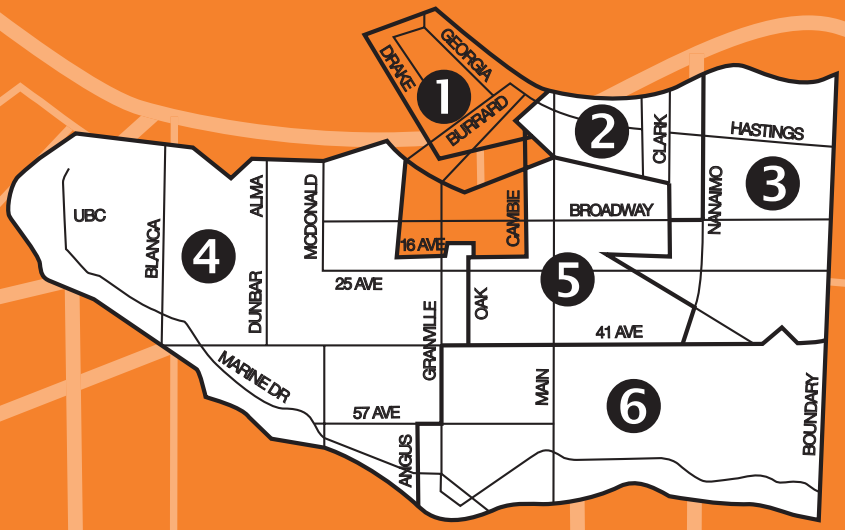
# A health and social profile

FALL 2013




Vancouver CoastalHealth
*Promoting wellness. Ensuring care.*

# Contents

# Health is where we live, learn, work and play

We are pleased to present this package of Health and Social Profiles for the six Community Health Areas (CHAs) in Vancouver. The full package includes Health and Social Profiles for CHA 1 (City Centre), CHA 2 (Mid-East), CHA 3 (North East), CHA 4 (Westside), CHA 5 (Midtown) CHA 6 (South Vancouver), as well as a Citywide Summary.

These profiles were prepared by Vancouver Coastal Health (VCH). They were compiled by Nerissa Tai, a student in the Master of Public Health Program at Simon Fraser University, with guidance from Community Developers in Vancouver; Charito Gailling, Katie Hume, Lisa McCune, Nicole Latham, Lycia Rodrigues and Jazmin Miranda as well as Dr. Jat Sandhu and Eleni Kefalas at the VCH Public Health Surveillance Unit (PHSU).

A population health approach aims to improve the health of the entire population.

VCH is the regional health authority responsible for providing public health services to over 1 million people in British Columbia. We serve the residents of Vancouver, Richmond, the North Shore and Coast Garibaldi, Sea-to-Sky, Sunshine Coast, Powell River, Bella Bella and Bella Coola. We operate 13 hospitals and also provide primary care, mental health and addiction services, community-based residential and home health care, and more. To deliver public health services in Vancouver, VCH divides the city into six geographical areas called "Community Health Areas" (CHAs). CHAs vary in population size and are each comprised of three to eight neighbourhoods.

While hospital care and clinical services are an important part of the health care system, Vancouver Coastal Health also uses a population health approach to address the determinants that influence the health of population. A population health approach aims to improve the health of the entire population and to reduce health inequities among population groups.

In these Health and Social profiles we report on some of the factors that influence the health of individuals and populations in Vancouver. These factors are called the "social determinants of health". In each profile we include population-level data about income, housing, education, employment and child development. We also report on health indicators such as life expectancy, birth rates, standardized mortality ratios and we include information about how health services are used and key community resources.

Addressing the social determinants of health can improve the health of the whole population and reduce health inequities. But Vancouver Coastal Health cannot do it alone. We need to work in partnership across sectors and with communities to address local issues, facilitate access to services and strengthen the environments in which people live, learn, work and play. We hope that these profiles will help VCH staff and our partners in community to identify emerging needs, undertake strategic planning, and implement health-supporting initiatives.

