **Hispanic or Latino/a adults (26%) and Black or African American adults (19%) consume at least one sugary drink per day** compared with Asian (5%) and White (7%) adults.[8]
- Adults earning less than $50k per year (i.e. earning less than 200% of the Federal Poverty Line (FPL) consume sugary drinks nearly four times more often as adults earning $100k or more– (19% vs. 5%).[9]

Sugary Drink Sales in San Francisco

Sugary drink sales in San Francisco have plateaued despite ongoing public health efforts of the Sugary Drinks Distributor Tax. Soda taxes are a meaningful step toward improving community health, but they are just one part of a broader, long-term strategy. The revenue helps to provide insight into consumption trends and the scale of sugary drink purchases across the city.

- Since 2018, the SDDT tax has generated over $100 million.[10]
- **In 2023 alone, over 1.2 billion fluid ounces of sugar sweetened beverages were sold in San Francisco - representing about 102 million 12-oz cans of sugary drinks, or 126 cans per resident.** Note, this estimate does not take into account the amount of sugary drinks consumed by non-residents and tourists.[11]

Impact of Sugary Drinks on SF Public Health

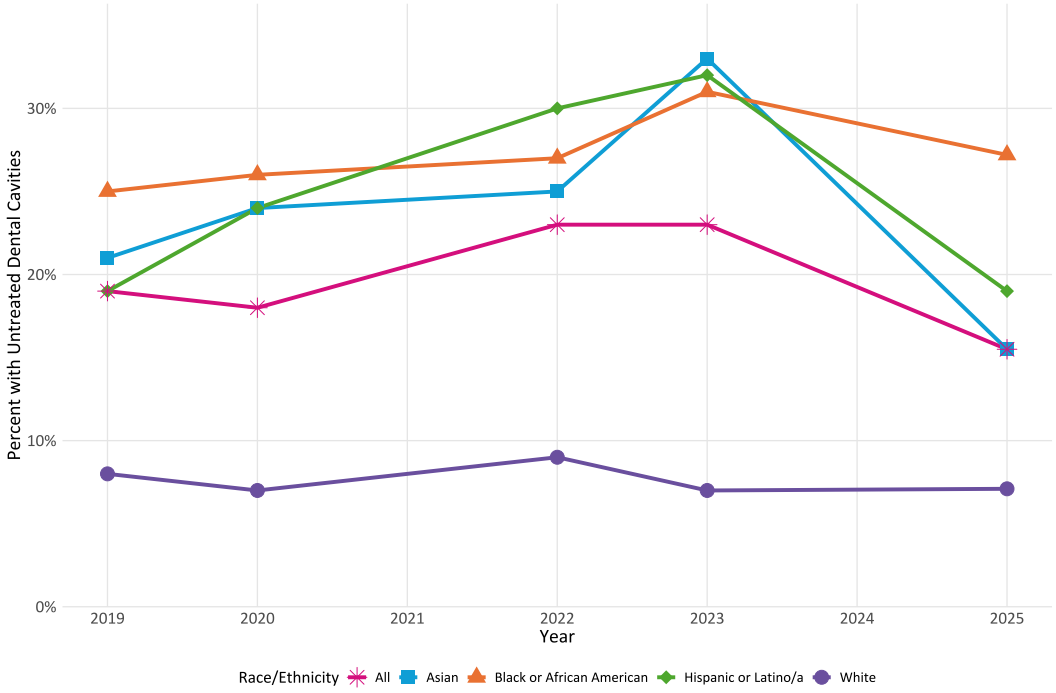
Oral Health Status Among SFUSD Kindergartners

Since 2023, there has been an overall decrease or no change in untreated cavity experiences among SFUSD kindergartners of all race/ethnicities. Citywide, the percentage of kindergartners with untreated cavities declined slightly from 19% in 2019 to 17% in 2020, followed by an increase to approximately 23% in both 2022 and 2023. In 2025, this trend reversed, with the citywide rate dropping sharply to around 16%.

These fluctuations likely reflect the impact of the COVID-19 pandemic, during which disruptions in school-based screenings and access to preventive dental care may have contributed to the rise in untreated cavities. The subsequent decline in 2025 suggests a recovery in access to dental services and preventive care.

Among racial and ethnic groups, **Asian kindergartners experienced the most pronounced changes, with the sharpest increase in untreated cavities observed in 2023, followed by the largest decrease in 2025.**

Prevalence of SFUSD Kindergartners with Untreated Dental Cavities by Race/Ethnicity and School Year, 2019-2025



Source: San Francisco Unified School District (SFUSD), Kindergarten Oral Health Screening Program, 2019-2025

Note: The year refers to the school year, so 2019 refers to the 2018-2019 school year. Estimates for 2020 were based on incomplete data from screenings that finished in the Fall of 2019, before the COVID-19 shelter-in-place orders and were weighted using enrollment data for 2019-2020. Estimates for 2022 and 2023 are not weighted. Estimates from 2020 through 2023 may not be comparable to other years. Estimates among American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander kindergartners are not reported due to too few observations (n<20). Estimates for multiracial and kindergartners that did not report their race or ethnicity are also not reported because the diverse and varied composition of these groups makes meaningful interpretation difficult. Estimates were not available for 2021 and 2024.

Food Security

While oral health reflects one aspect of nutrition-sensitive chronic disease disparities, access to food is another critical factor. Food insecurity not only limits healthy choices but also increases the risk of chronic conditions such as diabetes, heart disease, and hypertension. Limited access to affordable, nutritious foods often leads to greater reliance on low-cost, calorie-dense options—including sugary drinks—which can further exacerbate health risks. The following section examines trends in food insecurity among San Francisco residents and its implications for public health.

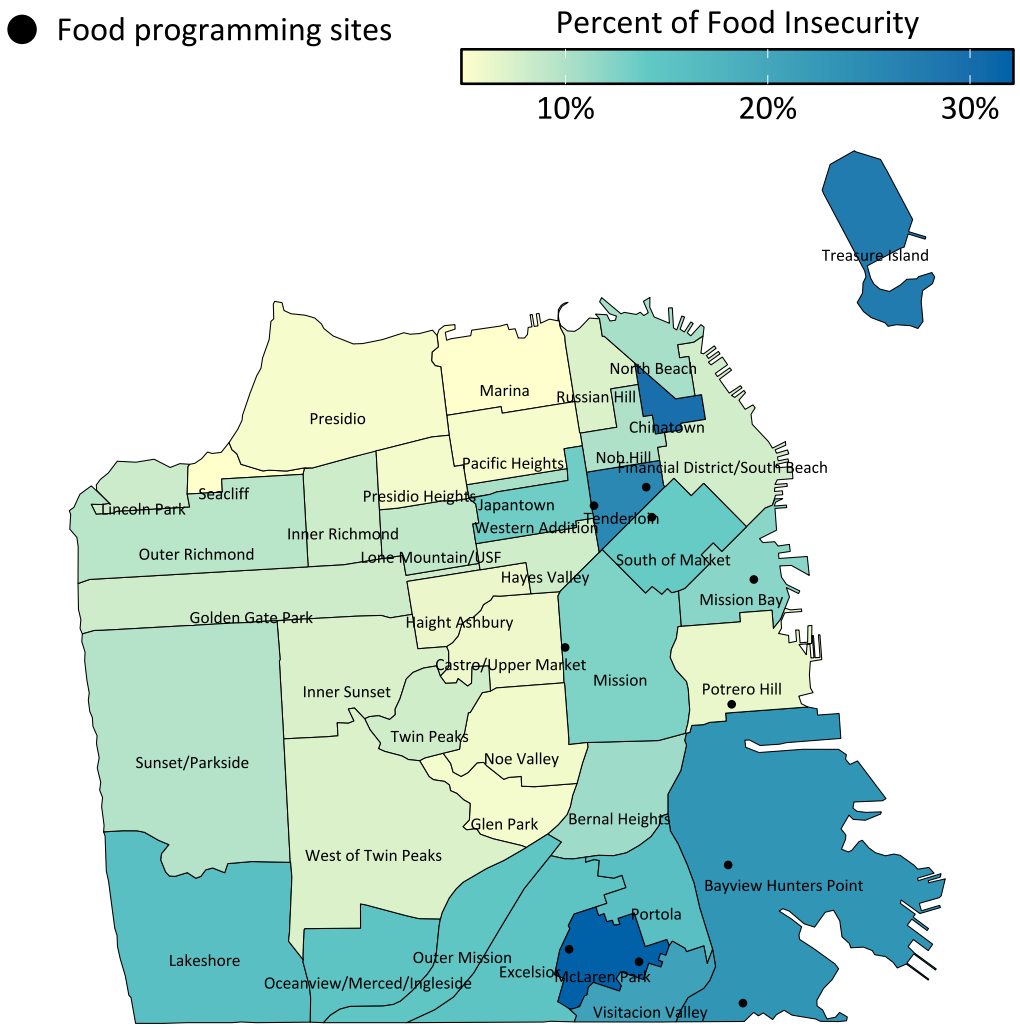
In 2020, food insecurity among San Francisco adults earning less than 200% of the federal poverty line may have declined sharply, though the estimate is statistically unstable. This decline was likely linked to the expanded federal assistance during the COVID-19 pandemic. However, food insecurity rates rose again, to 35% in 2021 and peaked at 67% in 2022. By 2023, the rate fell to 37%, following the all-time high the previous year.

In 2025, cuts to federal Supplemental Nutrition Assistance Program (SNAP) benefits are expected to have a lasting impact on food insecurity, particularly among low-income households. According to the San Francisco Human Services Agency, 110,000 individuals in 82,000 households rely on SNAP benefits in San Francisco. A public-private partnership in San Francisco provided one-time prepaid grocery cards to those who were CalFresh recipients, temporarily and partially filling the gap in November benefits from delays caused by the federal government shutdown. While the federal government has restored SNAP benefits, they eliminated SNAP-ed programs to provide food and nutrition education and this is likely to exacerbate negative public health outcomes. Without access to food and nutrition education, individuals may struggle to make informed choices about healthy eating. This gap can lead to increased rates of nutrition sensitive chronic diseases such as diabetes, heart disease, as well as poor maternal and child health outcomes. Overtime, these factors can widen health disparities,

strain healthcare systems, and undermine efforts to promote long-term wellness in vulnerable communities.

According to data from 2022, there are several neighborhoods where the percentage of adults experiencing food insecurity is more than double or triple the citywide average at 11.7%: Chinatown (29.7%), Treasure Island (27.6%), Bayview Hunter's Point (23.3%), and Visitacion Valley (20.9%). To address food needs, the SDDT tax funds several programs that deliver direct food services in these neighborhoods.

Percent of Adults in San Francisco that are Food Insecure by Neighborhood, 2022



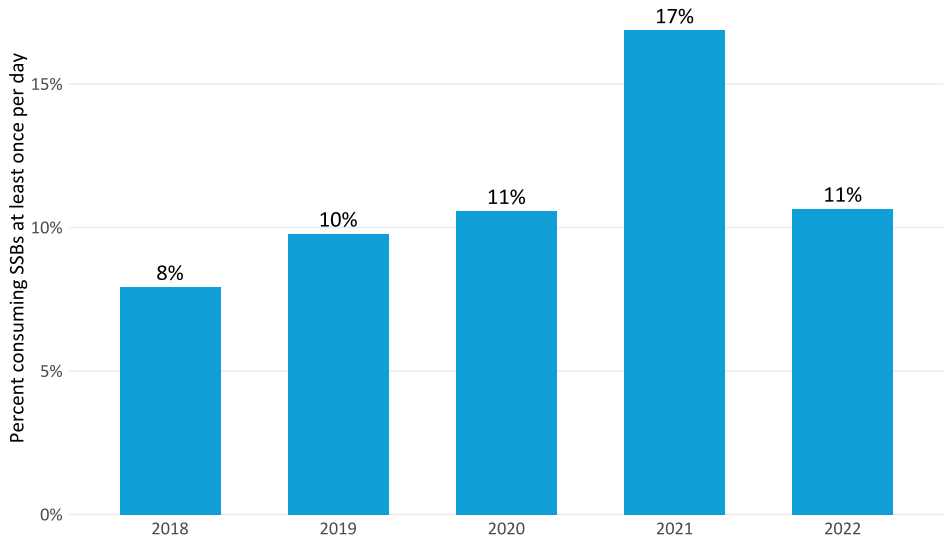
Source: Population Level Analysis and Community Estimates, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health, 2022.

Note: Data are the modeled crude prevalence of food insecurity in the past 12 months among all adults at the neighborhood level. Food programming sites are the main addresses for organizations funded by SDDT that provide food directly to residents of San Francisco.

Sugary Drink Consumption Among Adults

From 2018 to 2022, there was a gradual increase in the percentage of adults consuming sugar-sweetened beverages (SSBs) at least once per day, rising from 8% in 2018 to 11% in 2022. A notable spike occurred in 2021, suggesting a sharp rise in daily SSB consumption. However, this estimate carries greater variability compared to other years and should be interpreted with caution. Despite this, **the overall trend indicates a steady upward shift in daily sugary drink consumption among adults over the five-year period**.

Percent of San Francisco Adults Consuming SSBs at Least Once per Day by Year, 2018-2022



Source: Centers for Disease Control and Prevention (CDC). California Department of Public Health. Behavioral Risk Factor Surveillance System Survey Data, 2018-2022.

Note: Data are the percentage of adults that self-reported consuming soda or sugar-sweetened fruit drinks, sweet tea, or sports or energy drinks at least one time per day during the past 30 days.

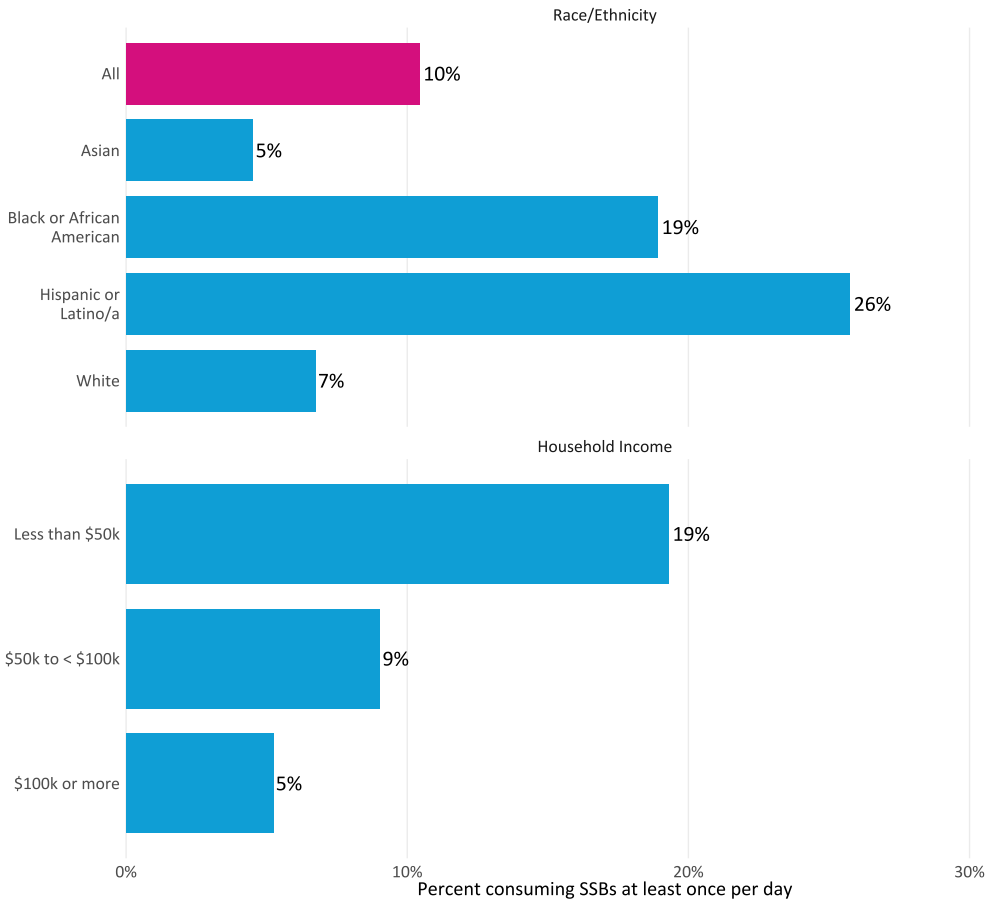
The two bar charts show the percentage of adults that reported consuming sugar-sweetened beverages at least once per day by race/ethnicity and household income. The bar chart data show significant disparities in daily sugar-sweetened beverage consumption among San Francisco adults. White (7%) and Asian (5%) adults reported the lowest rates of consuming at

least one sugar-sweetened beverage per day, while Hispanic or Latino/a adults reported the highest rate at 26%.

Overall, 90% of adults in San Francisco consume less than one sugary drink per day, indicating that daily consumption remains relatively uncommon across the population.

However, consumption patterns vary notably by income. **Nineteen percent of adults earning less than $50,000 per year reported daily sugar-sweetened intake compared to only 5% among those earning $100,000 or more**. This suggests that lower-income adults are disproportionately consuming more sugar-sweetened beverages, highlighting a potential priority area for public health interventions.

Percent of San Francisco Adults Consuming SSBs at Least Once per Day by Demographics, 2018-2022



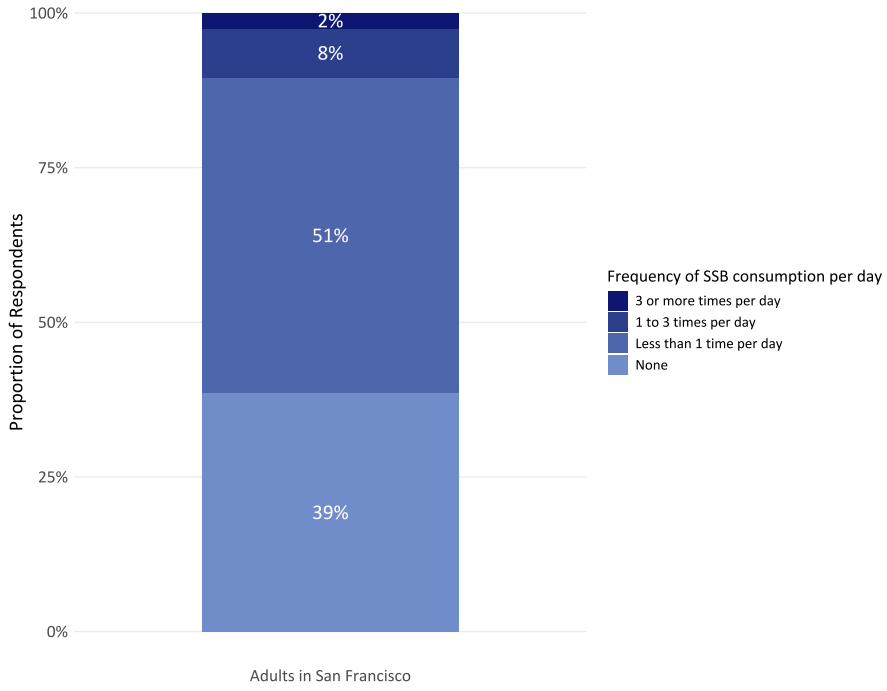
Source: Centers for Disease Control and Prevention (CDC). California Department of Public Health. Behavioral Risk Factor Surveillance System Survey Data, 2018-2022.

Note: Data are the percentage of adults that self-reported consuming soda or sugar-sweetened fruit drinks, sweet tea, or sports or energy drinks at least one time per day during the past 30

days. Data for American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander residents are not shown because too few observations were available. Data are pooled 5-year estimates.

