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

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# 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](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.



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## 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)

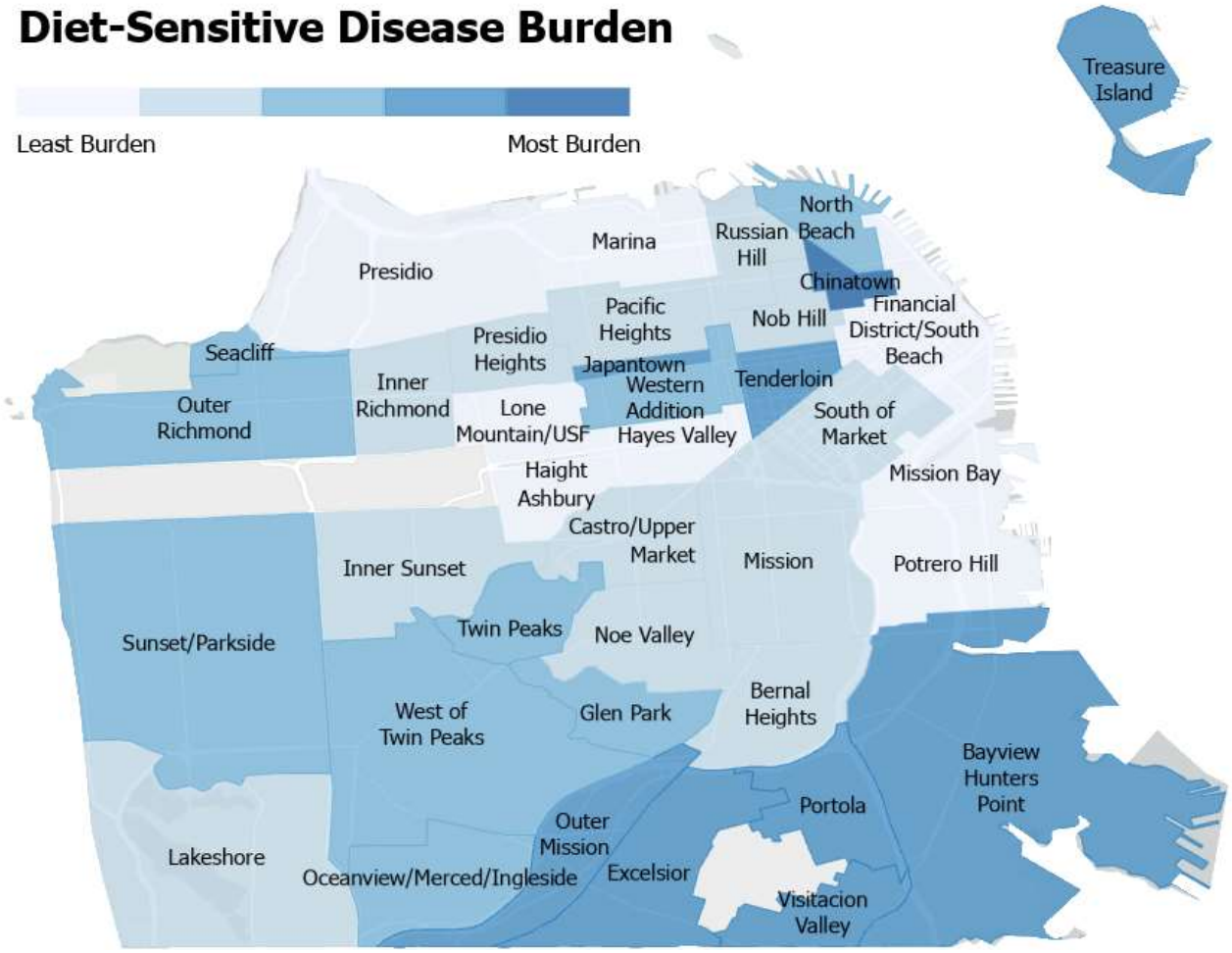
Although these priority populations are distinct, there is also considerable overlap between them, with many community members belonging to more than one of these communities and, thus, experiencing multiple intersecting and cumulative inequities.

### 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<br>• Increase community-driven health promoting education and services<br>• Increase sustainable employment opportunities | • Improve behavioral outcomes<br>» Decrease in sugary drink consumption<br>» Increase in tap water consumption<br>» Increase in fresh produce consumption<br>» Increase in breast/chestfeeding<br>» Increase in physical activity<br>• Improve community and economic conditions<br>» Increase in economic opportunity and stability<br>» Increase in food security |
| Mitigate structural inequities to create **Healthy Communities** | • Reduce availability and consumption of sugary beverages<br>• Increase access to and consumption of tap water<br>• Increase sustainability of healthy food systems and policies to increase access to healthy food<br>• Expand access to places that promote physical activity<br>• Reduce gaps in oral health services for children<br>• 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

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[‡] 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:**