The majority of the information presented in these profiles comes from BC Vital Statistics Agency, BC Statistics, the 2006 Statistics Canada Census and Vancouver Coastal Health databases (see the References at the end of each profile for a complete list of data sources).

Where possible, we have included information obtained through the 2011 Statistics Canada Census. Where data was unavailable for 2011, we have used information from the 2006 Census. The 2006 Census remains a valuable source of information about populations in Vancouver because it contains details collected through the mandatory long-form Census, which was discontinued prior to the 2011 Census. Also, at the time of publication of these Profiles, only limited data from the 2011 Census has been released.

We also consulted with community groups, public organizations and VCH staff to better inform the profiles and to share local knowledge about unique neighbourhood characteristics and emerging trends.

We hope that this will be a useful and motivating document in your work. Any comments or feedback is welcome at: phsu@vch.ca.

# Acknowledgements

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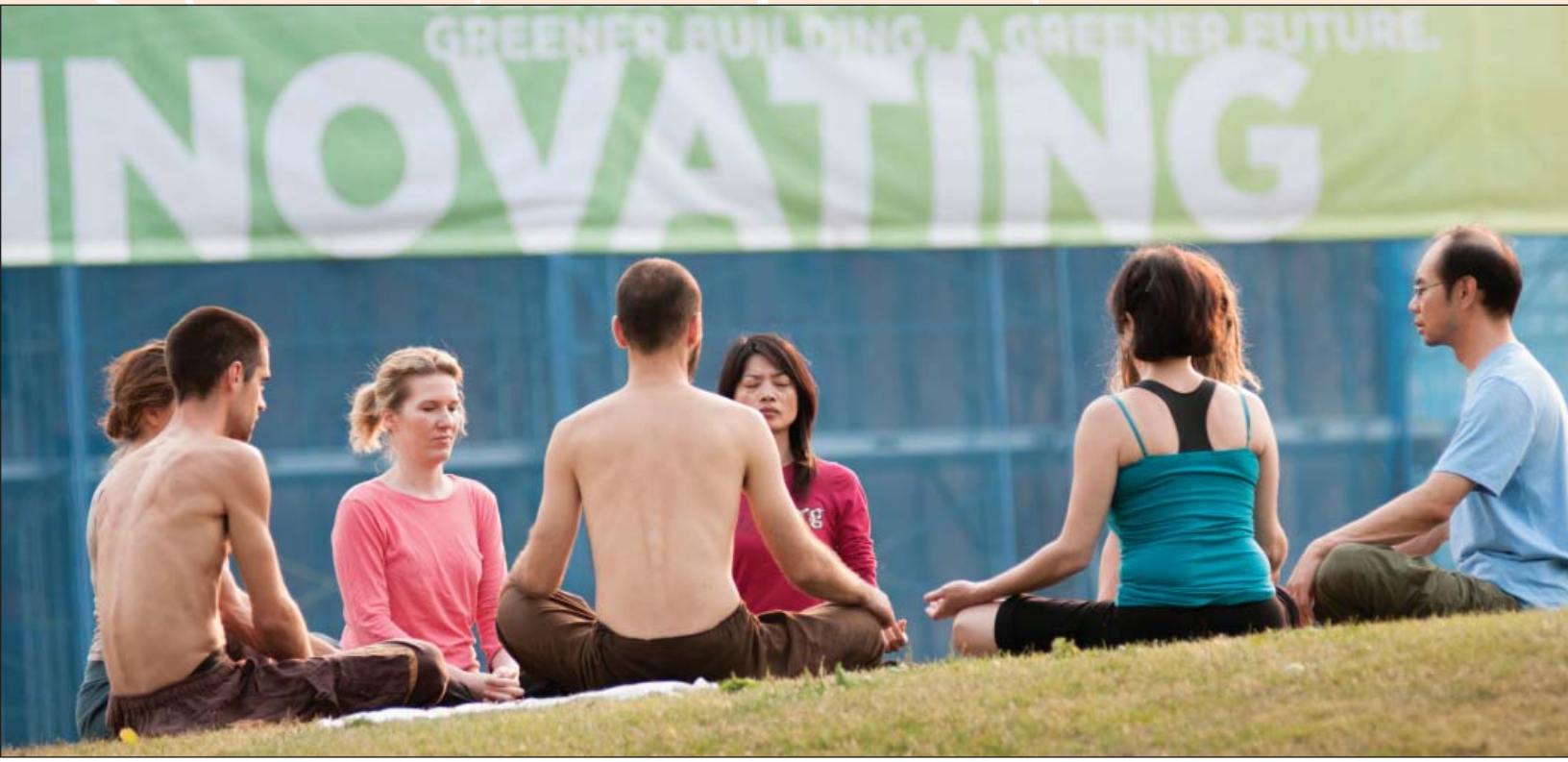