In San Francisco, **about 10.4% of adults consume SSBs one or more times per day**. Approximately half (51%) of SF adults consume SSBs occasionally – more than zero but less than once per day – while 39% report no consumption at all. A very small proportion, just 2.5%, consume SSBs three or more times daily.

Frequency of Sugar Sweetened Beverage (SSB) consumption per day among Adults in San Francisco, 2018-2022



Source: Centers for Disease Control and Prevention (CDC). California Department of Public Health. Behavioral Risk Factor Surveillance System Survey Data, 2018-2022.

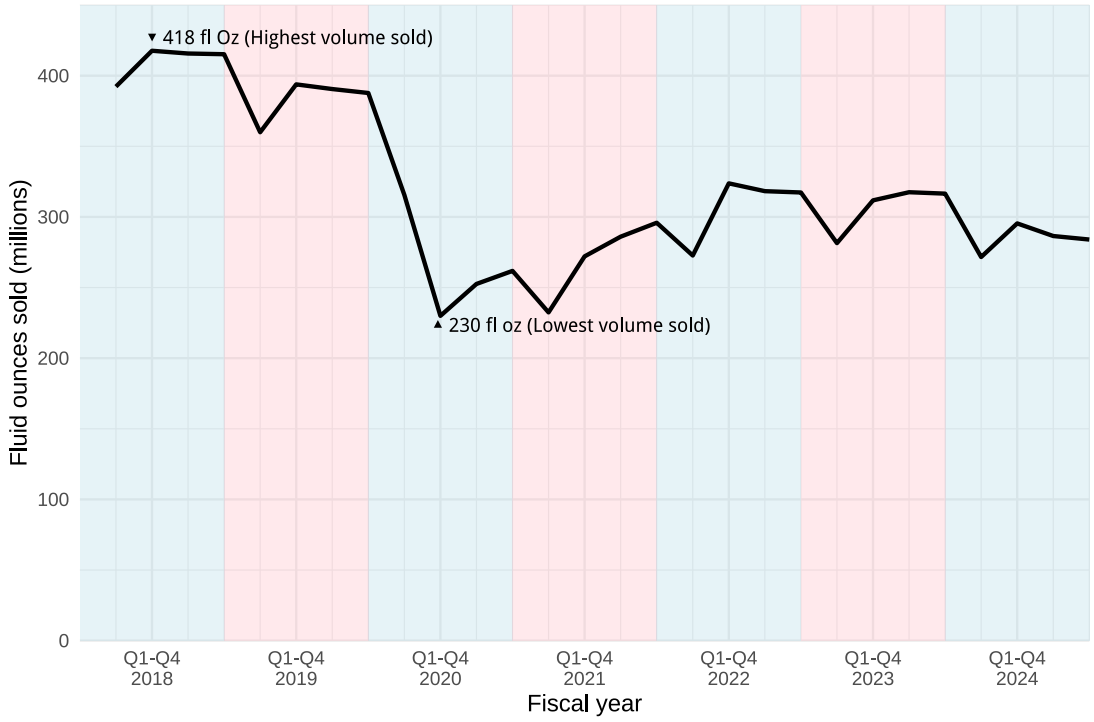
Note: Data are the proportion of adults consuming SSBs none, less than one, one to two, or three or more times per day. SSBs were recorded as soda or sugar-sweetened fruit drinks, sweet tea, or sports or energy drinks during the past 30 days. Data are pooled 5-year estimates.

Sugary Drinks Sales and Consumption in San Francisco

Data from the City Controller show that the total volume of SSBs sold in San Francisco declined from 2019 to 2020, likely due to the COVID-19 pandemic's impact on tourism and daily commuting. Since then, sales have remained noticeably below pre-pandemic levels, possibly reflecting the ongoing shift toward remote work.

In 2023, over 1.2 billion fluid ounces of SSBs were sold in the city – equivalent to approximately 126 twelve-ounce cans per resident. While overall sales are lower than before the pandemic, this figure underscores the continued prevalence of sugary drink consumption and the need for sustained efforts to reduce intake and promote healthier alternatives.

Volume of Sugary Drinks Sold in San Francisco (millions of fluid oz), 2018-2024



Source: San Francisco City Controller, Budget and Analysis Division.

Note: Volume is calculated using the amount of revenue collected for each fiscal quarter where 1 fluid oz equals $0.01. Data for 2024 may be preliminary as businesses can submit and amend their submissions at a later time.

Conclusion

Upstream prevention efforts take time to show measurable impact on chronic diseases, often unfolding over years or even decades. Soda taxes are a meaningful step toward improving community health, but they are just one part of a broader, long-term strategy. Achieving lasting change and reducing chronic disease disparities requires continued investment, time, and a commitment to evaluating outcomes. Data and evidence are essential to understanding what works, measuring progress, and guiding future efforts.

Encouragingly, initiatives funded by soda tax revenues are already driving systemic changes that help create healthier environments for all. However, the disparities highlighted in this data brief make one thing clear: **Black/African American, Latinx, Asian, and Native Hawaiian and Pacific Islander populations continue to experience higher burdens of chronic disease and food insecurity, alongside elevated sugary drink consumption.** These inequities are influenced by structural factors such as targeted marketing of sugary drinks and limited access to affordable healthy foods, which compound health risks over time.

Building healthier communities requires more than soda taxes—it requires long-term investment, rigorous evaluation, and an equity-driven approach to ensure systemic change and measurable impact.

For more information and reports: sf.gov/sddtac
Learn more about the San Francisco Soda Tax: sf.gov/sodatax
Data source notes and limitations: See 2025 SDDT Data Brief Appendix at sf.gov/sddtac

References

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5. California Department of Public Health, Vital Records Business Intelligence System (VRBIS) Death Statistical Master File, 2020-2024. Rates were calculated using 2022 Population Estimates Program data from U.S. Census Bureau, Population Division.
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Appendix B: 2025 SDDT Data Brief Appendix

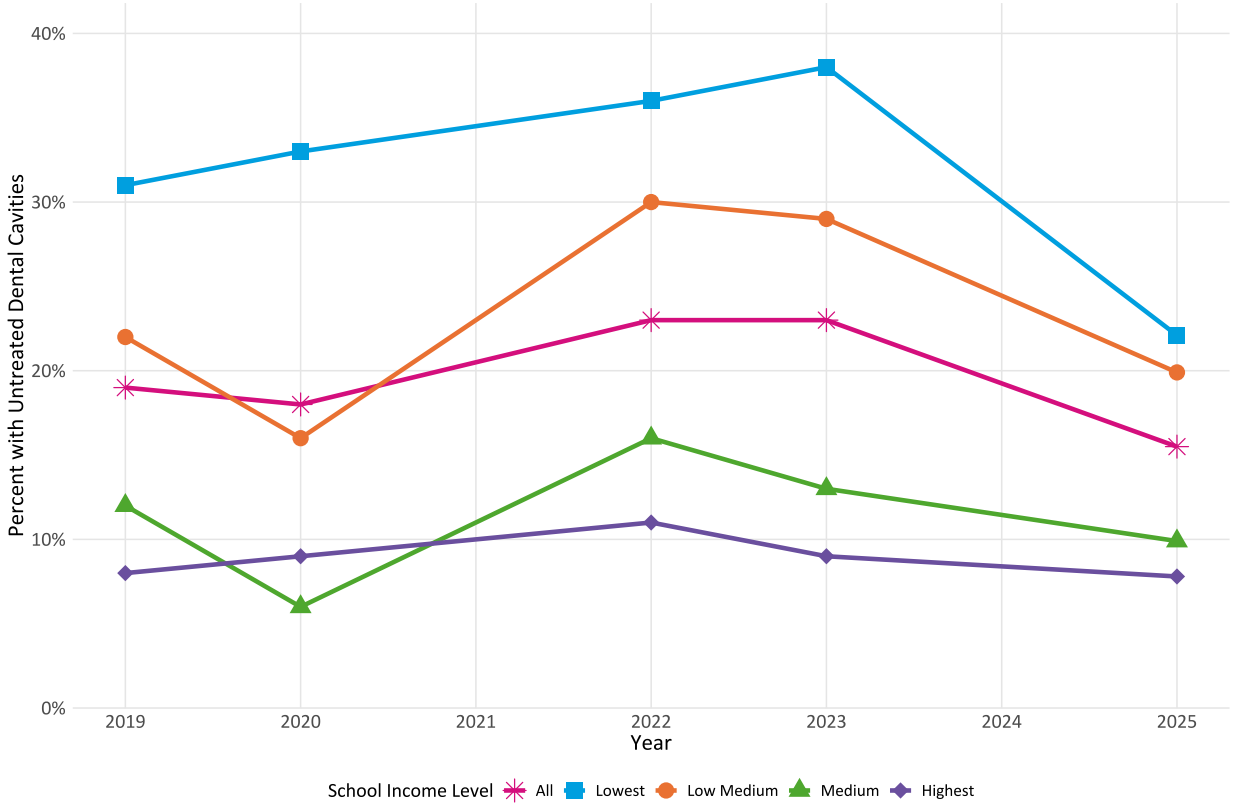
2025 Sugary Drinks Distributor Tax (SDDT) Data Brief Appendix

This appendix accompanies the 2025 Sugary Drinks Distributor Tax (SDDT) Data Brief.

Contents

Data graphs not included in the 2025 Data Brief

Percent of SFUSD Kindergartners with Untreated Dental Cavities by School Income and School Year, 2019-2025



Source: San Francisco Unified School District (SFUSD), Kindergarten Oral Health Screening Program, 2019-2025

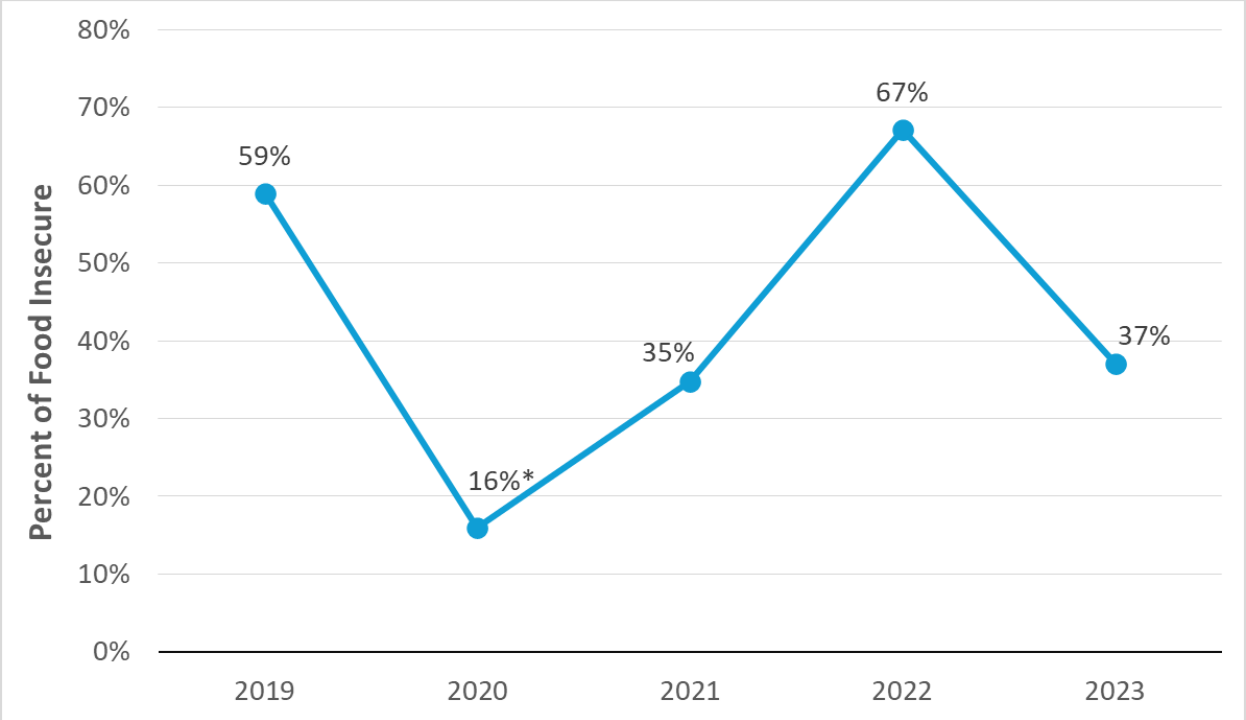
Note: The year refers to the school year, so 2019 refers to the 2018-2019 school year. Estimates for 2020 were based on incomplete data from screenings finished in the Fall 2019, before the

COVID-19 shelter-in-place orders and were weighted using enrollment data for 2019-2020. Estimates for 2022 and 2023 are not weighted. Estimates from 2020 through 2023 may not be comparable to other years. Estimates were not available for 2021 and 2023.

Comments:

- Kindergartners in the lowest income school experienced the sharpest drop in the prevalence of untreated dental cavities from 2019 to 2025
- Across all years, the lowest and low medium income schools have the highest prevalence of untreated dental cavities among kindergarteners

Percent of Adults Earning Less Than 200% of the Federal Poverty Level that are Food Insecure, 2019-2023



Source: UCLA, California Health Interview Survey (CHIS), 2019-2023

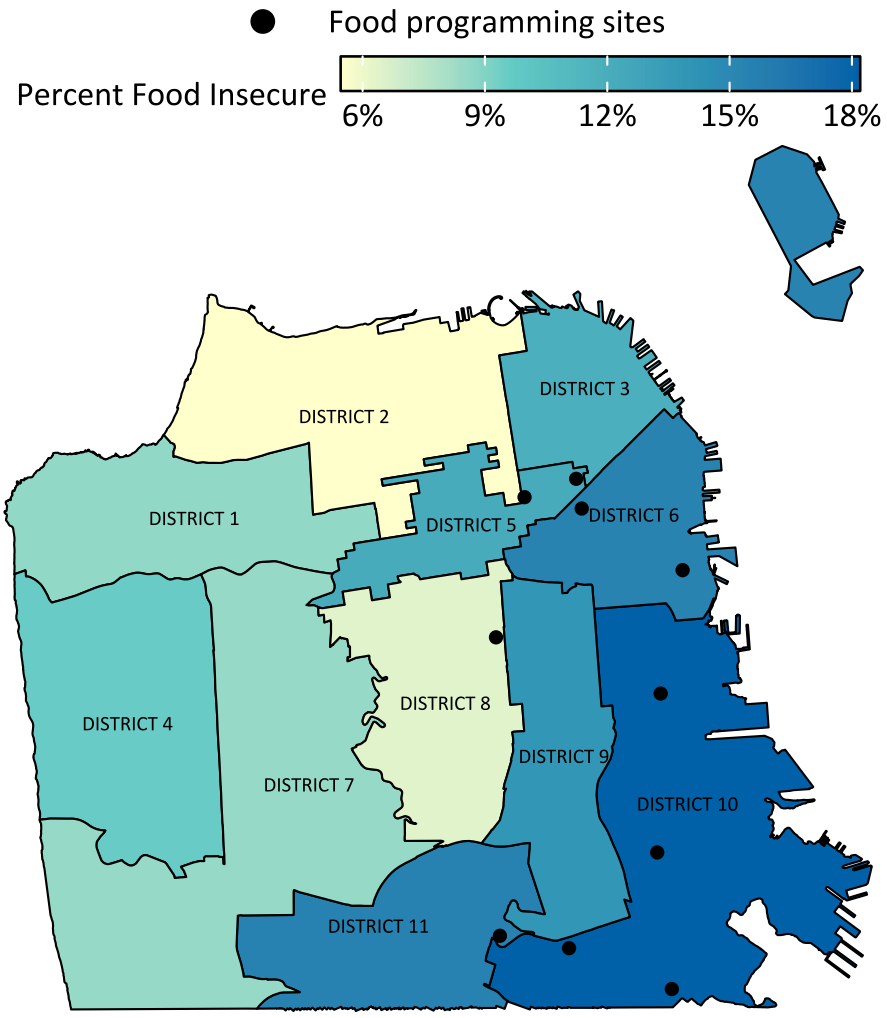
Note: * indicates an estimate that is statistically unstable. The California Health Interview Survey only asks individuals earning less than 200% of the federal poverty level about food security.

Comments:

- In 2020, the percentage of adults earning less than 200% of the federal poverty level who were food insecure may have dropped substantially before increasing again to 35% in 2021 and 67% in 2022. While the lower estimate for 2020 is statistically unstable, this may be explained by federal support in 2020 and 2021 during the COVID-19 pandemic.

- In 2023 the percent of adults in San Francisco earning less than 200% of the federal poverty level that were food insecure dropped to 37% from an all-time high of 67% in 2022. The reason for this observed drop is unknown but may be due to the small sample sizes used to generate these population estimates.

Percent of Adults in San Francisco that are Food Insecure by Supervisorial District, 2022



Source: Population Level Analysis and Community Estimates, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health, 2022

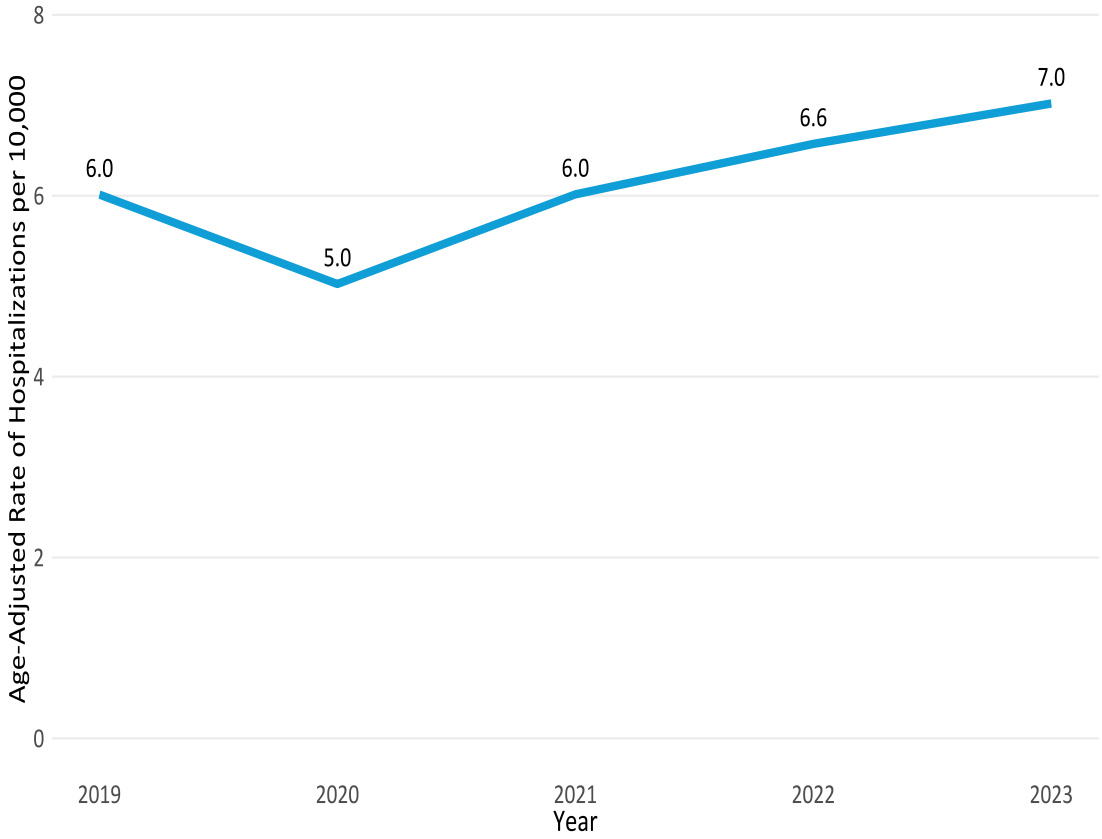
Note: Data are the modeled crude prevalence of food insecurity in the past 12 months among all adults at the supervisorial district level. Food programming sites are the main addresses for organizations funded by SDDT in FY2324 that provided food directly to residents of San Francisco.