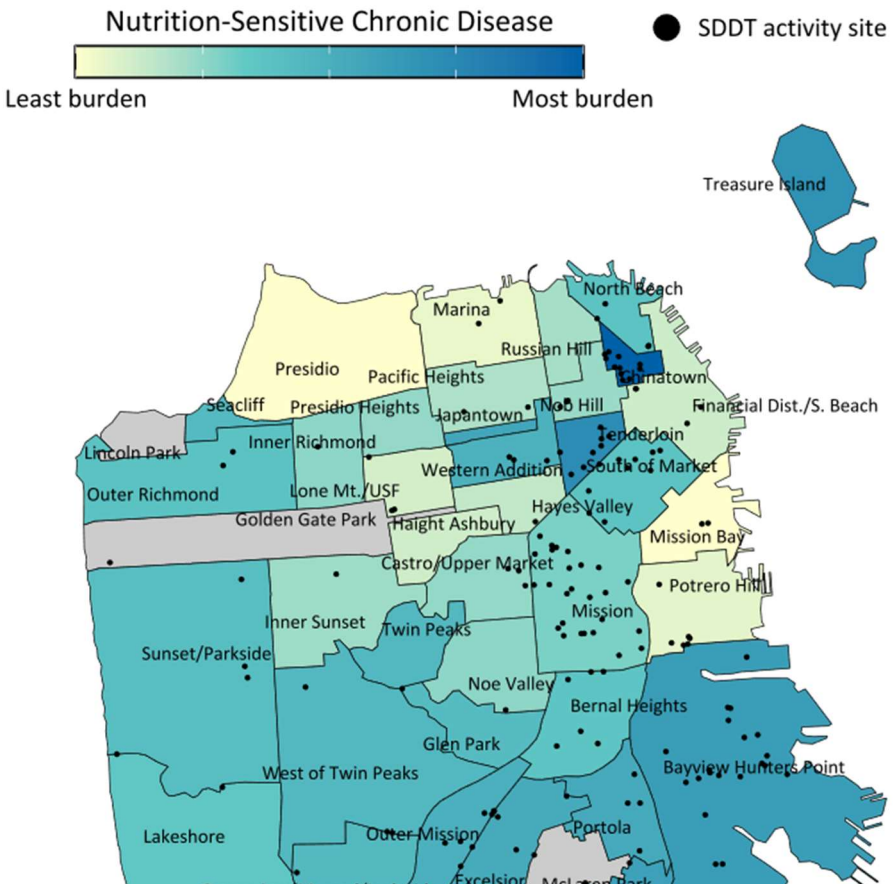
| | | |
|---|---|---|
| **19 programs** across **159 sites** in San Francisco. | **31,332 participants,** of which, over 28,606 were San Francisco residents. | **566,264 activity sign-ins** across programs. |

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**

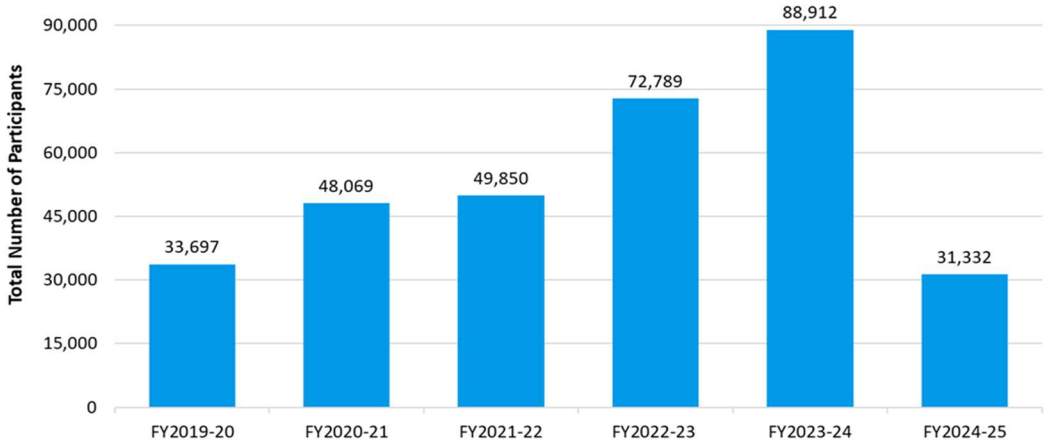



Data source: PLACES: Local Data for Better Health (2024) and SDDT grantee submitted report. Neighborhood profiles are defined by SFDPH and the Mayor's Office of Housing and Community Development, with support from the Planning Department. See https://data.sfgov.org/
Map created using RStudio V2025.09.0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

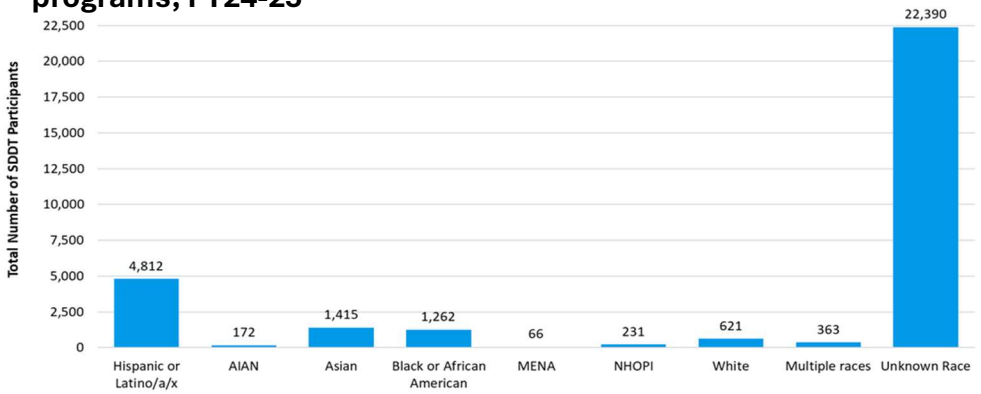



The significant decrease in the number of participants served in FY24-25 (88,912 to 31,332)[‡‡] was due to two factors. First, the introduction of a new data collection tool and training by SFDPH provided clearer and more standardized reporting instructions for all programs, which may have contributed 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.

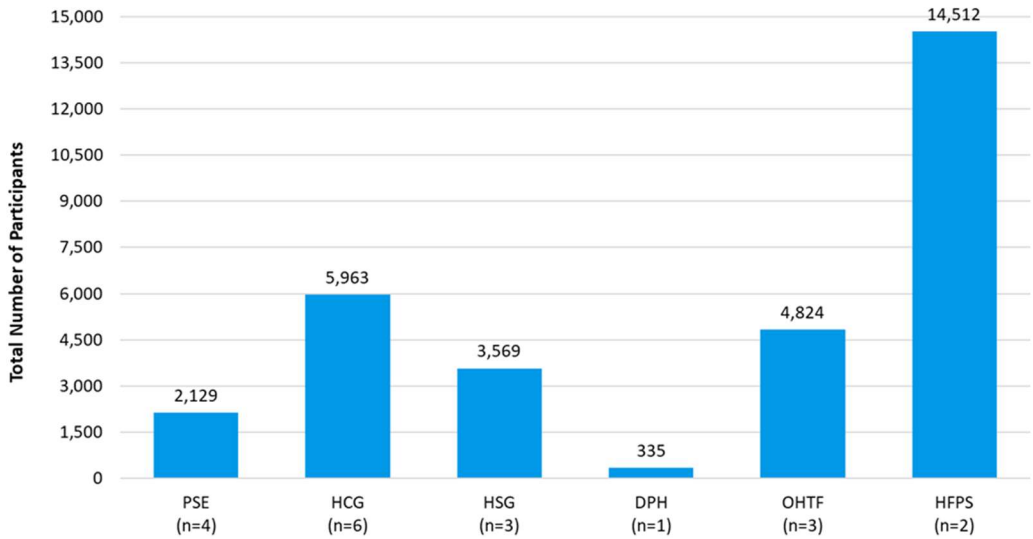
[§§] BIPOC participants *Black, Indigenous, and People of Color (BIPOC) is defined as anyone who self-identified as non-Hispanic White.

## 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)

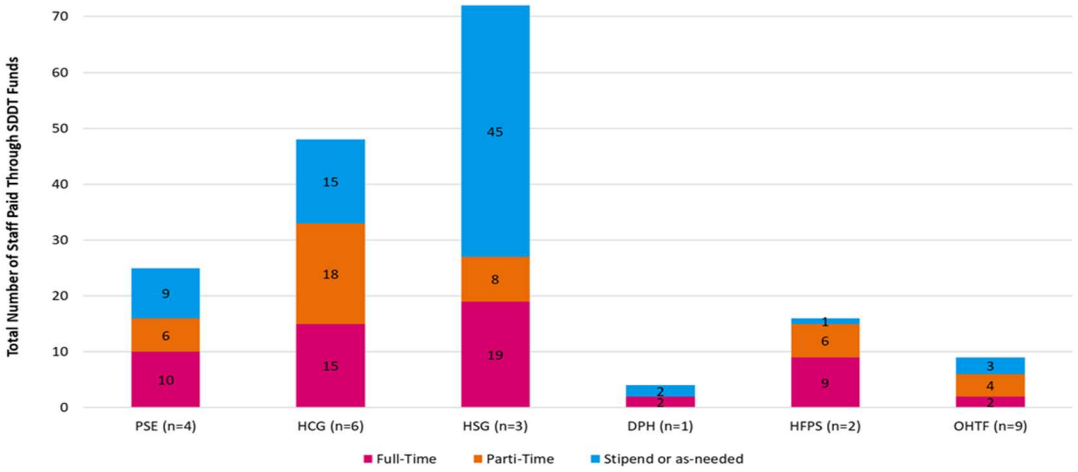
## SDDT Programs Emphasize Cultural Responsiveness

**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.

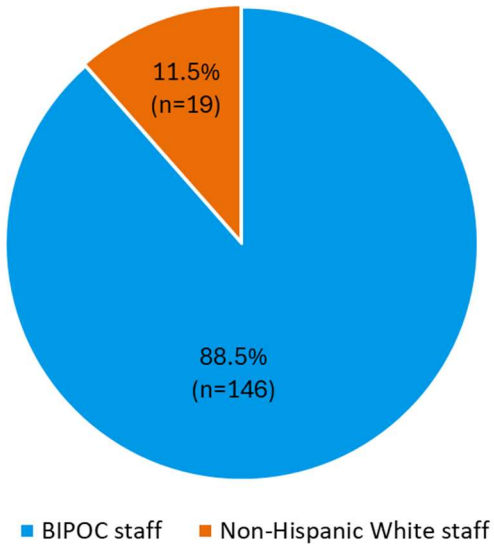
**64 (39%) spoke one or more languages beside English.**