Comments:

- Almost 1 in 5 adults in district 10 and 1 in 7 adults in districts 11 and 6 were food insecure in the past 12 months (18%, 15%, and 15% respectively).
- Organizations funded by the SDDT to provide food assistance are generally located in districts with higher rates of adult food insecurity.

Morbidity Data

Age-Adjusted Hospitalization Rates Due to Type 2 Diabetes by Year, 2019-2023

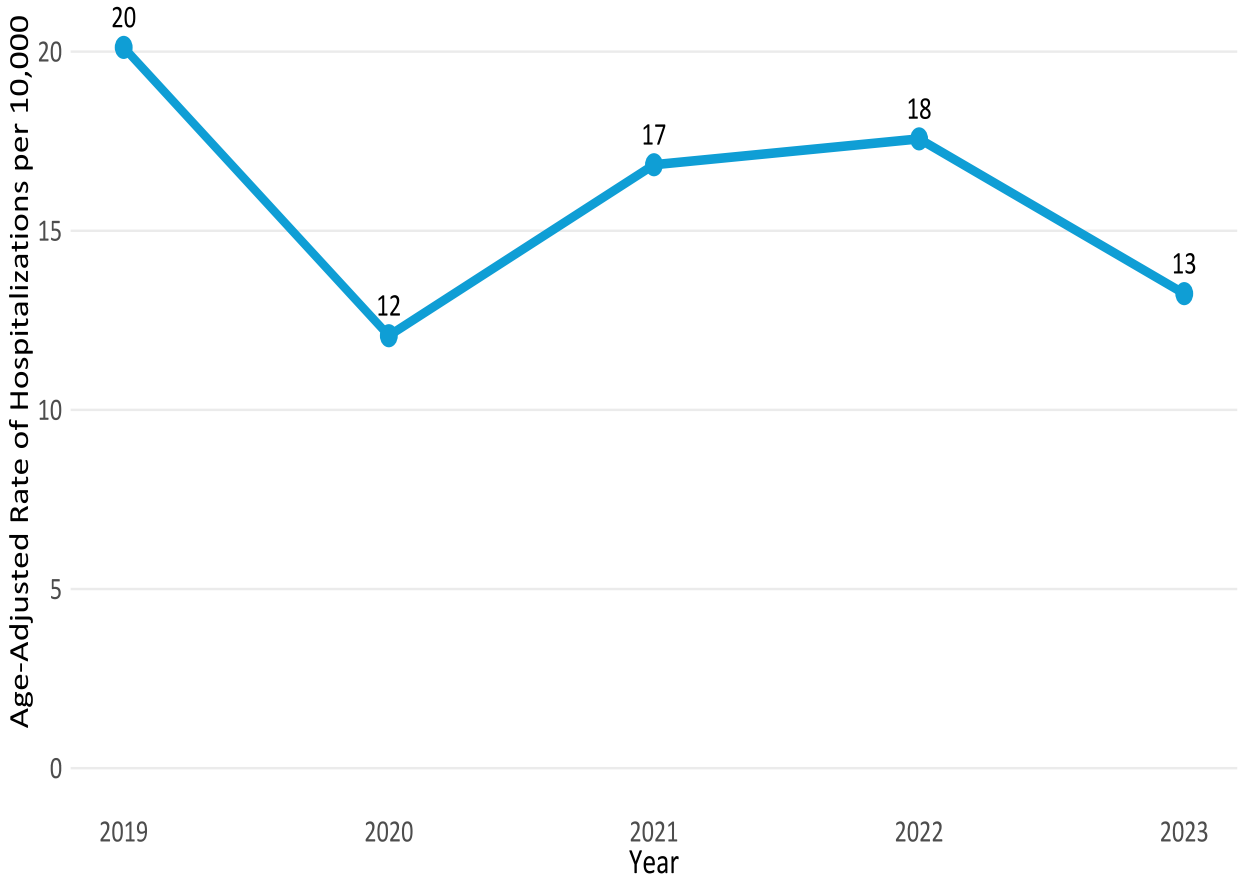


Source: California Department of Public Health, Department of Healthcare Access and Information 2019-2023.

Comment:

- Hospitalizations due to diabetes dipped in 2020 likely due to the COVID-19 pandemic but have slowly increased year over year since then.

Age-Adjusted Rates of Non-Traumatic Dental Emergency Department Visits by Year, 2019-2023

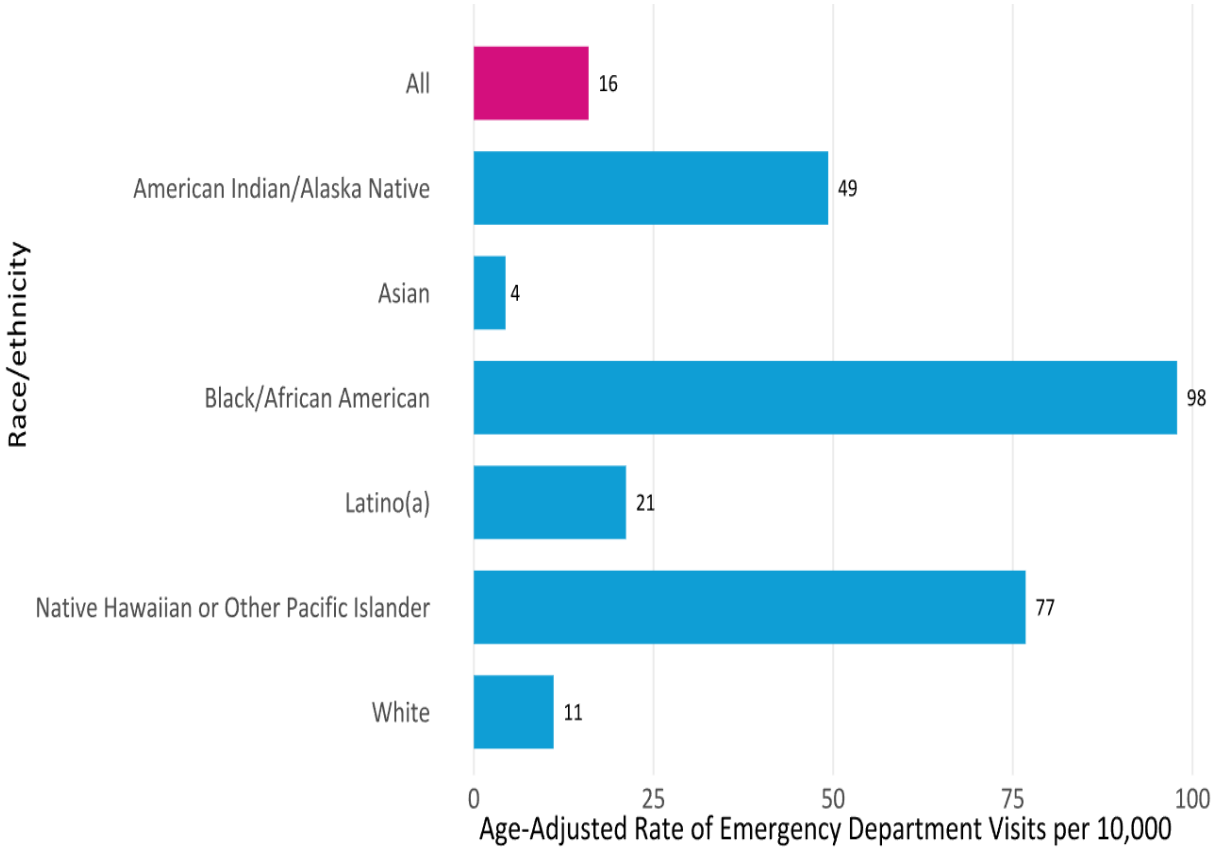


Source: California Department of Public Health, Department of Healthcare Access and Information 2019-2023.

Comments:

- Emergency department visits from non-traumatic dental conditions (NTDC) dropped significantly from 20 per 10,000 in 2019 to 12 per 10,000 in 2020 likely due to the COVID-19 pandemic. However, rates increased to 17 and 18 per 10,000 people in 2021 and 2022 before dropping to 13 per 10,000 in 2023. These data may potentially indicate that the increase in rates of NTDC are due to return to normal behavior of seeking emergency care and a temporary increase in the severity of illnesses presenting at the hospital due to delayed care in 2020.
- Overall the trend of NTDC emergency department visits from 2019 to 2023 is on the decline.

Age-Adjusted Rates of Non-Traumatic Dental Emergency Department Visits by Race/Ethnicity, 2019-2023



Source: California Department of Public Health, Department of Healthcare Access and Information 2019-2023.

Note: Data are pooled 5-year estimates.

Comments:

- Rates of emergency department visits from NTDCs are substantially higher for Black/African American, Native Hawaiian or Other Pacific Islander, and American Indian/Alaska Native residents than the overall citywide rate.
- Black/African American residents have more than 6 times the citywide rate (98 vs 16 per 10,000) while Native Hawaiian or Other Pacific Islander residents have almost 5 times the citywide rate (77 vs 16 per 10,000) and American Indian/Alaska Native residents have 3 times the citywide rate (49 vs 16 per 10,000).

Data Sources and Caveats

Sugary Drinks Distributors Tax Quarterly Revenue Data

Technical notes:

- Data are calculated from revenue generated by the sugary drink distribution tax using a $0.01/fluid ounce conversion.
- Data for the most recent year may be underreported as businesses can submit and amend their payments for previous quarters.

Behavioral Risk Factor Surveillance System

Technical notes:

- The survey question for soda consumption is, "**During the past 30 days, how often did you drink regular soda or pop that contains sugar? Do not include diet soda or diet pop**." The survey question for sweet drink consumption is, "**During the past 30 days, how often did you drink sugar sweetened fruit drinks (such as Koolaid™ and lemonade), sweet tea, and sports or energy drinks (such as Gatorade™ and Red Bull™)? Do not include 100% fruit juice, diet drinks, or artificially sweetened drinks**." A composite SSB consumption variable is created by translating both answers to times per day and summing the values.

Limitations:

- Data are self-reported consumption of sweet drinks and soda from the previous 30 days. The previous 30-day period at the time of the survey may not be representative of what someone typically consumes. As data are self-reported and SSB consumption has a negative connotation, data may be affected by a social desirability bias. Survey data are weighted and may not be from a representative sample – especially when the number of observations within groups is low.

California Department of Health Care Access and Information

Technical notes:

- Non-Traumatic Dental Conditions: ICD-10 codes for non-traumatic dental conditions were adopted by the Association of State and Territorial Dental Directors' Recommended Guidelines for Surveillance of Non-Traumatic Dental Care in Emergency Departments.
- Diabetes. ICD-10 codes for Diabetes are based on PQI 01: Diabetes Short Term Complications Admissions Rate, and PQI 03: Diabetes Long-Term Complications Admissions Rate technical specifications published by the Agency for Healthcare

Research and Quality (July 2024). A medical visit was determined to be primarily due to Diabetes if the primary diagnosis field contained on the identified ICD-10 (October 2015 and later) codes. To Identify visits where Diabetes was the primary cause only the patient's *primary diagnosis* field was searched for ICD-10 codes included in PQI 01 or PQI 03.

Limitations:

- Hospitalization and ER rates measure the number of discharges or visits, not the number of residents who are hospitalized. Admissions records may include multiple admissions by the same person.

Kindergarten Oral Health Screening Program

Technical Notes:

- Parents may opt their children out from screenings. Estimates for 2020 were based on incomplete data from screenings finished in the Fall 2019, before the COVID-19 shelter in place orders and were weighted using enrollment data for 2019-2020. Estimates for 2022 and 2023 are not weighted. Estimates from 2020 through 2023 may not be comparable to other years.

CDC PLACES

Technical notes

- PLACES data are estimates of health measures for small geographic areas, created using statistical modeling techniques that combine survey data with population information.

Measures

Food Security:

- Presented as crude prevalence (%). A detailed probability among adults who reported that the food that they bought always/usually/sometimes did not last, and they didn't have money to get more.
- In order to generate estimates at the supervisorial district level, geospatial analysis was performed using aerial weighting. Census tracts boundaries were intersected with supervisorial district boundaries, and a weighted proportion of the population was used to assign and calculate estimates at the supervisorial district level. Importantly, this method assumes a uniform distribution of food insecurity in each census tract which is likely incorrect. Although most census tracts can be completely assigned to one

supervisorial district, some overlap with more than one and food insecurity estimates at the supervisorial district level should therefore be interpreted with caution.

Burden of Nutrition Sensitive diseases:

- A detailed probability was calculated for the following:
    - high blood pressure: adults ever having been told by a doctor, nurse, or other health professional that they have high blood pressure. Women who were told they had high blood pressure only during pregnancy and those who were told they had borderline hypertension are not included;
    - diabetes: adults being told by a doctor or other health professional that they have diabetes (other than diabetes during pregnancy for female respondents);
    - coronary heart disease: adults ever having been told by a doctor, nurse, or other health professional that they had angina or coronary heart disease; and
    - high cholesterol: adults who report having ever been screened for high cholesterol and told by a doctor, nurse, or other health professional that they had high cholesterol.
- The probability for each chronic disease was then applied to the detailed population estimates at the appropriate geographic level to generate the prevalence. The 95% confidence interval was derived using Monte Carlo simulation. In order to generate estimates at the neighborhood level, the estimated crude prevalences for each chronic diseases were multiplied by the adult population estimate for that census tract, resulting in the estimated number of adults for each census tract that had the chronic disease of interest. These values were then summed across chronic diseases for each neighborhood and then divided by the adult population estimate for each neighborhood, creating a composite indicator of the summed crude prevalence of nutrition-sensitive diseases. Importantly, this method may overestimate the burden of disease for neighborhoods as this approach assumes mutually exclusive probabilities. We attempt to account for this by not reporting the actual values and instead show a gradient for the neighborhoods

Overall Limitations of PLACES

- Underlying health data is from BRFSS which is a state-based cross-sectional telephone survey conducted over landline and cellular telephones.
- Data are self-reported and may be subject to recall and social desirability biases.
- Survey data are weighted and may not be from a truly representative sample. For example, data may be subject to nonresponse bias.
- PLACES data are modeled small area estimates using a multi-level regression and post-stratification approach applied to BRFSS and ACS data.

California Department of Public Health (CDPH), Vital Records Business Intelligence System (VRBIS) - death data

Technical notes

The Vital Records Business Intelligence System (VRBIS) Master Death File is maintained by the California Department of Public Health (CDPH). Data is acquired from CDPH through a request process.

For more information, please see the following website:
https://www.cdph.ca.gov/Programs/CHSI/Pages/Data%20Types%20and%20Limitations.aspx

Limitations:

- The California Department of Public Health maintains a dataset of all deaths in California. Each death is recorded with a primary cause of death. The analysis presented in this document includes only the primary cause of death and does not consider comorbid or contributing causes of death. Specific cause-of-death categories were designed based on the World Health Organization Global Burden of Disease and Injury (WHO GBD) and the National Center for Health Statistics 113 Selected and 50 Rankable Causes of Death.
- Race/ethnicity was categorized according to San Francisco ethnicity data guidelines.
- The VRBIS dataset includes confidential and non-confidential identifiers, demographic information, and medical/health data from death certificates. The information in these certificates is provided by informants and clinicians, and its accuracy and completeness depend on the reporting parties.
- It is important to note that Vital Statistics data may not be fully accurate or complete due to various circumstances, including amendments to the legal records that may have been filed after the data files were produced. Additionally, death data files are not legal records and should not be used as substitutes for the official legal records from which they were derived.

California Health Interview Survey (CHIS)

Technical Notes:

CHIS is a population based multimodal (web and phone) address-based health survey that uses a stratified random sampling approach. A weighting procedure is applied to a sample in order to generate estimates that are representative of California's non-institutionalized population living in households and in counties. In San Francisco City and County, about 400 adults are sampled to generate county specific estimates. Data were obtained through the AskCHIS Neighborhood Edition.

Measure: Food insecurity

- Respondents were asked various questions related to food security.
- Asked only of adults whose income is less than 200% of the Federal Poverty Level.

Limitations:

- Though CHIS is a weighted survey, weighting adjustments may not fully control for nonresponse bias. Nonresponse can lead to bias if nonrespondents differ systematically from survey respondents in health status or behaviors.

Appendix C: FY 24-25 SDDT Evaluation Report

SODA TAX SF FOR HEALTH

San Francisco Sugary Drinks Distributor Tax (SDDT)

FY 2024-25 Evaluation Report

Letter of Introduction

March 1, 2026

DEAR MAYOR DANIEL LURIE, SAN FRANCISCO BOARD OF SUPERVISORS, AND SAN FRANCISCO RESIDENTS,

Enclosed is the Fiscal Year 2024-2025 (**July 2024 - June 2025**) Evaluation Report for San Francisco's Sugary Drinks Distributor Tax (SDDT). The Sugary Drinks Distributor Tax Advisory Committee (SDDTAC) remains committed to its legislative charge to evaluate the impact of the tax and provide community-informed and evidence-based recommendations to guide reinvestment.

The FY was marked by significant shifts in funding priorities amid broader citywide budget constraints. During this budget cycle, a substantial portion of SDDT revenue was reallocated to the Human Services Agency (HSA) to support its Citywide Food Access Programs. While the urgency of addressing food insecurity is significant, the reallocation resulted in reduced funding for community-based prevention efforts, mid-cycle grant terminations, and the conclusion of long-standing initiatives such as the Policy, Systems, and Environmental (PSE) grants and Requity programs. Community-based organizations reported staffing instability, program interruptions, and uncertainty that affected long-term planning and community trust. Prevention strategies require consistency and sustained investment.

Prevention remains a priority. **Nutrition-sensitive chronic diseases—including heart disease, hypertension, and diabetes—are among the top five causes of death in San Francisco, with mortality rates for Black adults two to four times higher than those of White or Asian adults.**[1] These disparities underscore the urgency of sustained investment in prevention strategies that address structural inequities and promote healthier environments. **The SDDT remains the only chronic disease prevention funding and its funded programs continue to deliver measurable benefits:**

- 86% of participants surveyed believe sugary drinks harm health, and nearly 90% reported drinking more water after participation.
- Over 90% of food-insecure participants reported eating more fruits and vegetables after program participation.
- Programs have strengthened community leadership and built culturally responsive strategies that resonate with San Francisco's diverse populations.

These investments continue to shape knowledge, behaviors, and environments related to reducing sugary drink consumption and preventing chronic disease. **However, this evaluation also highlights a clear caution: instability in prevention funding risks slowing progress in communities already experiencing disproportionate burdens of diet-related disease**.

We respectfully share this evaluation report with the shared goal of strengthening prevention, maintaining community trust, and advancing health equity for all San Franciscans. We appreciate your consideration of these findings and recommendations.

Sincerely,

Abby Cabrera, MPH **Laura Urban**

Sugary Drinks Distributor Tax Advisory Committee Co-chairs

Table of Contents

Executive Summary

Major Funding Shifts in FY 2024–25

FY 2024–25 was marked by unprecedented shifts in SDDT funding. Nearly half of SDDT revenue ($5.3 million, 45%) was redirected to the Human Services Agency's Citywide Food Access Programs to address urgent food insecurity needs during a period of citywide budget constraints. This reallocation resulted in mid-cycle cuts to community-based grants, reduced funding for culturally responsive health education, and the sunset of long-standing initiatives. These shifts had significant consequences: a 34% reduction in funded programs and a 65% decrease in participants served compared to FY 2023–24, along with disruptions to trusted partnerships in priority neighborhoods. Understanding these changes is essential for interpreting the evaluation findings that follow.

In FY 2024-25:

31,332 participants engaged in 19 SDDT-funded programs, across 159 sites in the neighborhoods with the greatest burden of nutrition sensitive chronic disease.

174 people were paid* with SDDT funds as staff or stipended positions.

86% of participants surveyed* believed that **sugary drinks can harm their health.**

82% of food insecure survey participants* reported they worried less about having enough food after participation in an SDDT program.

38 of those paid* were community health workers.

Nearly **9 out of 10 of survey participants* started drinking water more often** after participating in an SDDT program.

92% of food insecure survey participants* were able to eat more fruits and vegetables after participation in an SDDT funded program.

*based on self-reported, cross-sectional survey data

Overview of Findings

The following evaluation findings were generated for SDDT funding in Fiscal Year 2024–2025 (FY 24-25), which includes July 1, 2024 through June 30, 2025.

Finding 1: SDDT revenue continues to be invested in priority populations and places most targeted by the beverage industry.

Finding 2: SDDT investments continue to show improved healthy behaviors and attitudes related to drinking more water, drinking fewer sugary drinks, and increasing fruit and vegetable consumption and physical activity.

Finding 3: SDDT investments continue to alleviate food insecurity through direct services and long-term system change strategies.

Finding 4: SDDT investments strengthen connections and leadership in communities most impacted by health inequities leading to long term benefits.

Recommendations

1) Increase awareness about the negative impacts of sugary drinks and to reduce sugary drink consumption, especially among priority populations.
2) Promote tap water consumption through culturally responsive strategies.
3) Prioritize youth-focused strategies that reduce sugary drink consumption and promote tap water from early childhood through transition-age youth (TAY).
4) Invest in systems-level changes and comprehensive strategies to ensure equitable and sustained benefits to community health and wellbeing.
5) Invest in leadership development and job opportunities that support stronger, more resilient neighborhoods with meaningful connections to local, state, or national decision-makers.
6) Strengthen and support SDDT evaluation efforts.
7) Ensure stable funding to support chronic disease prevention.

Overview of Report

San Francisco Department of Public Health (SFDPH)'s Community Health Equity and Promotion (CHEP) Branch Healthy Eating Active Living (HEAL) team and Center for Data Science (CDS) conducted an evaluation of the Sugary Drinks Distributor Tax (SDDT) funded entity data for FY 2024-25. This report provides a comprehensive analysis of the program reach, participant demographics, and health outcomes of SDDT-funded programs across San Francisco. This report aligns with the 2020-2025 SDDTAC Strategic Plan. For more information, please see sf.gov/sddtac.

The findings summarized here represent a snapshot of the programs' impact during FY 2024-25 and are not directly comparable to previous years.

This report is organized into the following main sections:

Introduction: Explains the background and purpose of SDDT and the SDDTAC and describes the people and places more burdened by nutrition-sensitive chronic diseases.

Findings #1 - 4: Presents the main evaluation findings and data for FY 2024–25.

Conclusion: Summarizes the impact of FY 2024–25 funding shifts.

Recommendations: Outlines recommendations for consideration during future years of SDDT funding allocation.

Data Sources

SDDT Program Participant Survey

Technical notes:

- A single-point-in-time survey was administered after participation in an SDDT program. In FY 24-25, a total of 14 programs (12 SDDT-funded and 2 RPD programs that were not funded by SDDT) administered the survey in SurveyMonkey to their participants. The questions were designed to assess participants' perceptions of the program and any behavioral changes (e.g., physical activity, fruit/vegetable consumption, and sugar-sweetened beverage consumption) as a result of participation in an SDDT funded program. Questions varied slightly based on the SDDT program. For example, the survey for a program focused on physical activity, would ask about the time spent on physical activities, before program participation and after program participation. In addition to English, the

surveys were available in Spanish, Traditional and Simplified Chinese, Tagalog, and Arabic. As a thank you for participation, participants received a $20 gift card.

Limitations of using the SurveyMonkey Participant Survey data:

- Convenience sample with a small sample size: Program administrators were asked to advertise participation in the survey either during in-person activities or via email. While each program was allowed to choose their own approach, recommendations and survey administration protocols were provided. Approximately 1.8% of SDDT program participants in programs that administered the survey completed the survey. Consequently, the information collected may not be representative of the entire SDDT program participant cohort in FY 24-25.
- Recall and social desirability bias: For behavior change questions, respondents were asked to report on their lifestyles and activities both before and after program participation during the same survey administration. This approach may not accurately capture true behavior change due to potential recall and response bias.

SDDT grantee/program submitted report: SurveyMonkey, Excel, Word and other supplemental materials

Technical notes:

- Community-based organizations (CBO) and Agencies that receive SDDT funding are required to provide annual reports that include the following data. Note that annual report data from OHTF and Healthy Communities grantees were included in the analysis because they were initially funded through SDDT, though DPH provided non-SDDT one-time funds to prevent cuts when SDDT funds were reallocated.
  - Program activities and reach (e.g. activity types, locations, estimated number of participants served, languages services are offered in)
  - Program staff demographics (e.g. race/ethnicity of staff, position type, languages spoken, full-time equivalent, and neighborhood residence)
  - Program participant demographics (e.g. total unduplicated number of participants served, participant race/ethnicity, age, gender identity / sexual orientation, zip code/neighborhood residence, percent of participants who were low-income, and number of participants who were pregnant at time of service)
  - It is important to note that this report is based on programs' self-reported data collected via SurveyMonkey, Excel spreadsheets, Word documents, and any applicable supplemental materials. Many activities conducted were either policy, systems, and environmental changes or indirect education activities. Due to the nature of this type of work, it can be challenging to collect

accurate participant counts and demographic data. Therefore, many programs either provided estimates for these data or were unable to provide these data at all. All reach and participant data provided in this report should be considered estimations which might over or underestimate the true reach of these programs.

Limitations: Although CDS implemented a QA/QC protocol in RStudio to identify questionable responses reported by the programs, contacted programs for clarification, and corrected the data as needed, the final cleaned dataset may still not be fully accurate due to the following reasons:

- Although clear instructions and training were provided, programs may have interpreted the questions differently, resulting in variation in responses that could reflect potential measurement bias. For example, some programs reported staff headcounts that were not funded through SDDT in FY24–25. While CDS identified and corrected this error with assistance from the HEAL team, not all similar issues could be detected or corrected.
- The QA/QC script written in R language was able to detect mathematical errors using Boolean logic, in addition to the validation tools in SurveyMonkey; however, non-logical errors, such as data entry issues, could not be identified.

PLACES: Local Data for Better Health. Centers for Disease Control and Prevention

Technical notes:

- Census tract level estimates were provided for adults 18 and older or all age groups for selected health-related topics in the United States. PLACES data released on August 23, 2024 was used for this analysis. and provided the model-based estimates of various conditions using Behavioral Risk Factor Surveillance System (BRFSS) 2022 or 2021 data, Census Bureau 2010 population estimates, and American Community Survey (ACS) 2015–2019 estimates. A multilevel logistic regression model was constructed for each measure and calculates the predicted probability of having each outcome at the census tract level. When applied to the population counts at the census block level a predicted crude prevalence was obtained and these are then aggregated at the census tract level. The crude prevalence of 1) high blood pressure, 2) coronary heart disease, 3) high cholesterol, and 4) diabetes (types 1 and 2) from the PLACES data were selected categorized as “nutrition-sensitive chronic conditions” among adults in this report. See PLACES data for more information.

Limitation of using PLACES data:

- Given that the final composite measure used for this report is a simple sum of the estimated prevalence for diabetes, coronary heart disease, hypertension, and high blood pressure, and each nutrition-sensitive condition was tracked separately, adults with more than one diagnoses may be counted multiple times, potentially overestimating the total number of individuals with "nutrition-sensitive chronic conditions" among adults.

San Francisco Human Services Administration (SFHSA) Program Data

SFHSA Citywide Food Access (CFAT) program data was provided via presentations to the SDDTAC and via email to the SDDT Evaluation Team.

Sugary Drinks Distributor Tax (SDDT) Background

How it Works

In November 2016, San Francisco voters passed the Sugary Drinks Distributor Tax (SDDT) - more commonly known as the SF Soda Tax, which established a 1 cent per ounce fee on the initial distribution of drinks with added sugar. This chart shows how the tax revenue flows into the city and to the communities most targeted by the sugary drinks industry marketing and advertising tactics.

Learn more at
sf.gov/sodatax

1. Sugary Drink Distributors are Taxed

The SF Soda Tax is not a sales tax. Distributors are responsible for paying the tax. Merchants may choose to pass the cost of the tax along to consumers.

2. Revenue is Collected

The SF Soda Tax collects about $15-16 million each year. The revenue goes into the City's General Fund. About 22% is set aside for specific, voter-approved projects. The Tax Advisory Committee makes recommendations to the mayor on how to spend the remaining 78%.

3. Tax Committee Recommends Investments

The Committee talks to community members to learn about how the tax revenue could benefit people, especially low- income people and people of color who are most targeted by the beverage industry's advertising. The Committee then submits their funding recommendations to the Mayor.

4. City Budget Process Finalizes Investments

The Mayor submits a budget proposal to the Board of Supervisors, including recommendations for the SF Soda Tax funds. The Board of Supervisors votes on the budget and the Mayor signs it.

5. SF Soda Tax Funds Programs!

SF Soda Tax funds go to City departments who either implement programs and services directly or issue grants to community-based organizations to fund their important

SDDT Advisory Committee Values

Supporting community-led and culturally relevant work. Community-led work should be led by communities that are disproportionately impacted by marketing for and consumption of sugary beverages from the beverage industry and nutrition-sensitive chronic diseases (i.e., SDDTAC's priority populations), and culturally relevant work should be responsive to these communities and populations. This objective can be achieved by investing in priority communities and ensuring funded work is culturally responsive, linguistically relevant, and trauma informed.

Building strong collaborations and partnerships to increase capacity and effectiveness. Funding should support existing and new community-based partnerships and collaborations that align resources to increase capacity, effectiveness, and the impact of strategies, programs, and services. Eliminating structural inequities and achieving equity.

Equity (including health equity and racial equity) means that everyone has a fair and just chance to reach their full potential and be healthy. The root causes of structural inequities and health disparities (e.g., systems of oppression, intentionally and unintentionally/implicitly biased policies, and resource allocation) need to be addressed in order to achieve equity. This goal is done by mitigating health harms and holding the soda industry accountable.

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

11

Priority Populations

Using public health data and evidence, the SDDTAC identified communities who are targeted by the soda industry, who consume sugary drinks in high proportions, and who experience disproportionate elevated percentages of nutrition-sensitive chronic diseases like tooth decay, cavities, type 2 diabetes, hypertension (high blood pressure), and cardiovascular disease.

Specifically, the SDDTAC identified the following populations as those who should be prioritized in SDDT funding recommendations:

- Low-income San Franciscans
- Children, youth, and young adults 0-24 years old
- Community members who identify as any of the following:
    - Asian
    - Black/African American
    - Latine
    - American Indian or Alaska Native (AIAN)
    - Native Hawaiian or Other Pacific Islander (NHOPI)

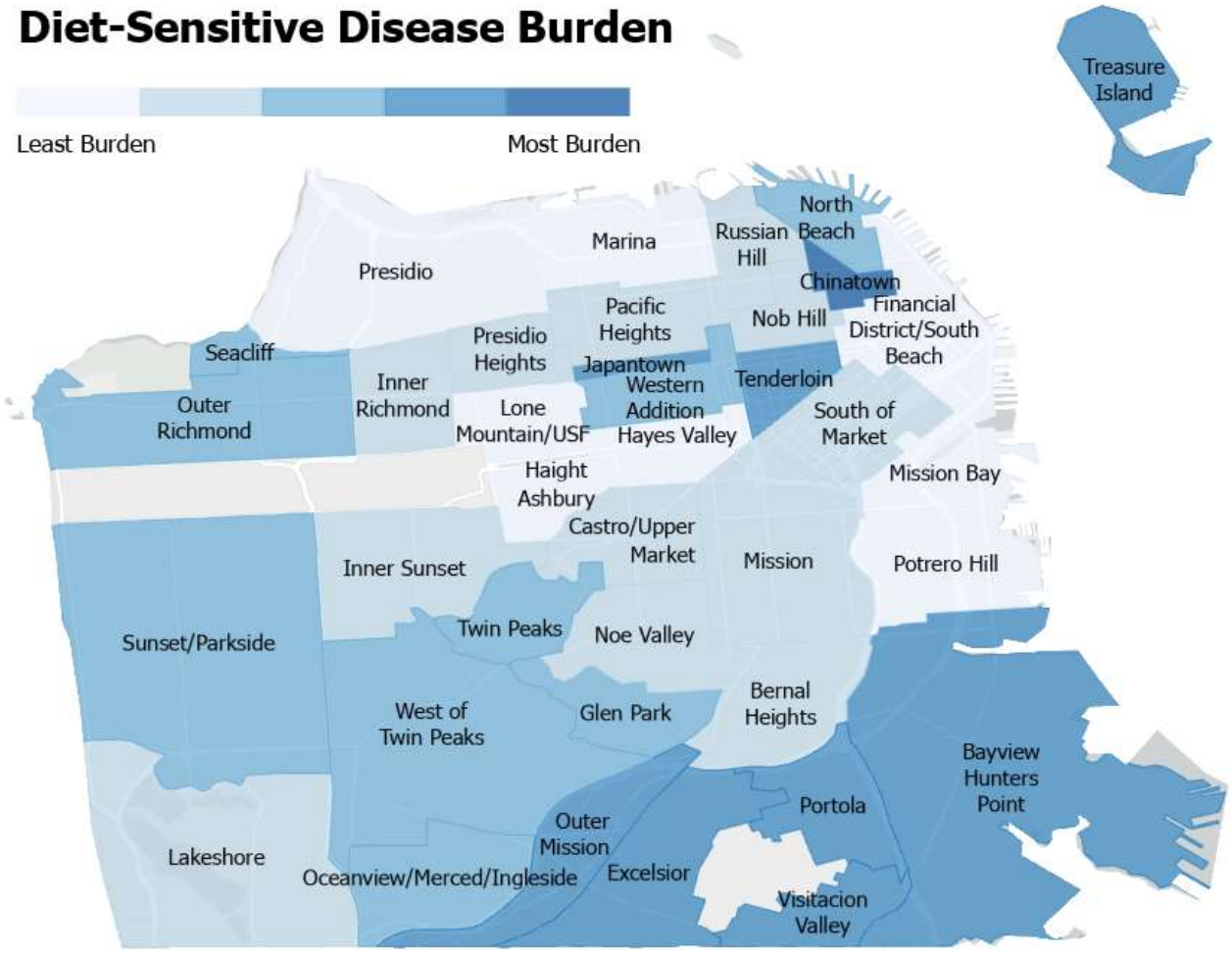
Although these priority populations are distinct, there is also considerable overlap between them, with many community members belonging to more than one of these communities and, thus, experiencing multiple intersecting and cumulative inequities.

A snapshot of health disparity data in SF:

- The **mortality rate among Black or African American adults for most nutrition-sensitive diseases is roughly two to four times higher** than that of White or Asian adults in San Francisco.[2]
- **Hospitalization rates due to type 2 diabetes were approximately nine times higher among Pacific Islanders, nearly four times higher among Black/African American residents, and nearly twice as high among Latinx residents** compared to all San Francisco residents during 2019-2021.[1]
- **Asian kindergartners** experienced the **sharpest increase (10%) in untreated dental cavities in 2023, followed by the largest decrease (20%) in 2025**.[2]

San Francisco Neighborhoods Most Impacted by Nutrition-Sensitive Disease

Health inequities exist between neighborhoods in San Francisco in addition to existing between demographic groups. Neighborhoods with the greatest burden of nutrition-sensitive chronic diseases like diabetes, hypertension, and heart disease were **Chinatown, Tenderloin, Visitacion Valley, Japantown, Portola, Bayview Hunters Point, Treasure Island, Excelsior, Outer Mission, and West of Twin Peaks.** Notably, older populations have greater rates of chronic disease than younger populations, so these neighborhoods represent those with greater proportions of older residents in addition to residents with greater health disparities.



Data source: PLACES: Local Data for Better Health (2024). Neighborhood profiles are defined by SFDPH and the Mayor's Office of Housing and Community Development, with support from the Planning Department. See https://data.sfgov.org/

Map created using *ArcGIS Pro* (Version 3.1) [Computer software]. Environmental Systems Research Institute, Inc. https://www.esri.com

SDDT Evaluation Logic Model

The SDDT evaluation logic model, presented below, aligns with the SDDT Advisory Committee's strategic plan. In 2023, the SDDT evaluation team made some updates to the strategies and values in the SDDT evaluation logic model to address feedback from funded entities that some of the strategies from SDDTAC strategic plan were overlapping and to ensure the intent of the values was clear.

Goals	Strategies	Short-Term Outcomes
Strengthen community leadership to support **Healthy People**	• Expand community capacity and develop leadership • Increase community-driven health promoting education and services • Increase sustainable employment opportunities	• Improve behavioral outcomes » Decrease in sugary drink consumption » Increase in tap water consumption » Increase in fresh produce consumption » Increase in breast/chestfeeding » Increase in physical activity • Improve community and economic conditions » Increase in economic opportunity and stability » Increase in food security
Mitigate structural inequities to create **Healthy Communities**	• Reduce availability and consumption of sugary beverages • Increase access to and consumption of tap water • Increase sustainability of healthy food systems and policies to increase access to healthy food • Expand access to places that promote physical activity • Reduce gaps in oral health services for children • Support small business and increase economic opportunities	

Values

Support community-led and culturally relevant work
Build strong collaborations and partnerships to increase capacity and effectiveness
Address structural inequities
Support policy, systems, and environmental changes

Long-Term Outcomes

- Improve health outcomes
  - » Decrease in nutrition-sensitive chronic diseases (e.g., dental caries, heart disease, hypertension, stroke, Type 2 diabetes)

Desired Impact:

Eliminate health disparities and achieve equity, especially among priority populations.

SFUSD staff prepare a healthy, from scratch meal.

Government Agencies Receiving Funding in FY 2024-25

San Francisco Department of Public Health (SFDPH)

- School-Based Dental Sealant Program in public elementary schools with the highest need and greatest burden of disease.
- Grants to community-based organizations are administered through SF Department of Public Health including:
    - Healthy Food Purchasing Supplement Grants provide funding for food vouchers that can only be used on healthy foods.
    - Policy, Systems, & Environment (PSE) Multi-Year Grants provide multiple years of grant funding to support the identification and implementation of community-supported ways to improve health equity through changes to policies, systems, and/or physical environments. FY 2024-25 was the fifth and final year of funding for three PSE grantees.
    - Healthy Communities Multi-Year Grants* for small community-based organizations provide multiple years of grant funding to support Education, Programs, or Services related to reducing consumption of sugary drinks and other aligned health outcomes. FY 2024-25 was the second year and final year of funding in a multi-year grant cycle for six grantees, two of which were previously funded.
    - Children's Oral Health Community Task Forces† (each led by a community-based organization serving as fiscal sponsor) educate parents and other caregivers in marginalized and disenfranchised communities about how to keep their children's teeth and mouths healthy and how to reduce the risk of children getting caries and improving other oral health outcomes.