**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.

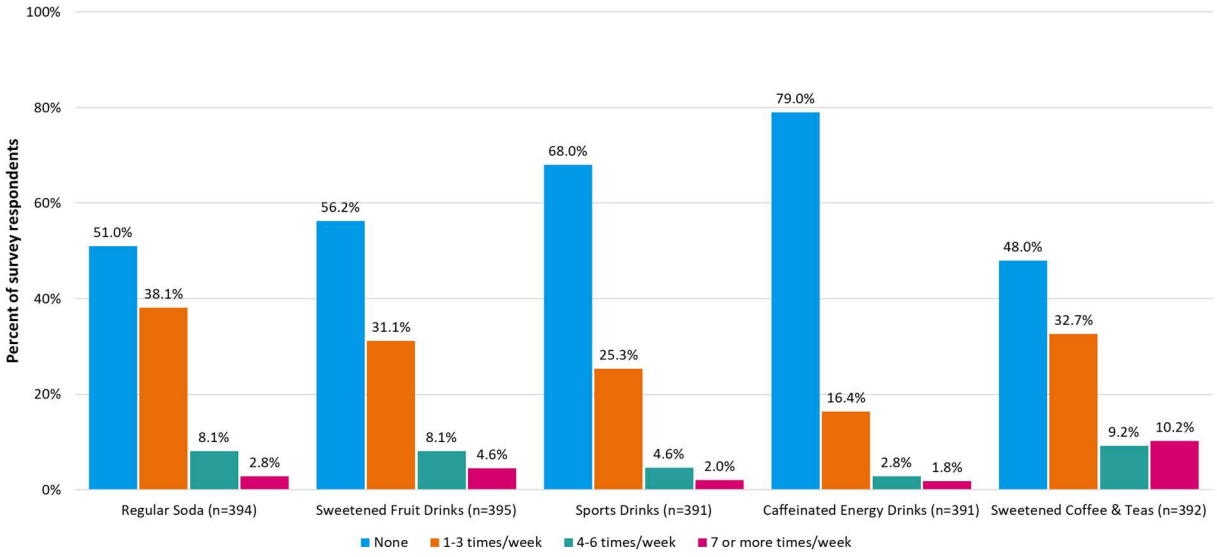
## Sugary Drinks Consumption

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.**

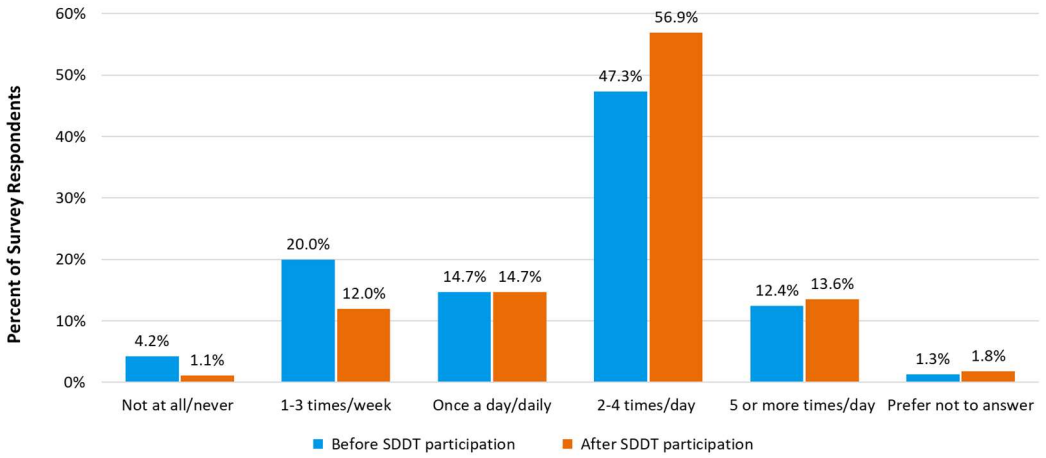
# Fruit and Vegetable Consumption

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

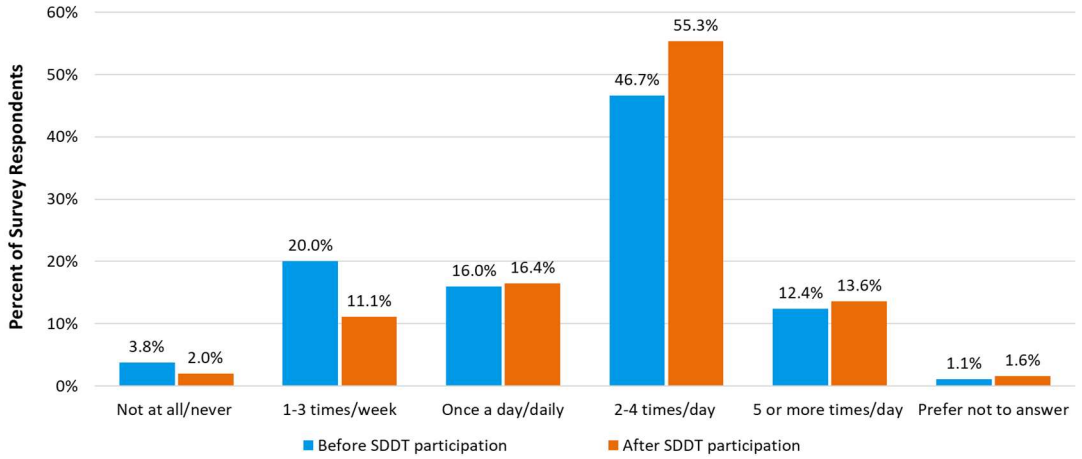
71% of respondents reported consuming vegetables at least 2 times per day after participating in a SDDT program. 69% reported consuming fruits at least 2 times per day after participating in a SDDT program. Conversely, the proportion of individuals who consumed vegetables and fruits infrequently (e.g., 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)