San Francisco Human Services Administration (SFHSA)

- Citywide Food Access Programs address ongoing food and nutrition gaps by granting funds to CBOs to implement direct programming including purchasing power (grocery voucher) programs, supplemental meal services, community food production (urban agriculture), neighborhood-based grocery access, and the D10 Community Market.

* The Healthy Communities Grants budget was reduced to include only organizations providing "direct food services". SFDPH identified reduced one-time funding to continue to supporting all of the six grantees in FY24-25.

† The Children's Oral Health Task Force grant budgets were eliminated. SFDPH identified reduced one-time funding to continue supporting the three grantees in FY24-25.

Office of Economic & Workforce Development

- The Healthy Retail Initiative, led by a community-based organization, works with corner stores and community ambassadors to improve access to healthier food and beverages in local stores, especially in areas where there may be limited options.[‡]

San Francisco Unified School District (SFUSD)

- Student Nutrition Services: classroom-based health, food, nutrition, and water education, student-led action, and hydration station installation.
- SFUSD administers the Healthy Schools Grants to community-based organizations.

Community-Based Organizations that Received SDDT Funding in FY 2024-25

Healthy Food Purchasing Supplement Grants

- EatSF/Vouchers 4 Veggies (UCSF)
- Heart of the City Farmers Market

Children's Oral Health Community Task Forces[§]

- Chinatown Children's Oral Health Task Force (NICOS Chinese Health Coalition)
- Mission Children's Oral Health Task Force (CARECEN SF)
- District 10 Children's Oral Health Task Force (Dental Robin Hood)

SDDT Healthy Communities Grants for Small Community-Based Organizations - Cohort 2[**]

- All My Usos (AMU) & Fa'atasi Youth Services

[‡] Due to delays in the funding process, there has been no implementation of the Healthy Retail Initiative since June 30, 2023. As a result, no evaluation data is currently available.

[§] Original SDDT funding amount was cut for all three Children's Oral Health Community Task Forces. SFDPH provided limited one-time non-SDDT funding. Workplans were modified due to decreased funding amounts.

[**] Original SDDT funding amount was cut for All My Usos (AMU) & Fa'atasi Youth Services, Association of the Ramaytush Ohlone, Community Awareness Resource Entity (CARE), and South of Market Community Action Network (SOMCAN). SFDPH provided limited one-time non-SDDT funding. Workplans were modified due to decreased funding amounts.

- Association of the Ramaytush Ohlone
- Community Awareness Resource Entity (CARE)
- Farming Hope
- Florence Fang Community Farm
- South of Market Community Action Network (SOMCAN)

SDDT Policy, Systems, & Environment (PSE) Change Multi-Year Grants

- 18 Reasons
- Central American Resource Center (CARECEN)
- Tenderloin Neighborhood Development Corporation (TNDC)

SDDT Healthy Schools Grants for Community-Based Organizations Serving SFUSD

- Project Commotion
- Ultimate Impact
- Urban Sprouts

Finding 1: SDDT revenue continues to be invested in priority populations and places most targeted by the beverage industry.

In FY 2024-25, SDDT funds supported:

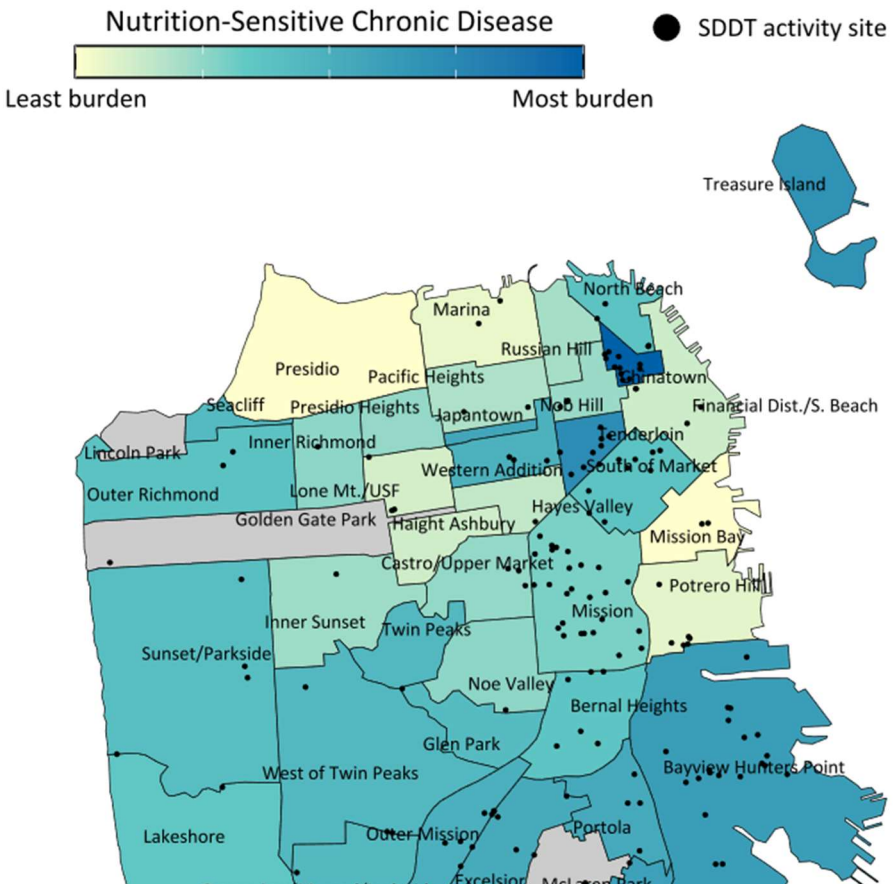
19 programs across **159 sites** in San Francisco.	**31,332 participants,** of which, over 28,606 were San Francisco residents.	**566,264 activity sign-ins** across programs.

This evaluation shows a 34% decrease in total number of programs from 29 in FY23-24 to 19[††] in FY24-25. The reduction is due to the significant shifts in funding allocations from previously funded community-based grant programs and place-based Recreation and Parks Department (RPD) programs to Human Services Administration (HSA) Citywide Food Access Team Programs, the latter of which are reported separately on page 34.

Despite shifts in funding, SDDT-funded programs **continued to reach the places and people most targeted by the beverage industry bearing higher burdens of nutrition-sensitive chronic disease such as diabetes, hypertension, and heart disease.**

Program sites were concentrated on the eastern side of San Francisco, with bigger clusters **observed in Mission, Bayview/Hunters Point, Excelsior, Potrero Hill, Visitacion Valley, and Tenderloin/South of Market—**neighborhoods known to experience higher burdens of **nutrition-sensitive chronic diseases such as diabetes, hypertension, and heart disease.**

FY24-25 SDDT-funded program activity locations overlaid the prevalence of nutrition-sensitive disease burden

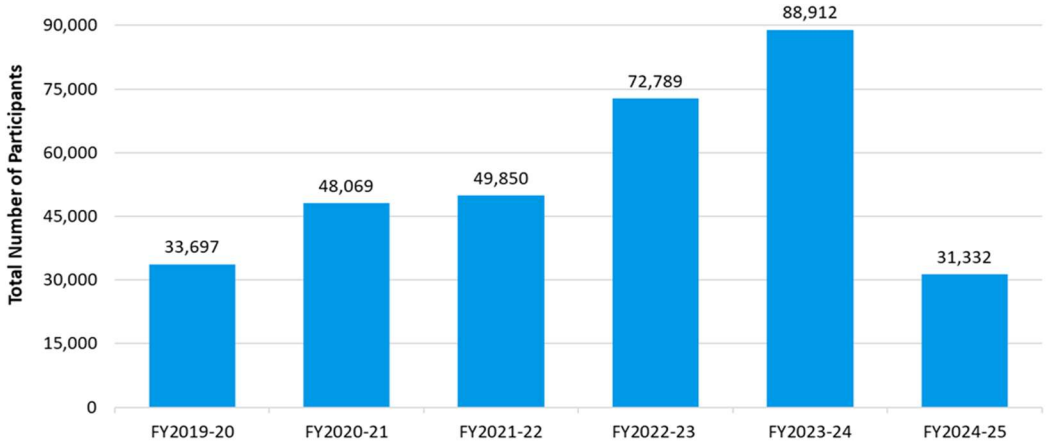


Data source: PLACES: Local Data for Better Health (2024) and SDDT grantee submitted report. Neighborhood profiles are defined by SFDPH and the Mayor's Office of Housing and Community Development, with support from the Planning Department. See https://data.sfgov.org/
Map created using RStudio V2025.09.0 [Computer software]

[††] This number only includes grant funded programs. RPD, HSA, and SFUSD were not included due to differences in funding structure.

The number of unique, unduplicated participants increased steadily from FY19-20 (n=33,697) to a record high of 88,912 participants in FY23-24. In FY24-25, Unduplicated participants dropped to a record low of 31,332 participants.

Number of Unique SDDT Participants, FY19-20 to FY24-25

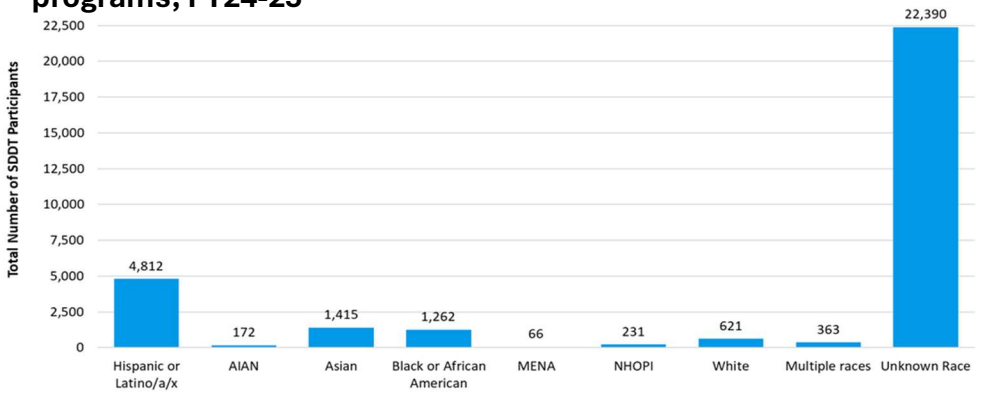


The significant decrease in the number of participants served in FY24-25 (88,912 to 31,332)[‡‡] was due to two factors. First, the introduction of a new data collection tool and training by SFDPH provided clearer and more standardized reporting instructions for all programs, which may have contributed to more accurate—but lower—reported participant numbers. Second, the Mayor redirected $5.2 million of SDDT revenue to the SFHSA Citywide Food Access (CFAT) portfolio, along with overall budget cuts that reduced available funding. The funding went to support SFHSA CFAT's baseline budget of $12.5 million which includes four food access programs. Since SDDT funding is added to baseline budget instead of going directly to one specific program, it is impossible to track the specific number of CFAT participants benefiting from soda tax funds. CFAT programs served an estimated **19,505 households in FY 24-25** (see page 34).

SDDT investments are successfully engaging BIPOC[§§] community members. Among participants who provided race/ethnicity data, 93% identified as BIPOC with the majority identified as Hispanic or Latino, followed by Asian and Black/ American individuals.

Among those who reported their age, **most participants were 24-65 years old.** The Healthy School Grant programs primarily served school-aged youth (aged 6–17 years).

Race/ethnicity breakdown among participants served by all programs, FY24-25



[‡‡] Reported numbers on this page include all OHTF and HCG grantees. These programs were counted because they were initially funded through SDDT, though DPH provided non-SDDT one-time funds to prevent cuts when SDDT funds were reallocated.

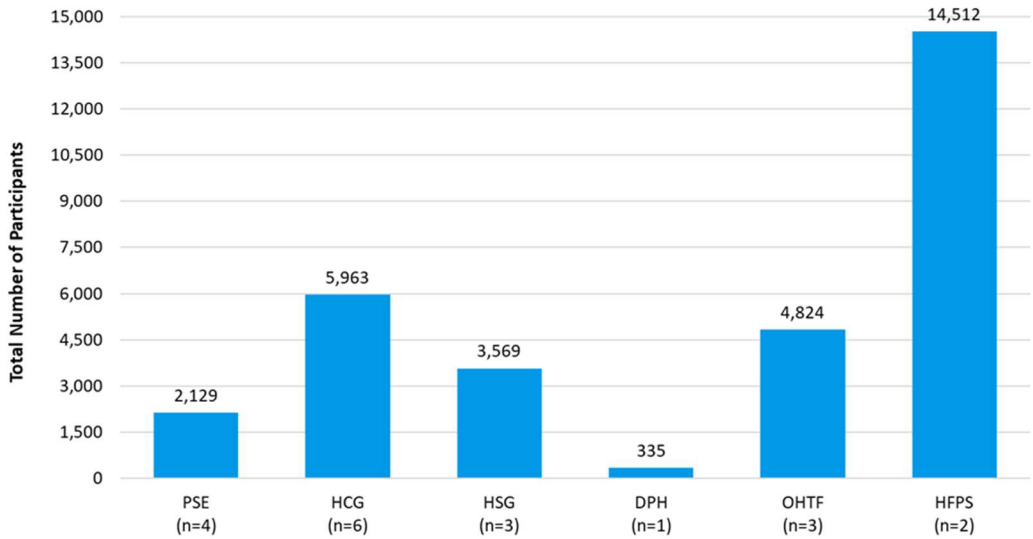
[§§] BIPOC participants *Black, Indigenous, and People of Color (BIPOC) is defined as anyone who self-identified as non-Hispanic White.

SDDT Program Strategies and Outcomes

The 19 funded programs fell under six program types: Policy, Systems and Environmental Change Grants (PSE); Healthy Community Grants (HCG); Healthy School Grants (HSG), Department of Public Health School-Based Dental Sealant Program (DPH); Healthy Food Purchasing Supplement Grants (HFPS); Children's Oral Health Task Forces (OHTF).

Funded programs employ strategies that are in alignment with the SDDT Evaluation Logic Model (page 10-11) that aim to **increase healthy behaviors including reducing sugary drink consumption, promoting tap water consumption, increasing fresh produce consumption, and increasing physical activity.** They also include **improving community and economic conditions.**

Total number of unique participants served by grantee program type, FY24-25



In FY 24-25, the most common program strategy was "increase community-driven health promoting education and services" (14 programs, 74%) followed by "Expand community capacity and develop leadership" (13 programs, 68%). Health education, food and nutrition education, and food distribution were the top three program activities. Grantees reported their programs focused on the following outcomes: increasing fruit/vegetable consumption (15 programs, 79%), decreasing sugary drink consumption (13 programs, 68%), and increasing food security (12 programs).

Top 3 Strategies (by # of programs)

1. Increase community-driven health promoting education and services (14)
2. .Expand community capacity and develop leadership (13)
3. Increase sustainability of healthy food systems and policies (10)
3. Increase access to and consumption of tap water (10)
3. Reduce availability and consumption of sugary beverages (10)

Top 3 Most Common Activity Types (by # of programs)

1. Health education (9)
2. Food and nutrition education (7)
3. Food distribution (5)

Top 3 Reported Outcomes (by # of programs)

1. Increased vegetable/fruit consumption (15)
2. Decreased sugary drink consumption (13)
3. Increased food security (12)

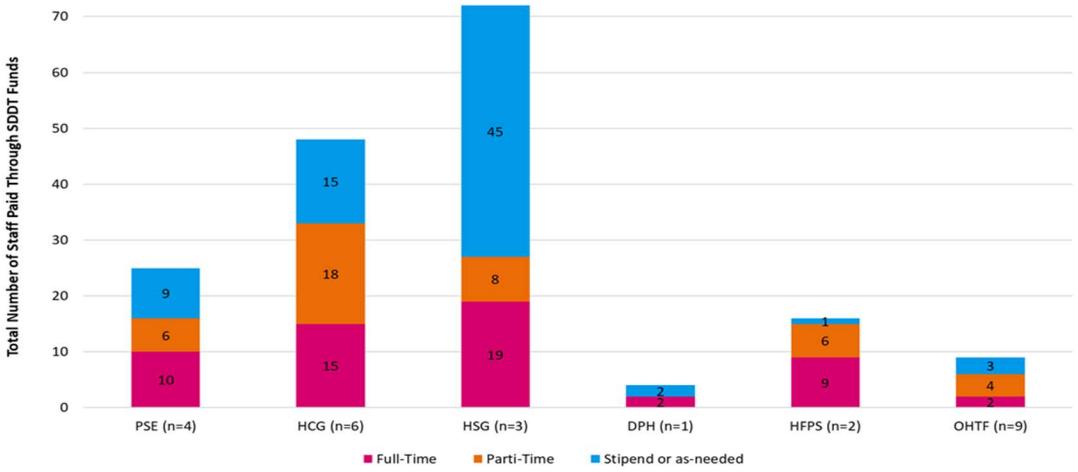
SDDT Programs Emphasize Cultural Responsiveness

Culturally responsive services are those that are shaped and informed by the languages, cultural practices, traditional knowledge, perspectives, and expressions reflective of the communities being served. Additionally, culturally responsive services are often provided by staff with **relevant lived experience and/or who are residents of the neighborhood they are serving.**

SDDT-funded programs and services are concentrated in the San Francisco neighborhoods with the highest burden of chronic disease and are staffed by residents of the same neighborhoods.

Neighborhoods with higher burden of nutrition sensitive disease	No. programs offering in-person activities in this neighborhood	No. Programs with participants from this neighborhood	No. programs with staff from this neighborhood
Mission	9	10	5
Bayview / Hunters Point	9	8	4
Excelsior	3	8	2
Potrero Hill	3	7	2
Outer Mission	4	6	2
South of Market	5	6	0
Visitacion Valley	4	6	1
Bernal Heights	4	5	2
Civic Center / Tenderloin	4	5	3

Total number of SDDT-funded staff stratified by grant type and full-time equivalent



The Healthy Schools Program employed the most people (72), followed by Healthy Communities (68) and PSE (25).

In FY24-25:

174 people were paid with SDDT funds as staff or stipended positions.

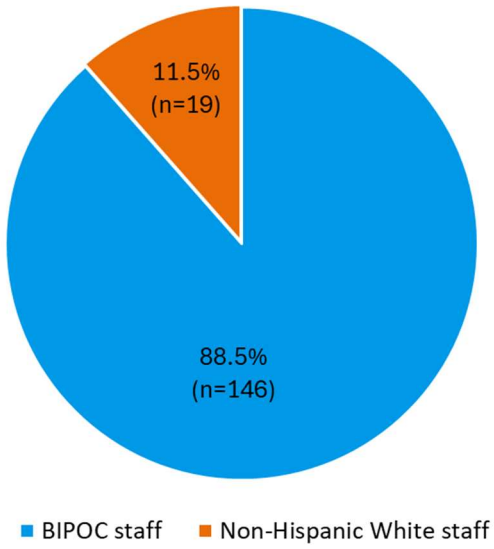
64 (39%) spoke one or more languages beside English.

38 (22%) were community health workers.

45 (25.9%) were youth ages 14-17 years old.

Positions funded through SDDT were diverse and included: **community health workers, youth interns, apprentices, program coordinators, program administrators, program managers, health educators, coaches/trainers, and leadership roles.**

Proportion of staff identified as BIPOC in FY24-25



Note: only staff with race/ethnicity data recorded (n=165) were included.

Approximately **89% of people paid identified as BIPOC.** The largest racial/ethnic group among staff identified as Hispanic or Latine (44%) followed by Asian (19%), Black/African American (12%), and White (11%). Staff identifying as Middle Eastern/North African (MENA), American Indian/Alaskan Native (AIAN), Native Hawaiian and other Pacific Islander (NHOPI), or multiracial together made up approximately 8% of all staff paid through SDDT.

Finding 2: SDDT investments continue to show improved healthy behaviors and attitudes related to drinking more water, drinking fewer sugary drinks, and increasing fruit and vegetable consumption and physical activity.

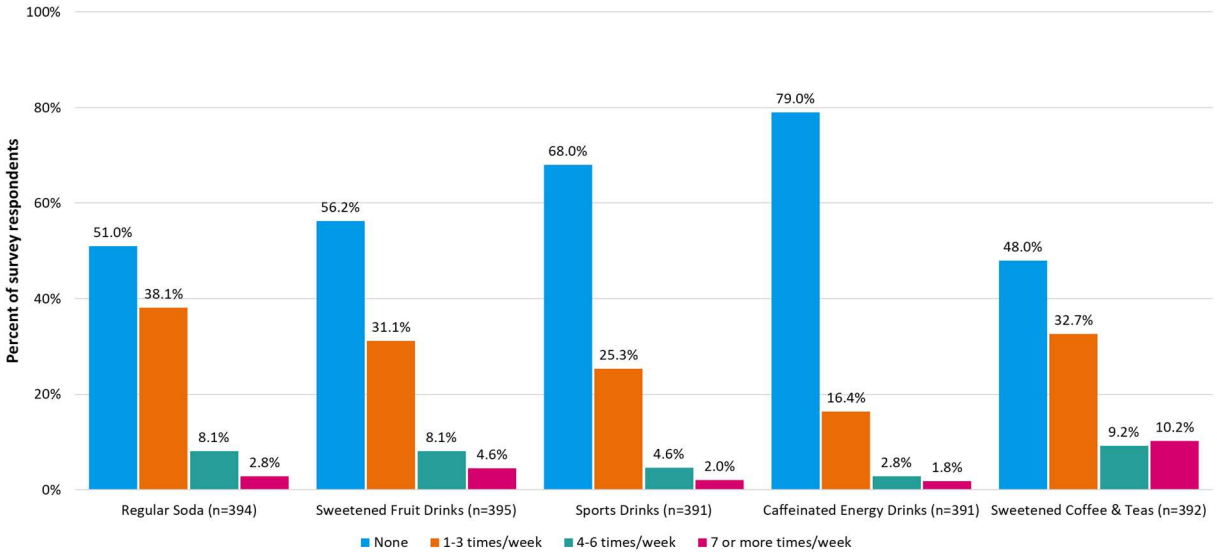
Sugary Drinks Consumption

SDDT participant surveys indicated that participants consumed a median of 3 sugary drinks in the past 7 days. Furthermore, **1 in 3 survey respondents reported consuming some form of sugary drink, either single type or in any combination, 7 or more times in the past week.** This suggests that on average, a **substantial number of survey participants still consume some sugar-sweetened beverages at least once per day in a typical week.**

The bar chart below shows number of sugary drinks consumed the past week, by drink type.

- The breakdown of regular non-diet soda, sweetened fruit drinks, and sweetened coffee/tea consumption in the past week was similar. More than half of respondents did not drink any, and approximately 1 in 3 respondents drank these beverage types 1-3 times in the past week.
- The proportion of participants who consumed any one type of sugar-sweetened drink 7 or more times per week was low across regular soda, sweetened fruit drink, sports drink and energy drink.
- Sweetened coffee and tea was consumed the most frequently – 1 out of 5 respondents consumed sweetened coffee and tea at least 4 times per week.

Weekly Sugary Drink Consumption among SDDT-Funded Program Participants, by Beverage Type



- Caffeinated energy drinks were consumed the least, nearly 8 out of 10 respondents did not consume any caffeinated energy drinks in the past week.

Among respondents, 52.4% of Hispanic or Latino/a/x individuals and 22.9% of Asian individuals reported consuming sugar-sweetened beverages (SSBs) seven or more times per week. Due to the small number of responses, data for Native Hawaiian and Other Pacific Islander, Black or African American, Multiracial, and White are suppressed.

Youth reported the highest consumption of SSBs. Among survey respondents that were younger than 18 years old, more than half reported having any SSBs 7 more times in the past week. In contrast, only 1 out of 5 seniors reported drinking SSBs 7 or more times per week. This finding aligns with the SDDT 2024 Data Report which found that Latino and Black/African American students were the most likely to consume at least one sugary drink the day prior to the survey while Asian students were the least likely (67%, 65%, and 54% for Latino, Black, and Asian students, respectively). **These patterns highlight the need for continued and targeted interventions to further reduce sugary drink consumption among youth, particularly within priority populations.**

SDDT Programs educate about the harms of sugary drinks and promote drinking water.

86% of participants surveyed believed that **sugary drinks can harm their health.**

Nearly **9 out of 10 (87%) participants surveyed started drinking water more often,** potentially indicating the effectiveness of SDDT-funded programs.

The proportion of participants who reported **increased water consumption after participation in the SDDT program** was highest among those who identified as **NHOPI, Asian and Latino.**

Age-tailored strategies may be needed to strengthen impact among younger participants. Over 90% of seniors and individuals aged 25–34 reported increased water consumption since participating in the program. In contrast, **only 76% of children and youth under 18 reported an increase in water consumption.**

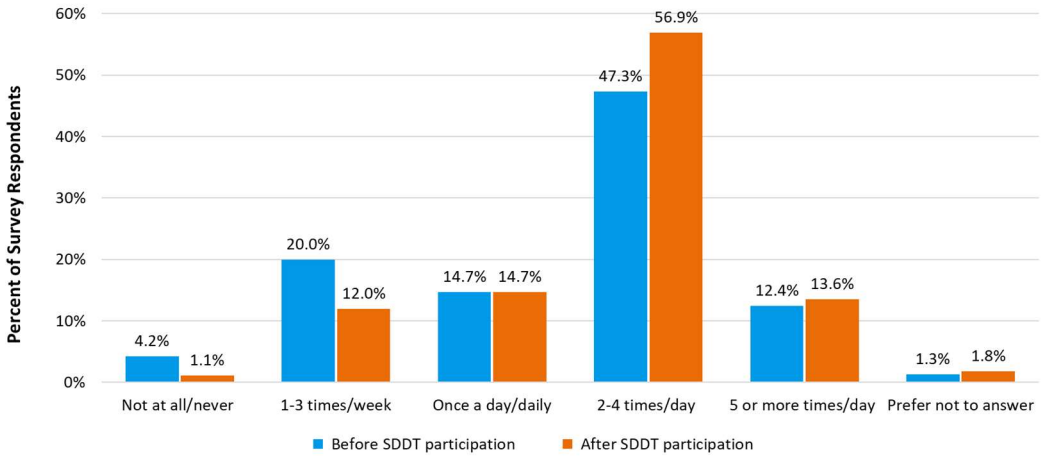
Fruit and Vegetable Consumption

The proportion of respondents who ate vegetables and fruit two or more times per day increased after SDDT program participation.

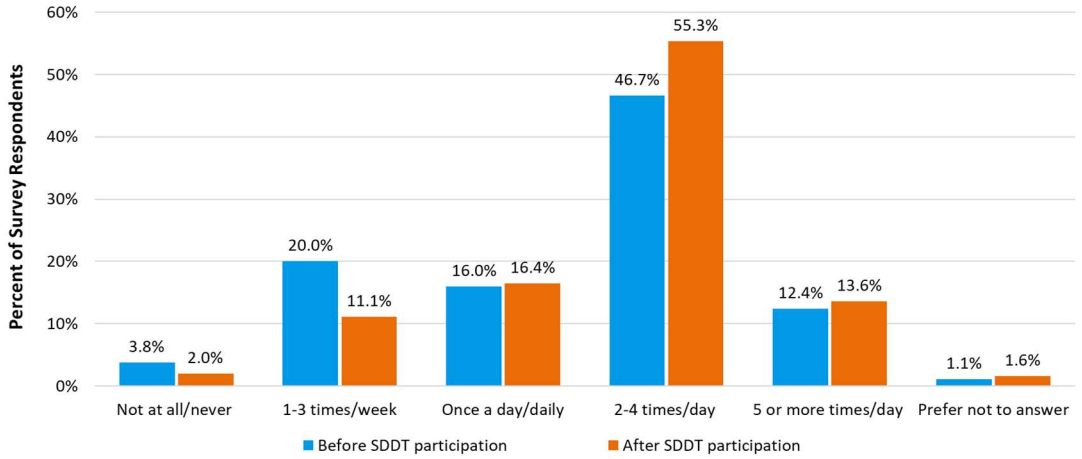
71% of respondents reported consuming vegetables at least 2 times per day after participating in a SDDT program. 69% reported consuming fruits at least 2 times per day after participating in a SDDT program. Conversely, the proportion of individuals who consumed vegetables and fruits infrequently (e.g., once a day or less) decreased, this may suggest that **the SDDT program positively impacted overall vegetable and fruit consumption among program participants in FY24-25.**

Nearly **90% of participants** surveyed agreed they **have been able to eat more fruits and vegetables**

Vegetable Consumption Before and After SDDT Participation (N=450)



Fruit Consumption Before and After SDDT Participation (N=450)



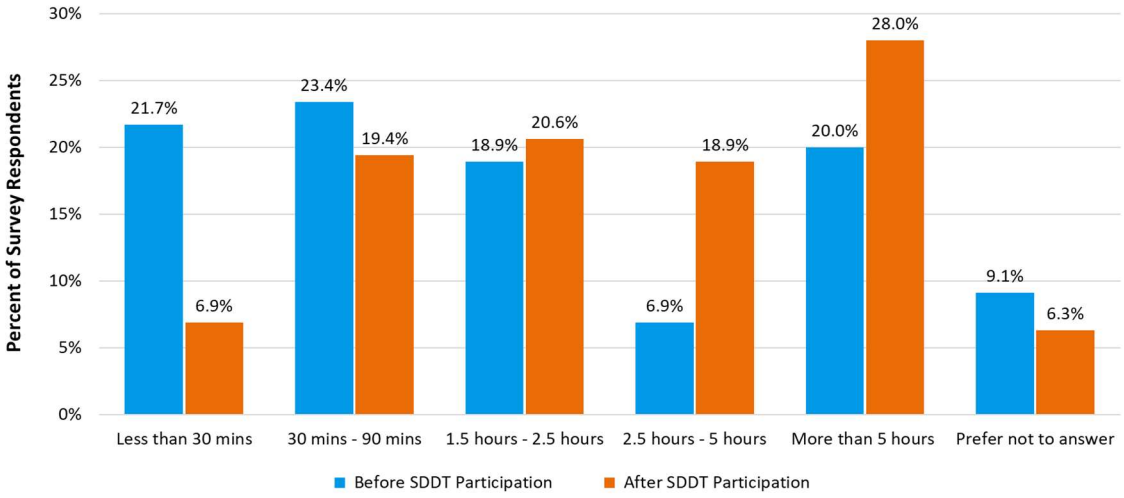
Physical Activity

After participating in an SDDT program, **50% of participants surveyed met physical activity guidelines compared to 30% prior to participation.**

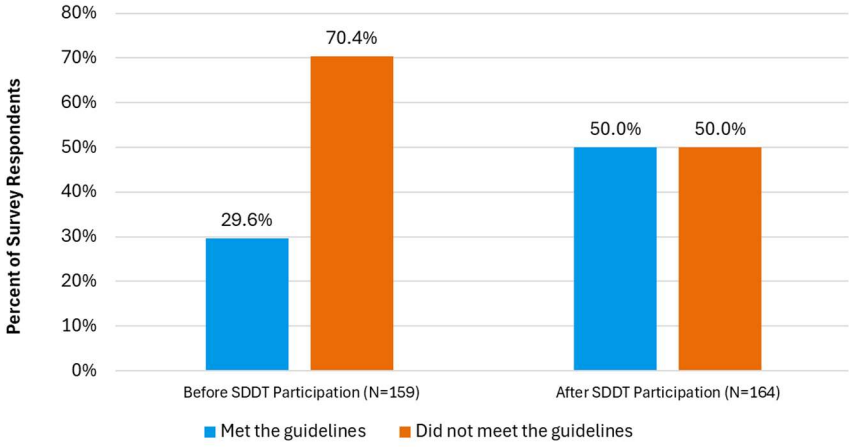
The proportion of survey respondents spending 1.5 hours or less per week on physical activities decreased after program participation. In contrast, the proportion of respondents spending up to 2.5 hours per week on physical activities, meeting the CDC physical activity guidelines***, increased.

Ultimate Impact summer camp participants and coaches.

Time Spent Doing Physical Activity Before and After Program Participation (N=175)



Proportion of program participants meeting vs. not meeting CDC guideline for physical activity before and after program participation



*** According to the Centers for Disease Control and Prevention, adults need at least 150 minutes of moderate-intensity physical activity a week.

Finding 3: SDDT investments continue to alleviate food insecurity through direct services and long-term system change strategies.

Although the food insecurity rate among adults in San Francisco earning less than 200% of the Federal Poverty Line (FPL), decreased from 67% in 2022 to 37% in 2023[2] disparities persist across geography, race and income. For example, neighborhood-level food security rates highlight gaps: Chinatown (30%), Tenderloin (25%), and Bayview Hunter's Point (23.2%) face rates 5-6 times the prevalence seen in neighborhoods like Marina, Presidio, and Pacific Heights (5%).[2] Food insecurity **increases risk of multiple chronic conditions including diabetes, heart disease and hypertension, and exacerbates physical and mental health conditions.**

SDDT funding has historically taken a comprehensive approach to improving food security by **supporting community-led services that directly help residents facing food insecurity, while also working to create long-term changes in systems and structures that contribute to the problem.**

The **Food Insecurity Screening assesses a person's ability to consistently and reliably access food** but does not necessarily tease out if the food participants can access is healthy. For example, someone may be food secure but still be unable to eat as many fruits and vegetables as they desire because they can only afford processed foods. **The Nutrition Security Screener allows us to assess if the participant needs support accessing healthful foods, specifically.**

The FY24-25 SDDT participant survey found:

72% of participants surveyed (337 total) identifed as experiencing food insecurity within the year.

When stratified by race/ethnicity, **71% of Latine, 74% of Asian, 70% of Black, and 73% of Native Hawaiian and Other Pacific Islander (NHOPI) survey respondents were food insecure.**

Approximately **one in three (39%) participants surveyed** also reported **needing support to access healthy food.**

The highest proportions were observed **among Latine respondents (47.3%) followed by Asian (22%).** Black/African American, White, and NHOPI data has been supressed due to small sample size.

Participant survey results suggest SDDT-funded programs may improve food security and increase fruit and vegetable access and consumption, particularly among food-insecure participants.

In FY24–25, seven SDDT-funded programs (18 Reasons, C.A.R.E. TNDC, Florence Fang Community Farm, Farming Hope, Urban Sprouts, and All My Uso's) offered direct food services at 54 locations, including groceries for home cooking and prepared meals, reaching approximately 6,600 individuals.

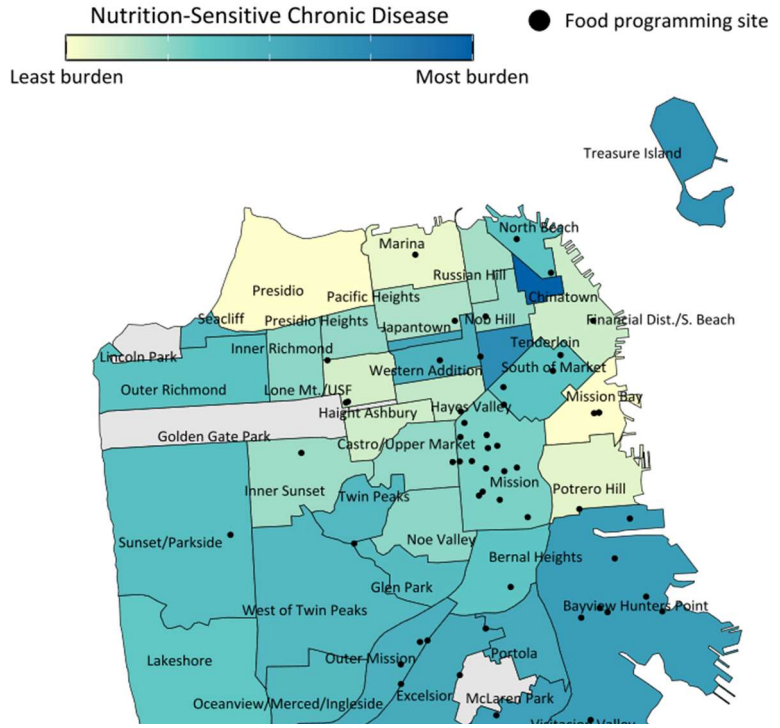
Food distribution sites were concentrated in neighborhoods with a **higher burden of nutrition-sensitive diseases including Chinatown, Tenderloin, Bayview Hunters Point, and Excelsior as well as the Mission, an area with moderate burden of diseases but notable health disparities.**

Additionally, SDDT funding supported SF Human Services Agency City-Wide Food Access Programs, extending reach to an additional 19,505 households (see page 35).

82 % of food insecure participants surveyed reported they worried less about having enough food after participation in an SDDT program.

92% of food insecure participants surveyed were able to eat more fruits and vegetables after participation in an SDDT-funded program.

SDDT program locations offering direct food service in FY24-25 overlaid the prevalence of nutrition-sensitive disease burden in San Francisco



Data source: PLACES. Data source: PLACESCenters for Disease Control and Prevention (2024) and SDDT grantee submitted report.: Local Data for Better Health (2024) and SDDT grantee submitted report.
Neighborhood profiles are defined by SFDPH and the Mayor's Office of Housing and Community Development, with support from the Planning Department. See https://data.sfgov.org/
Map created using RStudio V2025.09.0 [Computer software]

Healthy Food Purchasing Supplement Grants

The Healthy Food Purchasing Supplement (HFPS) is a grant program that increases the food budget for participating low-income San Franciscans while simultaneously incentivizing fruit and vegetable consumption. In FY 2024-25, the two HFPS grantees were Heart of the City Farmers Market (HOTCFM), which operates the Market Match program, and EatSF, which manages San Francisco's Vouchers4Veggies (V4V) program. Both HFPS programs are examples of **structural interventions** that increase access to healthy food options for low-income residents in San Francisco. By helping these residents incorporate more fruits and vegetables into their diet, HFPS programs have been shown to change long-term healthy nutritional behaviors and, thus, reduce health inequities.[3,4] Together, **the two programs served 14,510 low-income participants in FY 24-25.**

Market Match

Heart of the City Farmers Market (HOTCFM) operates Market Match, a statewide program of the Ecology Center partially funded through the California Department of Food and Agriculture and the USDA's National Institute of Food and Agriculture and is a lifeline for food-insecure families and California farmers that incentivizes CalFresh recipients to spend their benefits at farmers markets. For every dollar CalFresh shoppers spend with their EBT card at HOTCFM, they receive a dollar-for-dollar match—up to $30 per month.