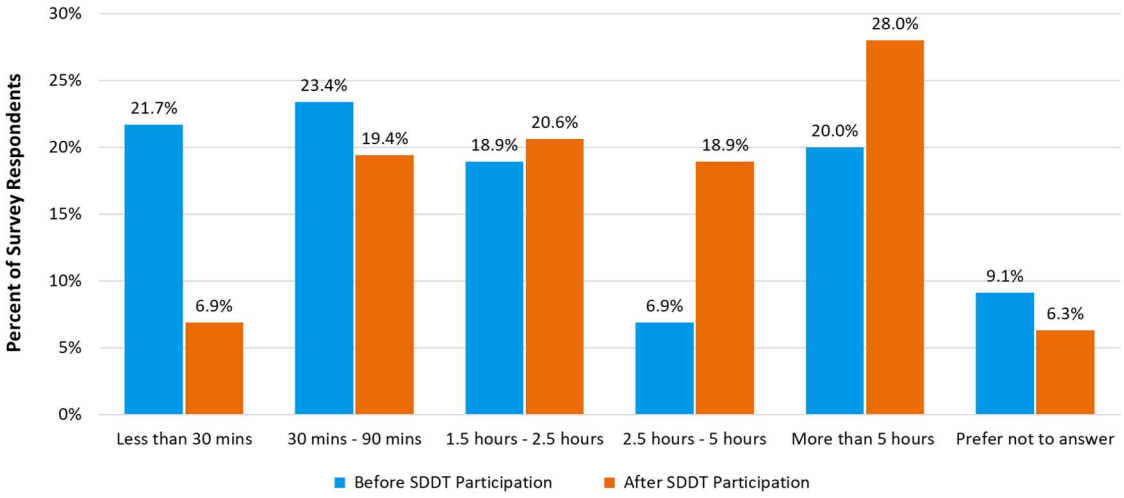
# Physical Activity

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

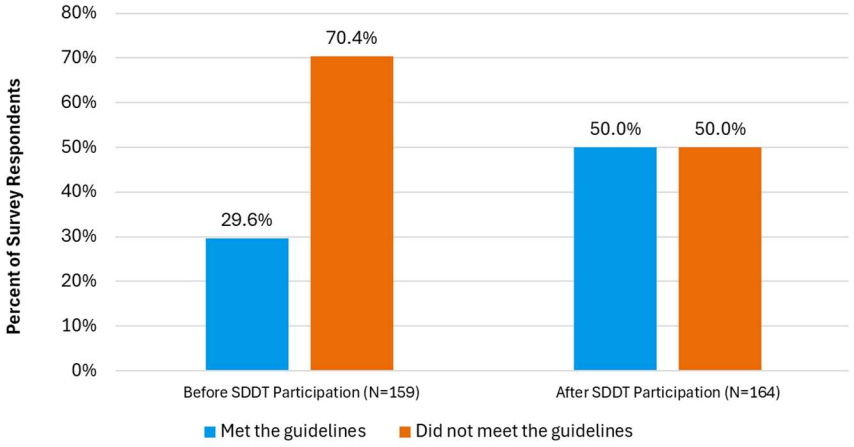
The proportion of survey respondents spending 1.5 hours or less per week on physical activities decreased after program participation. In contrast, the proportion of respondents spending up to 2.5 hours per week on physical activities, meeting the CDC physical activity guidelines***, increased.

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.**

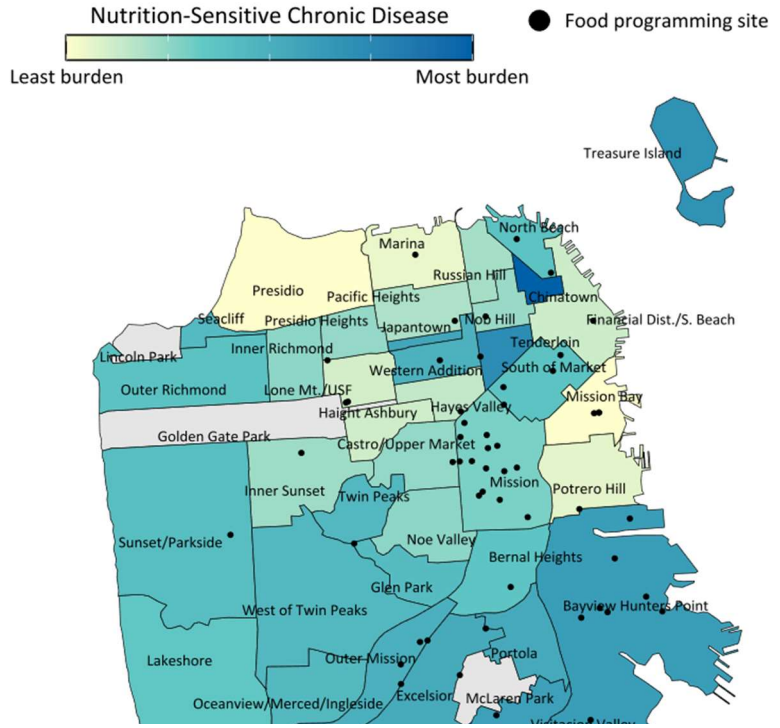
Food distribution sites were concentrated in neighborhoods with a **higher burden of nutrition-sensitive diseases including Chinatown, Tenderloin, Bayview Hunters Point, and Excelsior as well as the Mission, an area with moderate burden of diseases but notable health disparities.**

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.**

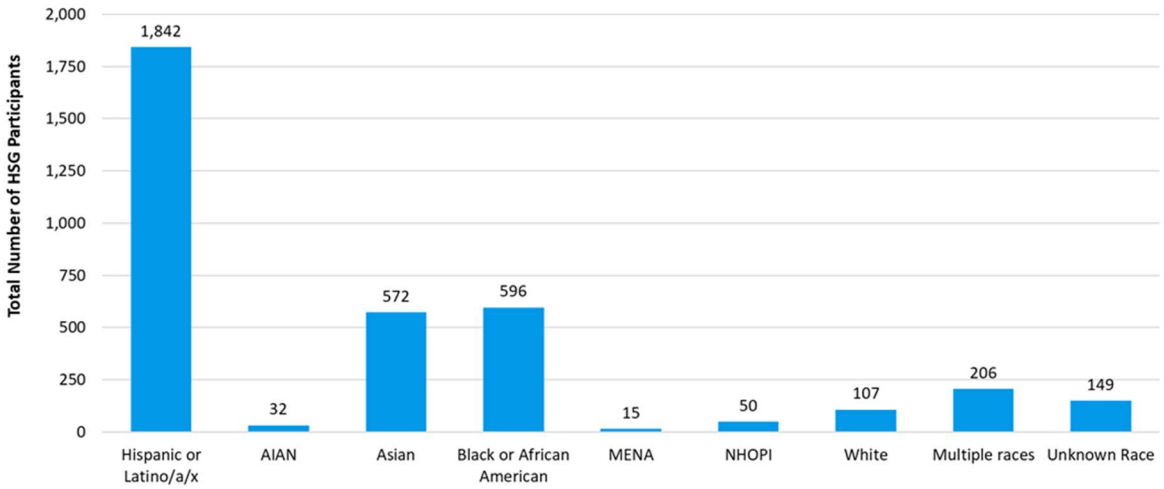
**70 hydration stations have been installed since 2018.**


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

## Healthy School Grants (HSG)

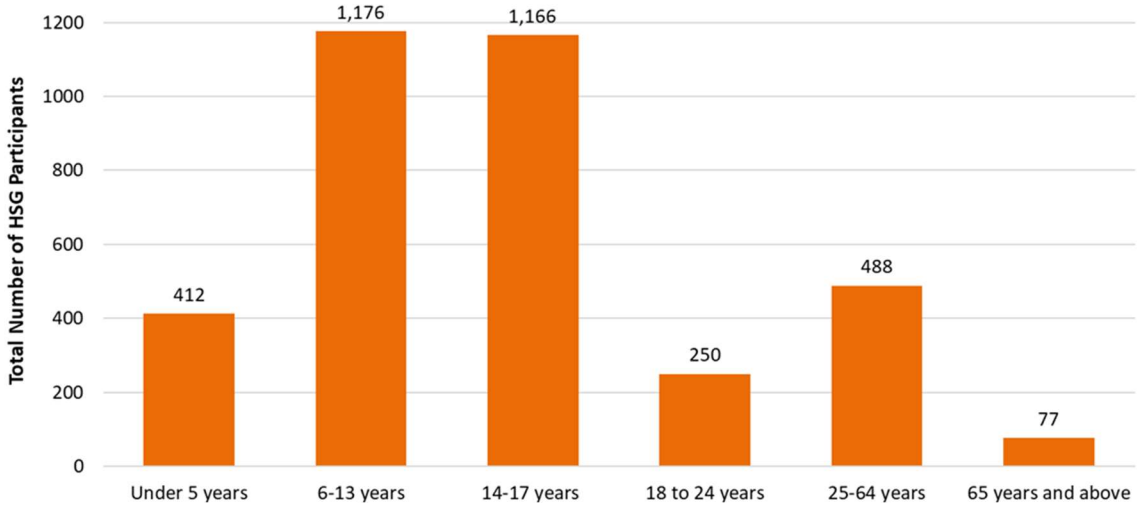
Healthy Schools Grants support organizations implementing programming that serve **high-priority San Francisco Unified School District (SFUSD) schools where over 60% of the students qualify for free and reduced school meals. Three organizations (Project Commotion, Ultimate Impact, and Urban Sprouts)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