In FY24-25,

- **11,941[†††] low-income participants were served.**
- Revenue generated by the Market Match Program:
  - Market Match incentives redeemed: $541,854
  - Total EBT sales: $1,368,938

EatSF/Vouchers for Veggies

Vouchers4Veggies (V4V) is a fruit and vegetable voucher program operated by EatSF. Vouchers are redeemable at local food retailers including corner stores, grocery stores, and farmers markets. In FY 2024-25, EatSF partnered with SF Department of Public Health and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to provide WIC participants with $40 per month in fruit and vegetable vouchers for twelve months.

In FY24-25:

- 2,571 low-income pregnant people were served.
- The majority of participants identified as Latina, followed by Asian and Black/African American.
- 10 WIC clinics distributed vouchers.
- 55 stores that accepted vouchers.
- $409,629 in vouchers were redeemed in FY23-24.[‡‡‡]

[†††] Note due to limitation of how unique participants were being tracked, the actual number of participants served was much higher than 11,941.
[‡‡‡] FY23-24 data became available in spring 2025 and is included here as an update to the FY2023-24 SDDT Evaluation Report.

Economic Impact of HFPS

In addition to helping low-income residents access fresh produce and stretch their household budgets, the HFPS grantees also make a **significant contribution to the local economy, especially supporting small and BIPOC-owned businesses.**

In FY 2024-25, HFPS funds directly supported local, small, and primarily BIPOC-owned corner stores and BIPOC farmers.

- **38 (69.1%) of V4V redemption site vendors were small businesses and/or BIPOC owned**. In FY 23-24, **$409,629 in vouchers were redeemed.**
- **$541,854 in Market Match incentives were redeemed and in combination with $1,368,938 in EBT sales**, generated **nearly $1.9 million in total food purchases and supporting local vendors at HOTCFM**.
- **41 HOTCFM vendors directly benefited from the increase in EBT sales,** while an additional 64 total vendors that did not accept EBT or Market Match vouchers (including hot food, cheese, and flower vendors) were positively impacted by the increased foot traffic in the market brought in by the program.
- About **50% of HOTCFM vendors were BIPOC local, small farm families.**

A small business owner stocks the produce section in a corner store.

Family farm vendors sell strawberries at the Heart of the City Farmers Market.

School Food/SFUSD

SFUSD's Student Nutrition Services (SNS) department provides over 40,000 meals per day across 136 schools across San Francisco. SDDT investments in kitchen facility upgrades and staff development from 2019 through 2021 allowed SFUSD middle and high schools to transition from pre-made Heat & Serve meals to **Refresh meals, which are freshly prepared on site from scratch with fresh and mostly local ingredients.**

20,997 SFUSD students attended schools serving daily fresh meals (Refresh).

53,785 activity sign-ins for food and nutrition education, urban agriculture/gardening, and/or health education.

9 Hydration Stations were installed in FY 2024-25.

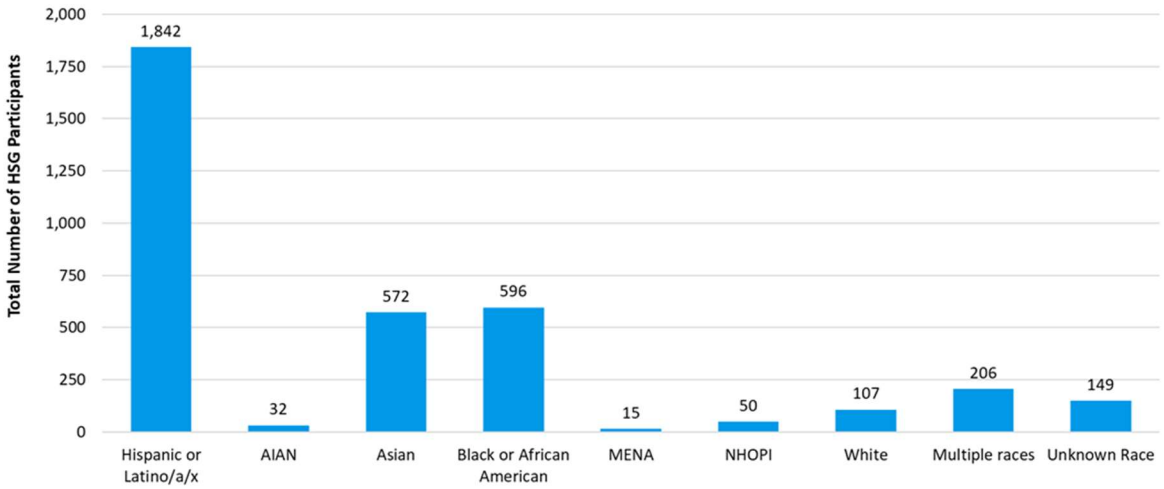
70 hydration stations have been installed since 2018.

SFUSD Muni Art Contents posters featuring student art promoting drinking water.

Healthy School Grants (HSG)

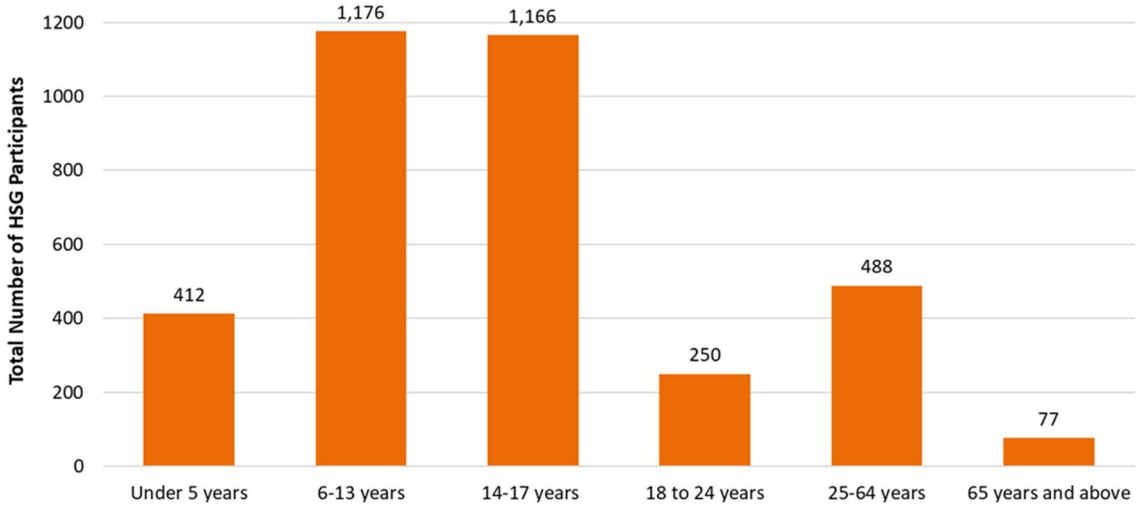
Healthy Schools Grants support organizations implementing programming that serve **high-priority San Francisco Unified School District (SFUSD) schools where over 60% of the students qualify for free and reduced school meals. Three organizations (Project Commotion, Ultimate Impact, and Urban Sprouts) were funded to bring movement, sports, urban agriculture, and youth development programing to SFUSD students.**

Race/ethnicity breakdown among participants served by HSG programs, FY24-25



Overall, **the Healthy Schools programs served 3,569 students, 94% of whom were low-income students.** Among participants with race/ethnicity data, the greatest number of participants identified as Hispanic or Latino, followed by Black/African American, and Asian. Two-thirds of those who reported age were between 6 and 17 years old. The Healthy Schools programs reached school aged children and youth as well as adult educators and parents.

Age breakdown among participants served by HSG programs, FY24-25



HSA Citywide Food Access Programs

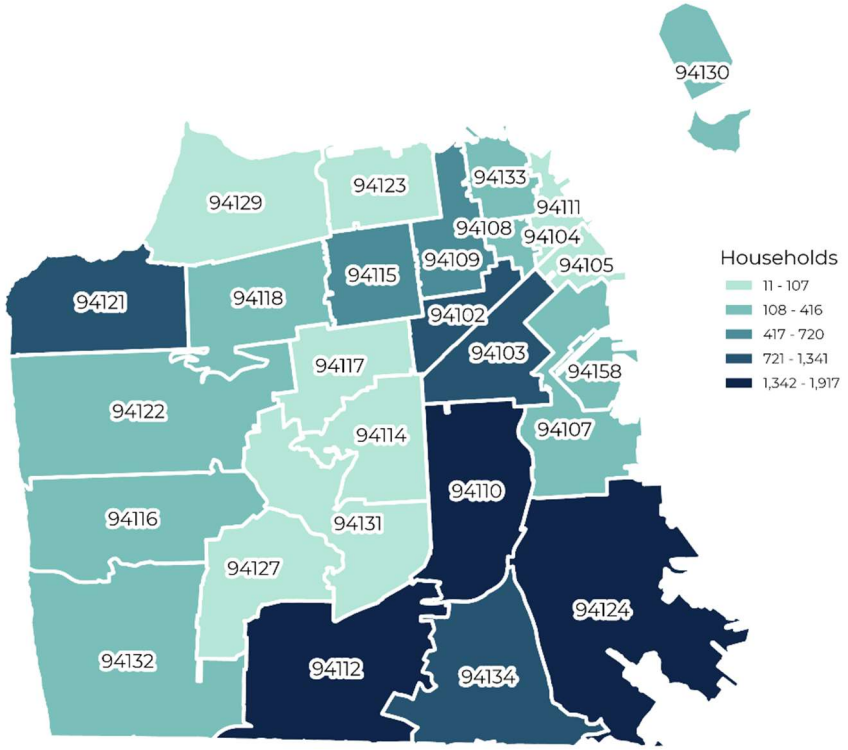
In FY 2024-25, SDDT funding was allocated to the HSA Citywide Food Access Team (CFAT) Programs for the first time. CFAT Programs, established in 2020 in response to increased food insecurity during the COVID-19 pandemic, address ongoing food and nutrition gaps by granting funds to community-based organizations to implement direct programming. SDDT funds supported $5.2 million (42%) of the total CFAT Program $12.5 million budget. Because SDDT funds contributed to the CFAT baseline budget, it is not possible to track the specific number of CFAT participants benefiting from SDDT funds. Therefore, the full portfolio of programs is included in this section.

In FY 2024-25, CFAT programs reached:

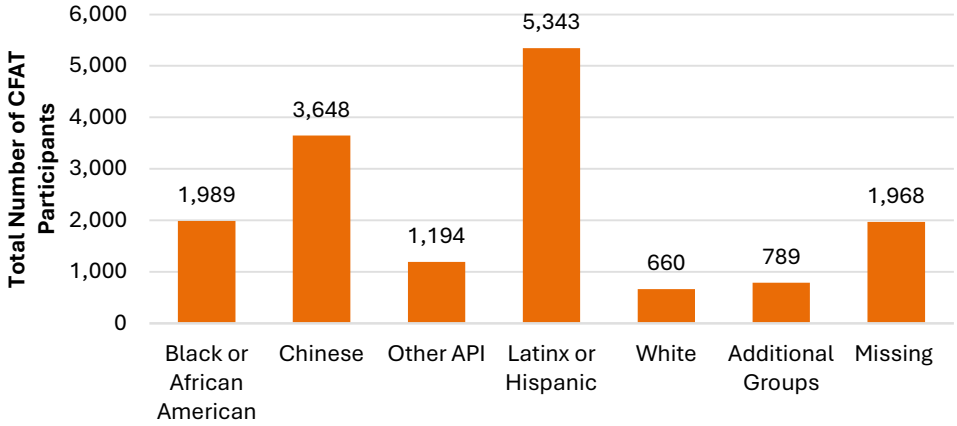
an estimated **19,505 households**

23 organizations across the city

FY24-25 CFAT Participant Residence by Zip Code



Race/ethnicity breakdown among participants served by CFAT programs, FY24-25



The largest proportion of participants identified as Latinx or Hispanic (34%), followed by Chinese (23%), Black/African American (12%), other Asian/Pacific Islander (8%), additional groups (5%), White (4%), and unknown (13%). The greatest number of participants were concentrated in 94112, 94124, and 94110. 94134, 94103, 94102, and 94212 also had large numbers of participants.

FY 2024-25 CFAT Programs Strategies and Impact

Program Area	Strategy	Funded Organizations in FY 24-25	Total Reach
Grocery Access	Culturally responsive food provided by neighborhood organizations tailored to local community preferences;	APA Family Support Services Bay Area Community Resources Bayanihan Equity Center Booker T. Washington Community Services Chinatown YMCA Curry Senior Center Dolores/Mission Action Farming Hope HOMEY Mission YMCA Self Help for the Elderly Southwest/IT Bookman Tenderloin Neighborhood Development Corp. The Richmond Neighborhood Center	253,218 grocery units distributed
Meal Support	Supplemental meals for families with young children and adults in need of a hot meal without another option (Tenderloin & other high-need areas)	SF New Deal for "Family Meal Pack"	233,655 meals served
Grocery Vouchers	Vouchers to purchase groceries at grocery stores and farmers market across the City; centering choice and healthy food access for low-income households	EatSF	196,133 grocery vouchers distributed
Community Food Production	Urban farms that provide freshly grown produce to low-income households in the community, while training	Friends of Alemany Farms Florence Fang Community Farm SF Housing Development Corp for Peacock Lounge Farming Hope Chinatown YMCA	39,609 pounds of produce grown

A survey (n=5,040) conducted by HSA in FY24-25 found:

66% of CFAT participants were food insecure.

92% reported their household was less hungry as a result of the program, demonstrating the program helps alleviate food insecurity.

89% of respondents reported being able to eat more fruits and vegetables as a result of the program, strengthening nutrition security.

Finding 4: SDDT investments strengthen connections and leadership in communities most impacted by health inequities, leading to long term benefits.

SDDT-funded programs build community connections.

In FY 2024-25,

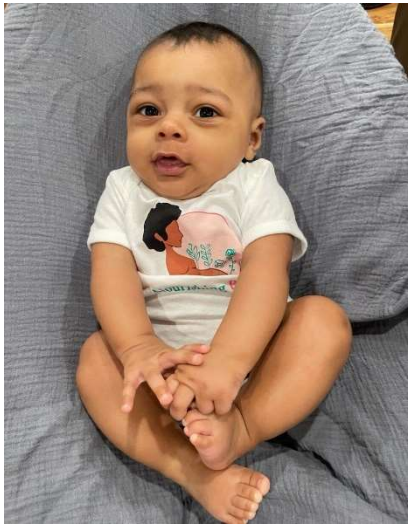
87% of participants surveyed agreed with the statement that they **felt more connected with others** after participating in an SDDT program.

88% of participants surveyed reported having a **positive outlook on their future** since participation in an SDDT program.

99 Tenderloin Food Policy Council members traveled to Sacramento on 2025 Hunger Action Day to meet with legislators, advocate, and participate in a rally.

Policy, System, and Environmental Change (PSE) Grant Program

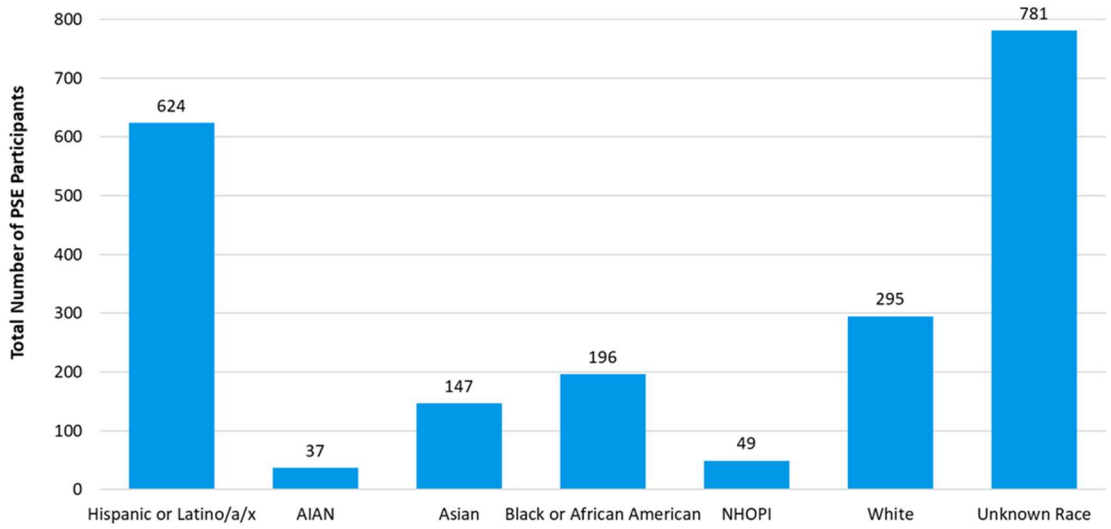
Launched in 2020, the SDDT Policy, System, Environmental Change (PSE) Grant Program provided multiple years of grant funding to support population-level change through community-driven policy, system, environmental (PSE) interventions. Amidst the COVID-19 pandemic, the PSE grantees quickly pivoted to provide direct food and social supports during a time of immediate need. The community trust gained throughout the pandemic laid the foundation for the grantees to work alongside the communities they serve to identify key issues and develop system-level strategies to address them. **From 2020 through 2025, the PSE grantees served 12,341 participants and supported communities by providing food and social services, provided health education, and developed leadership and knowledge for community members, and amplified community voices to advocate to make system-level change.** At the end of FY 24-25, due to the city-wide budget deficits, SDDT funding previously allocated to the PSE program was shifted towards food security and the program sunsetted on June 30, 2025.



A healthy 18 Reasons Nourishing Pregnancy baby.

In FY 24-25, PSE programs reached **2,129 San Franciscans with tailored education, direct nutrition and food supports, and built community leadership and voices to advocate for change**. 18 Reasons reached 193 pregnant people with weekly groceries and culturally relevant prenatal nutrition education. Race/ethnicity data was available for approximately 37% of the PSE program participants. Among 1,348 PSE participants with race/ethnicity data, nearly half of the participants were Latine, followed by White, Black/African American, and Asian. Two-thirds of those who reported age were between 25 and 64 years old.

Race/ethnicity breakdown among participants served by PSE programs, FY24-25



Abbreviations: AIAN, American Indian / Alaskan Native; NHOPI, Native Hawaiian and Other Pacific Islander.

PSE Grantee Highlights (Funding term: FY 2020-21 to FY 2024-25)

Organization | Project	18 Reasons | Medically Supportive Food for Pregnant People	CARECEN SF | Water Confidence in SF's Latine Community	Tenderloin Neighborhood Development Corporation (TNDC) | Tenderloin Food Policy Council
Direct Services	Launched **Nourishing Pregnancy,** a 6-month program delivering weekly groceries and culturally relevant prenatal nutrition education to low-income Black and Latine pregnant people. *"This program was a blessing during my postpartum period. Having a space to talk about things we're going through and relating to others. I truly felt a weight lifted off of me in terms of always having the food staples and especially with the recipes and having different healthy options for dinner. My five year old started eating carrots and that's huge because he never eats vegetables. So thank you thank you thank you!!!" – Nourishing Pregnancy Participant*	Provided **connections to essential social services such as food assistance, housing, and medical care** to individuals and families, which was critical during the pandemic years.	Opened **Kain Na**, a free community market in Mission Bay, which distributed groceries twice weekly to 639 food-insecure households in FY24-25. **Food Justice Leaders** provided sugary drinks education and water promotion in partnership with Tenderloin corner stores at least once a week for five years.
Increased community capacity and partnerships	Partnered with **over 50 San Francisco organizations** to bring the Nourishing Pregnancy to more pregnant people.	Trained **16 *promotoras* (Community Health Workers) to provide essential services, drive water advocacy pilot, and advocate for improved policy.**	Organized residents to form the **Tenderloin Food Policy Council**, advocating for food justice and systems change.