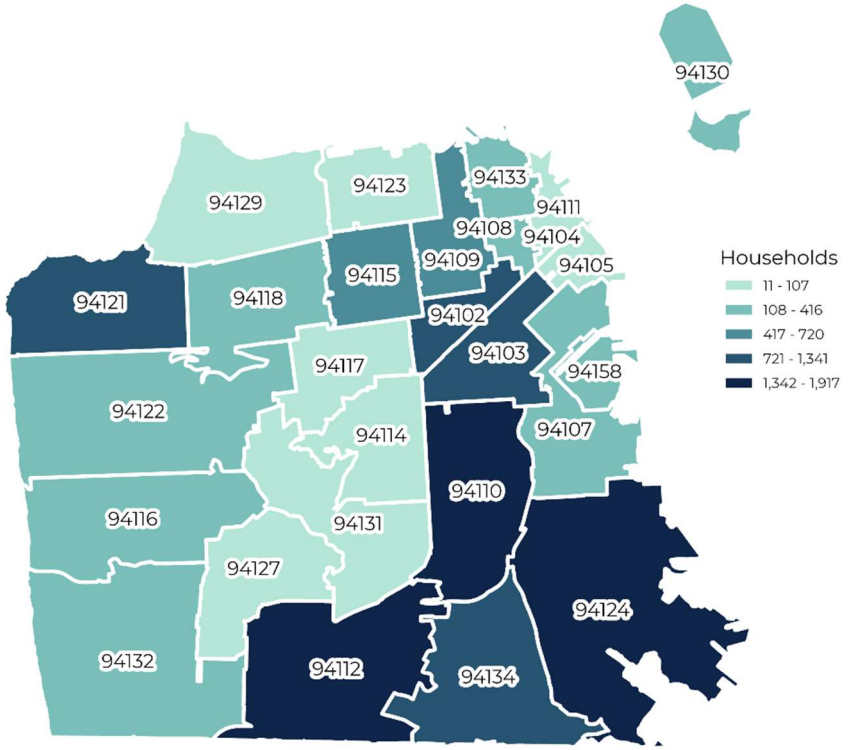
In FY 2024-25, SDDT funding was allocated to the HSA Citywide Food Access Team (CFAT) Programs for the first time. CFAT Programs, established in 2020 in response to increased food insecurity during the COVID-19 pandemic, address ongoing food and nutrition gaps by granting funds to community-based organizations 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:**

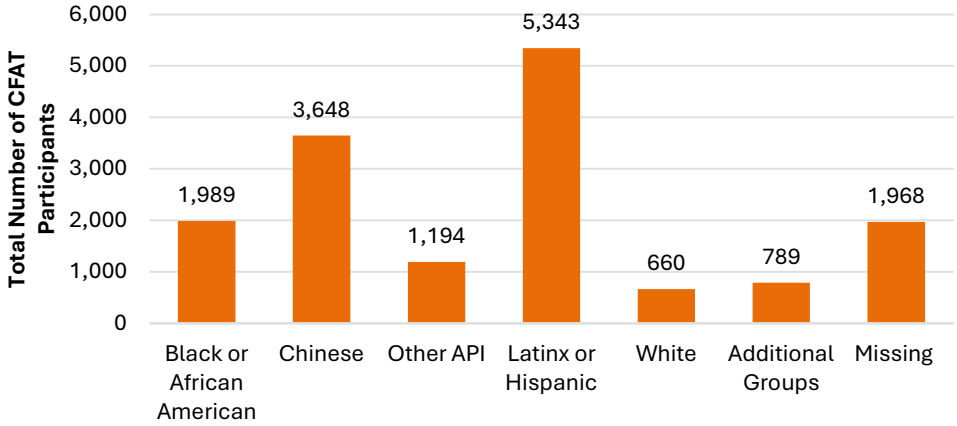
an estimated **19,505 households**

**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<br>Bay Area Community Resources<br>Bayanihan Equity Center<br>Booker T. Washington Community Services<br>Chinatown YMCA<br>Curry Senior Center<br>Dolores/Mission Action<br>Farming Hope<br>HOMEY<br>Mission YMCA<br>Self Help for the Elderly<br>Southwest/IT Bookman<br>Tenderloin Neighborhood Development Corp.<br>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<br>Florence Fang Community Farm<br>SF Housing Development Corp for Peacock Lounge<br>Farming Hope<br>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,**

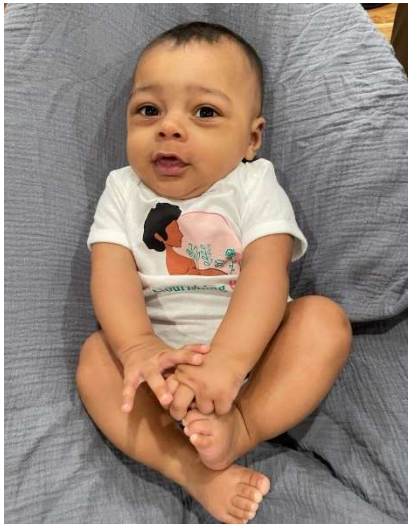
**87% of participants** surveyed agreed with the statement that they **felt more connected with others** after participating in an SDDT program.

**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

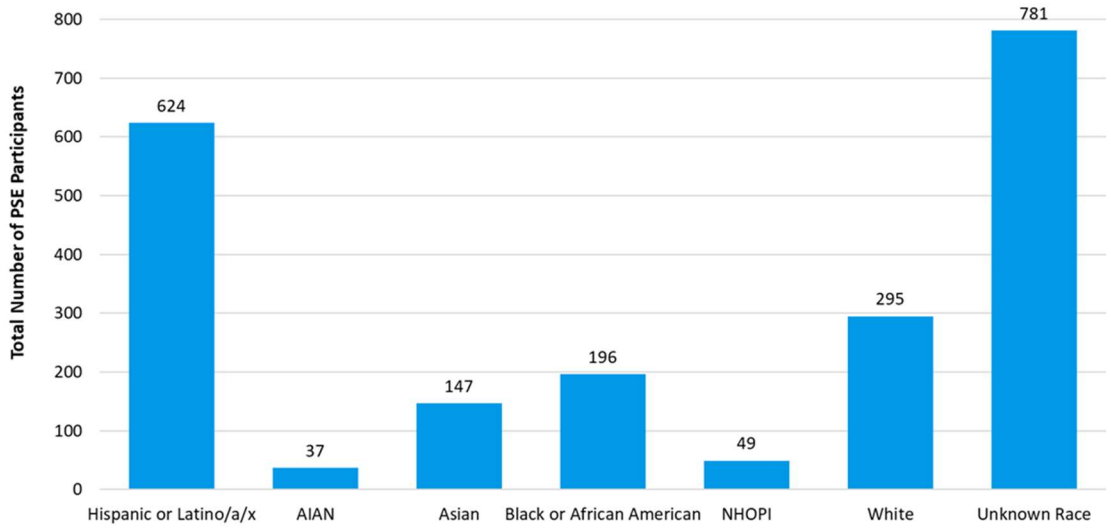
Launched in 2020, the SDDT Policy, System, Environmental Change (PSE) Grant Program provided multiple years of grant funding to support population-level change through community-driven policy, system, environmental (PSE) interventions. Amidst the COVID-19 pandemic, the PSE grantees quickly pivoted to 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.<br><br>*"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.<br><br>**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.**<br><br>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.<br><br>*"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.**<br><br>Healthy Retail and Food Policy Council programs served an estimated 4,481 people. |

| | | | |
|---|---|---|---|
| | | *the water even tasted good!"*<br>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.**<br><br>**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.<br><br>**Empowered community members to advocate for their needs.**<br>*"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.<br><br>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. |

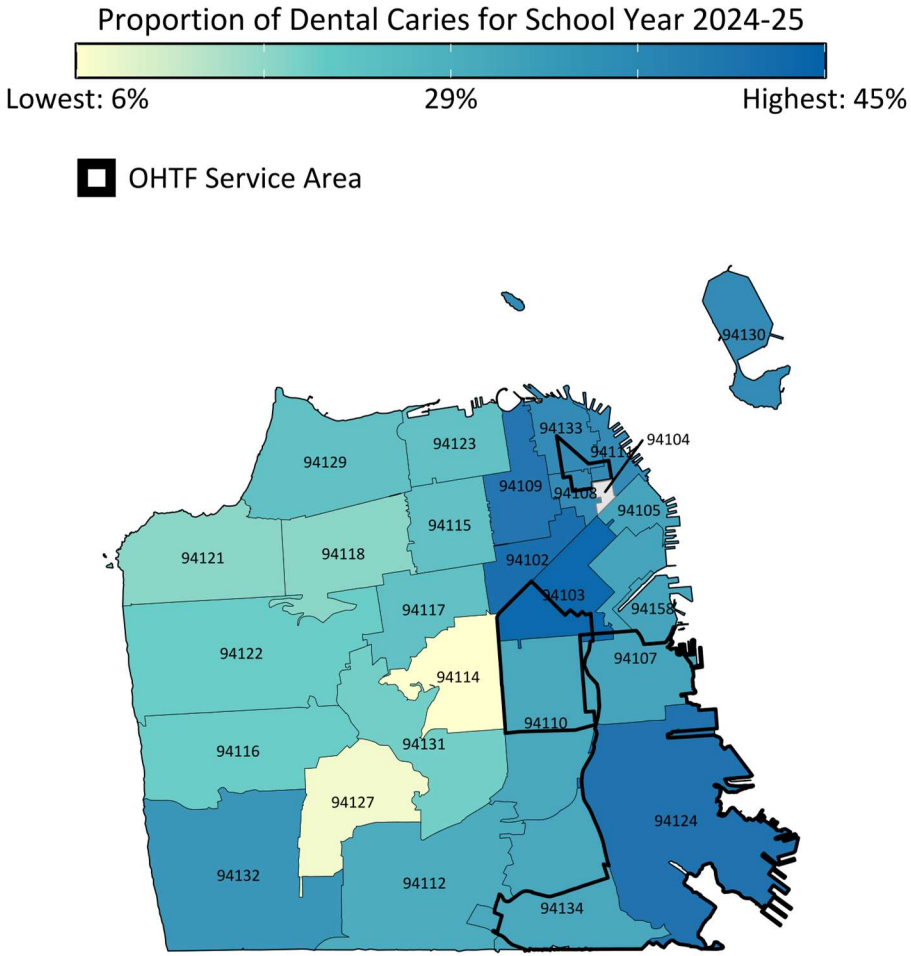
## Oral Health Programs – CavityFree SF

**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.

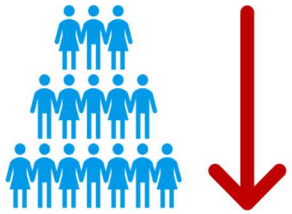
Peace Parks staff group photo

## 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.

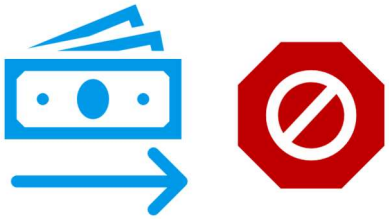
### Key Impacts of Shift in Funding Priorities

**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.

**Contribution:** Results interpretation, report review, and editing.

## 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.

**Contribution:** Results interpretation, report writing, editing, design, and formatting.

## 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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