		Conducted a **community assessment reaching 217 community members** and stakeholders revealing high distrust in tap water and high sugary drink consumption among Latine residents.	The Food Policy Council hosted monthly multilingual meetings—in English, Cantonese, Arabic, and Spanish—bringing together 60–75 Tenderloin seniors, immigrant families, disabled individuals, and BIPOC residents.
Outcomes (short-term)	**Served an estimated 4,481 participants over five years.**	**Served an estimated 2,203 participants over five years.** Partnered with SF Public Utilities Commission to implement a pilot that increased trust in tap water from 10% to 47% through culturally tailored education and free home lead testing. *"I was at SF General Hospital waiting for my 85% of the survey respondents started drinking water more often, indicating the effectiveness of the educational programs offered by SDDT. medical appointment and realized I was so thirsty. I saw a water fountain and normally I would not drink from it, but because of these community meetings and all the information I've received about the quality of San Francisco's water I decided to drink from the water fountain. And*	**Kain Na served an estimated 1,243 people over five years.** Healthy Retail and Food Policy Council programs served an estimated 4,481 people.

		the water even tasted good!" CARECEN SF Program Participant	
Outcomes (long-term)	In 2025, 18 Reasons secured a contract (through Anthem) to offer Nourishing Pregnancy as a CalAIM benefit, **creating a sustainable funding stream for medically supportive groceries through Medi-Cal.** **18 Reasons will be expanding the model to Merced, Monterrey, and Santa Cruz** and as of June 30, 2025 were exploring expansion in San Mateo and Santa Clara Counties.	**Provided training to SF Public Utilities Commission (SFPUC) on how to craft culturally responsive messaging and outreach materials** to the Latine immigrant community ensuring SFPUC can continue to improve attitudes around drinking SF tap water. **Empowered community members to advocate for their needs.** *"It is not easy to make public comments. It is very scary, especially if you do not speak English and you are not from this country. But I felt like I had to do it because this program has meant so much to me. I have learned so much and I felt I could speak out because I knew that CARECEN was supporting me." – Community Member and participant in CARECEN program"*	**Kain Na served as proof of concept for a community and food hub,** a model that has been adopted by and expanded upon by the SF Marin Food Bank. In 2024, the FPC **amplified Tenderloin community voices to successfully preserve $35 million in statewide Market Match funding,** protecting the program for low-income families across California.

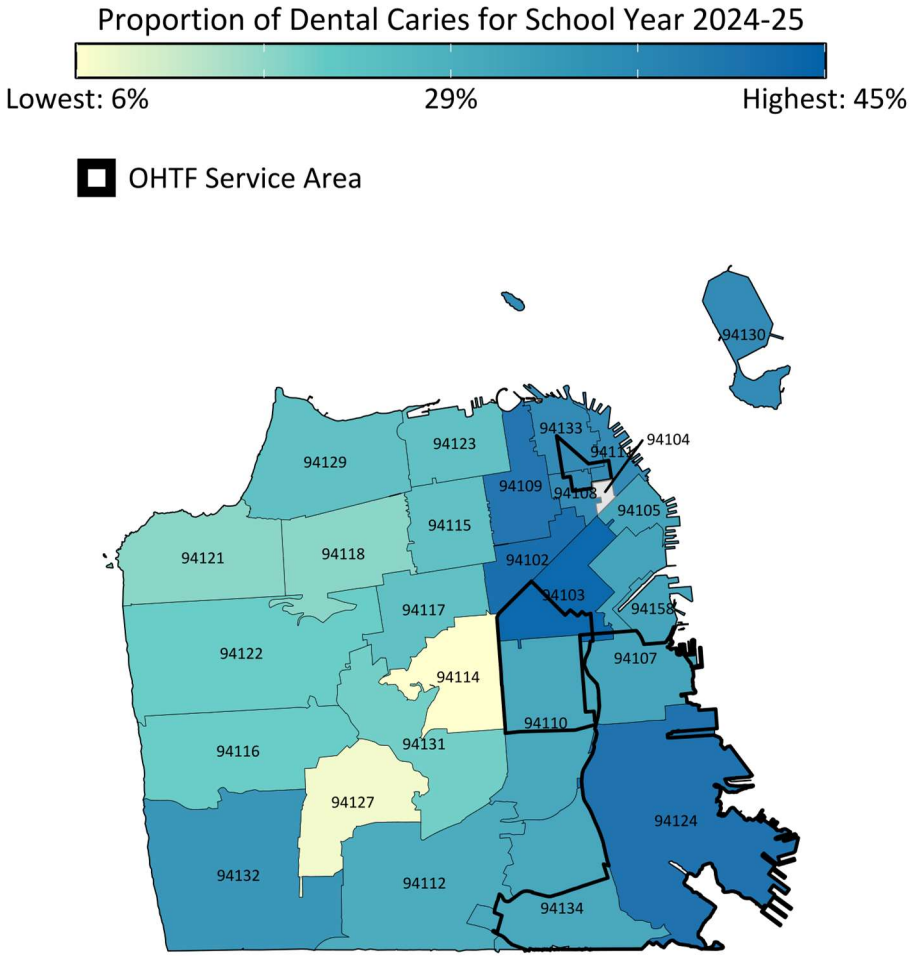
Oral Health Programs – CavityFree SF

CavityFree SF is a citywide collective impact partnership dedicated to achieving optimal oral health for all San Francisco children. The partnership aims to eliminate oral health disparities by influencing policy and establishing systems that provide preventive services and treatment. Utilizing a **collective impact model**, they work with partners across the city to **promote healthy behaviors and increase access to oral health care for children.** The partnership has been funded through a combination of private grants, state funding, and SDDT. The SDDT programs within the CavityFree SF initiative are the **DPH School Based Dental Sealant Program** and **Children's Oral Health Task Force Community-based Grant Program**. The two programs work hand-in-hand to promote healthy habits and link to oral health care services (Task Forces) and provide access to clinical preventative services (Dental Sealant Program). In FY 2024-25, the SDDT funding for the Task Forces was directed to other program areas and SFDPH identified one-time funding to continue the grant program at reduced service levels.

The **Children's Oral Health Task Forces (Task Forces) are community health collaboratives in Chinatown, the Mission, and District 10, areas with some of the poorest children's oral health outcomes in San Francisco.** The Task Forces aim to increase access to dental and oral healthcare, provide culturally and linguistically responsive oral health education, and collaborate with other oral health stakeholders through CavityFree SF.

In FY 2024-25, each Task Force conducted messaging and oral health education to residents of the target neighborhoods and to children and families enrolled in four SFUSD elementary schools (ES) including Gordon J. Lau ES, John Yehall Chin ES, Mission Education Center, and

Areas served by Oral Health Task Forces: Chinatown, Mission, and District 10 and the proportions of children experiencing dental caries in school year 2024-25



Data source: San Francisco United School District and San Francisco Department of Public Health Kindergarten Oral Health Assessment Program from the 2024-25 school year.

The following adjacent zip codes with fewer than 20 children and similar percent dental caries were combined to protect student privacy: 94105, 94107 and 94158; 94108, 94133, 94111 and 94130; 94115 and 94117; 94123 and 94129; 94116 and 94122; 94118 and 94121.

Children with missing zip code data were excluded. No data were available for zip code 94104.

Cleveland ES. **They collectively reached 4,824 participants, of which over 99% were SF residents.** Among the 1,040 participants of the Task Force program with race/ethnicity data, more than half identified as Hispanic or Latino/a/x, while Black or African American participants represented the second largest racial/ethnic group served by the Task Forces in FY24–25.

In FY 2024-25, DPH's School Based Dental Sealant Program had limited reach due to a delay in the memorandum of understanding (MOU) with SF Unified School District (SFUSD) and the resignation of two clinical staff. The program conducted screenings and oral health education in the same target SFUSD elementary schools where the Task Forces focused efforts (Cleveland ES, Gordon J. Lau ES, John Yehall Chin ES, and the Mission Education Center). Out of 476 enrolled 2nd and 5th graders at these schools, 368 (77%) consented to receiving services, and 335 (70% of enrolled) were screened for the application of sealants, 11 (2% of screened) children were identified as having active caries needing urgent care, and zero received dental sealants due to staff vacancies.

The impact of the deep collaboration amongst CavityFree SF partners can been seen in parental consent rates for the DPH Dental Sealant Program. In the schools where the Task Forces focused their efforts, the consent proportion for sealants was 77% compared to historical citywide proportion lower than 50%. Consent forms are critical to SFUSD students receiving screenings and sealants.

At the end of FY 24-25, DPH one-time funding was no longer available and SDDT funding was not restored, so the Task Forces had to lay off many key personnel. However, they remain committed to the work and continue to seek a sustainable funding source to support the communities they serve.

DPH Dental Sealant Staff and the D10 Oral Health Task Force (Dental Robin Hood) staff conduct outreach at a community event.

Dental practitioners conduct screenings at Gordon J. Lau Elementary.

SF Department of Recreation and Parks (RPD)

In FY24–25, San Francisco Department of Recreation and Parks (RPD) did not receive SDDT funding for the first time since 2019 as funding was directed to other program areas. Despite this, **Peace Parks and Requity**—both flagship programs originally launched with SDDT funds—**continued in FY24-25 with one-time funds** amid citywide budget cuts. After FY24–25, Requity was sunsetted, while Peace Parks will continue as a citywide program. This transition highlights the **legacy of SDDT as an investment that spurred equity-centered programs within City departments, even after direct funding ended.**

FY 24-25 Peace Parks Program sites:

- Joseph Lee Rec Center
- Herz Playground
- Youngblood Coleman Park
- Garfield Clubhouse
- Margaret Hayward Playground
- Potrero Hill Rec Center

Requity Scholarships for FY24-25 (final year):

- $459,071 was awarded to 393 recipients.
- Recipient categories: unhoused (n=75), public housing (n=302) and foster children (n=16)
- Due to summer landing between 2 fiscal years, scholarship data is for Summer 2024 to Spring 2025.

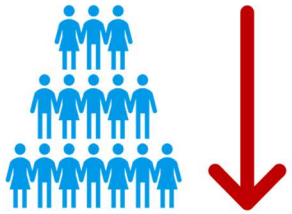
Peace Parks staff group photo

Conclusion: Significant shifts in SDDT funding in FY24-25 were disruptive and will have lasting impacts on communities and the organizations that serve them.

While SDDT continues to demonstrate measurable benefits, shifts in funding priorities led to mid-cycle reductions to community-based organizations. These cuts were extremely disruptive and resulted in gaps in service delivery, reduced program reach, loss of community trust, and ultimately resulted in the elimination of key programming and layoffs.

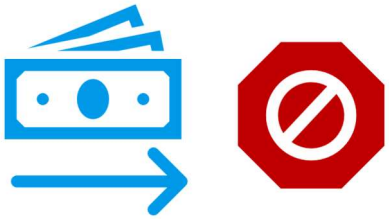
Key Impacts of Shift in Funding Priorities

88,912 → 31,332
(↓65%)
Participants served



29 → 19
(↓34%)
Programs funded

$5.3M out of $11.6M (45%) redirected to SFHSA Citywide Food Access Programs



Reductions, delays, and/or sunsetting of equity-based programs: PSE and Healthy Communities Grants, Children's Oral Health Task Forces, Peace Parks, Requity.

- **SDDT-funded staff positions face instability and risk of layoffs.** In FY24-25, SDDT supported 174 staff positions at community-based organizations, including 38 community health workers. Unstable funding puts these jobs at risk and threatens access to essential services.
- **Reduced access to culturally-responsive health education and oral health programs.** For example, due to loss of funding, CARECEN laid off their bilingual, bicultural Heath Promotion team (3 full time staff) and *promotoras* (13 stipend positions), effective June 30, 2025, representing a devastating loss in personnel who were skilled in delivering culturally responsive services to the Latine

community. Heightened fears around immigration enforcement and discrimination within the immigrant Latine community make trusted, culturally competent staff even more critical.

- **Loss of leadership and workforce development opportunities in priority neighborhoods and populations.** For example, funding was eliminated for All My Usos Fa'atasi Youth Services' program to train and support NHOPI CHWs and address some of the greatest health disparities in San Francisco (NHOPI adults are admitted to the hospital for type 2 diabetes at a rate six times greater than the overall average[5]).
- **Erosion of trust built through long-standing partnerships.** Mid-cycle funding cuts disrupt programs and further disenfranchises communities, as programs come in with promise but end abruptly when funding priorities shift.

Recommendations

This evaluation report demonstrates both the progress and the vulnerabilities of SDDT-funded efforts. Programs have shown to reduce sugary drink consumption, promote tap water, improve food security, and build trusted partnerships in priority communities. Yet the progress is at risk due to unstable funding and systemic barriers. Mid-cycle cuts have led to staff layoffs, loss of culturally responsive services, and erosion of trust—threatening the infrastructure that supports health equity. The following recommendations focus on investments in evidence-based and data-informed strategies to strengthen the achievements of SDDT, promote sustainability, and ensure accountability for long-term, equitable impact.

1) **Increase awareness about the negative impacts of sugary drinks and to reduce sugary drink consumption, especially among priority populations.**
   Based on the results of the SDDT participant survey, a substantial number of survey participants still consume sugar-sweetened beverages at least once per day in a typical week and sweetened coffee/tea and regular soda have the highest rates of daily consumption. SDDT should invest in greater levels of education on the health harms of excessive consumption of SSBs and the beverage industry's continued financial exploitation of BIPOC communities. All SDDT-funded programs and interventions should include information about the health harms of SSBs in interactions with community members.

2) **Promote tap water consumption through culturally responsive strategies.**
   Continue to utilize SDDT-funded entities to address perceptions and beliefs of reported concerns with the safety of drinking tap water with special attention to immigrant communities. Continue to work on environmental and systems changes (e.g., hydration stations and institutional policies and practices around serving drinking water) that support tap water consumption.

3) **Prioritize youth-focused strategies that reduce sugary drink consumption and promote tap water from early childhood through transition-age youth (TAY).**
   Based on the results of the SDDT participant survey, youth have the highest rates of sugary drink consumption and progress in encouraging water consumption is less pronounced in children/youth. Therefore, SDDT should invest age-tailored messaging and interventions to reduce excessive soda consumption and promote drinking water in children and youth.

4) **Invest in systems-level changes and comprehensive strategies to ensure equitable and sustained benefits to community health and wellbeing.**
   For example, address food insecurity through a comprehensive approach that includes direct services, upstream systems change, and educational programming to ensure increased access to and knowledge about healthy, nutritious foods in the long term.

5) **Invest in leadership development and job opportunities that support stronger, more resilient neighborhoods with meaningful connections to local, state, or national decision-makers.**
   Uplift community members from SDDT priority populations to strengthen skills in implementation, evaluation, and policy engagement. Facilitate opportunities for SDDT-funded partners and community leaders to connect with local, state, and national decision-makers so community-informed perspectives shape policy, systems, and environmental change efforts and contribute to long-term neighborhood resilience.

6) **Strengthen and support SDDT evaluation efforts.**
   Robust, comprehensive evaluation is essential to demonstrate SDDT's impact on health equity and ensure SDDTAC recommendations remain evidence-based and data-driven.

   Invest in SDDT-funded entities to build capacity to collect participant demographic data which are critical to understanding SDDT-funded program reach and assessing impact to advance health equity. Continue participant surveys to document changes in knowledge, attitudes, beliefs, and behaviors. In addition, systematically evaluate SDDT-funded structural interventions over time to assess their sustained and population-level impacts.

7) **Ensure stable funding to support chronic disease prevention.**
   Shifts in funding priorities have led to mid-cycle grant reductions to community-based organizations, causing significant disruptions including gaps in service delivery, reduced program reach, loss of community trust, and ultimately the elimination of key programs and staff layoffs. Ensure that the Mayor allocates per the recommendations and evaluation of the SDDTAC, as voters intended.

A dedicated revenue source, such as a dedicated soda tax or a community reinvestment fund—would ensure stable, predictable funding and protect programs and the communities they serve.

Contributor Biographies

Christopher Lee, MPH

Christopher Lee is an epidemiologist on the Health Equity team in the Center for Data Science - Population Health Division at the San Francisco Department of Public Health (SFDPH). Before working with the Health Equity team at SFDPH Christopher worked on the COVID-19 response for San Francisco and Santa Clara County where he co-led the development and maintenance of both internal and public reporting systems. Prior to Santa Clara County Christopher worked at the UCLA Center for Health Policy Research where he helped evaluate the efficacy of public health policy work.
Contribution: Review of participant data.

Melinda Martin, MPH

Melinda Martin, MPH, Healthy Eating Active Living Team in the Community Health Equity and Promotion Branch of SFDPH. She is the backbone staff for the Sugary Drinks Distributor Tax Advisory Committee. The advisory committee makes recommendations to the Mayor and the Board of Supervisors on the effectiveness of the Sugary Drinks Distributor Tax (SDDT), evaluates the impact of SDDT and funding recommendations regarding potential establishment of programs to reduce the consumption of sugar-sweetened beverages in San Francisco.
Contribution: Report review and editing.

Kaela Plank, MS, MPH

Kaela Plank is the Health Equity Program Manager in the Center for Data Science - Population Health Division at SFDPH. In this role, she supports SFDPH in using data to inform public health practice and advocating for policy, systems, and environmental changes that support health. Prior to joining SFDPH, Kaela worked at the Nutrition Policy Institute where her research focused on food security, school meal access, and evaluation of the CalFresh Healthy Living Program.
Contribution: Data cleaning and analysis, results interpretation and editing of final report.

Marianne Szeto, MPH

Marianne Szeto, MPH, is the Chronic Disease Prevention Programs Manager in the Community Health Equity and Promotion Branch of SFDPH. Marianne leads the Healthy Eating Active Living (HEAL) Team and provides backbone support for the Shape Up SF Coalition and the Sugary Drinks Distributor Tax Initiative. In partnership with many key stakeholders, Marianne's efforts helped lay the foundation for the San Francisco soda tax by implementing education and awareness campaigns and training community partners and health equity coalitions on the health impacts of sugary drinks and industry tactics. She holds a Master of Public Health from San Jose State University and a Bachelor's in Classics from UCLA.

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Kim Wong, MPH

Kim Wong, MPH, Healthy Eating Active Living (HEAL) Team in the Community Health Equity and Promotion Branch of SFDPH. As the Wellness Grants Coordinator, Kim oversees request for proposals (RFP) processes to distribute SDDT funds per SDDTAC recommendations, manages contracts with SDDT grantees, and provides technical assistance and capacity building support to SDDT funded entities. Prior to joining SFDPH, she managed nonprofit wellness, nutrition, and healthy food access programming in New York City (BronxWorks) and San Francisco (SF Marin Food Bank). Kim earned her Bachelor's from UC Davis and MPH from CUNY School of Public Health at Hunter College.

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Cathleen Xing, PhD, MPH, CPH

Cathleen Xing, PhD, MPH, CPH is an epidemiologist on the Health Equity Team within the Center for Data Science - Population Health Division of SFDPH. She contributes to data analysis and reporting initiatives, including SDDT, Gender Health, and Vision Zero SF. Before joining the Health Equity Team, Cathleen worked at SFDPH's Tuberculosis Control Branch, where she was also activated to support the COVID-19 pandemic response. Cathleen graduated from Rutgers University in 2019, where she conducted breast cancer research at the Rutgers Cancer Institute of New Jersey, focusing on health disparities among Black/African American women.

Contribution: Data cleaning and analysis, results interpretation, and editing of final report.

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