# Introduction by community partner

ERIC KOWALSKI, EXECUTIVE DIRECTOR,
WEST END SENIORS' NETWORK

**Statistics are human beings with the tears wiped off.**
~ Paul Brodeur, Outrageous Misconduct

Not just living but also working in the West End – as the Executive Director of the West End Seniors' Network – my view of CHA 1 is decidedly focused on this area. In reviewing the draft of the Health and Social Profile for the area, how do the statistics compare to my experience as a service provider in the community?

Most of us will tell you that the West End is truly a unique neighbourhood. With its dense population, vibrant shopping areas and amenities like Stanley Park and the seawall, the West End is often viewed as a higher-end enclave for well to do urban professionals. Clearly, there is some truth in that remark, particularly as the rising rents and condo prices of the last decade or more have forced many lower income individuals and families out of the area.

But the statistics also show us that the neighbourhood continues to be much more diverse than people might generally believe. The median after-tax household income is the lowest in the CHA and approximately 1/5 of seniors live on low-incomes. The West End also has the highest percentage of live-alone seniors in the city. 2011 Census figures show an increase in the 65+ age group from about 11% of the population in 2006 to more than 13% in 2011.

When we look at the CHA as a whole, we can see that fully one third of the population lives on low income, almost 16% of those being children. If 20% of our seniors and 16% of our children live in relative poverty, and the suicide rates for the very young (under age 24) and the very old (over age 85) are the highest of any CHA in the city, what might that tell us about our communities? Clearly, by many measures – e.g., education levels, childcare spaces, chronic disease incident rates – life appears to be good for the majority of residents.

Yet, when we consider that significant numbers of our very young and very old feel that life isn't worth living…if single parent households can't afford housing in the neighbourhood… if one third of the population lives with the daily stress of stretching limited incomes to cover increasingly expensive cost of living… we are reminded that "averages" and "medians" can easily mask some very real human suffering. And not only do individuals and families suffer – the community as a whole loses its diversity and vibrancy.

The CHA reports are valuable tools for those of us providing community services to prod us to ask, "Who am I seeing/serving?" And, perhaps even more importantly, "Who am I not seeing/serving?" Along with our own experiences in dealing face to face with people living and working in our neighbourhoods, the information in the CHA reports provide a critical lens through which to view our neighbourhoods and our work.

# Population estimates and projections

Population estimates and projections provide social agencies, government and other service providers with an opportunity to plan for emerging trends.

Population projections can be used to gauge future population and composition rates.

Multiple projection series are produced using different combinations of assumptions about future fertility (births), mortality (deaths), and migration.

**TABLE 1.** Population estimates. Community Health Areas, Vancouver, and British Columbia, 2011

| | CHA 1 | CHA 2 | CHA 3 | CHA 4 | CHA 5 | CHA 6 | Vancouver | BC |
|---|---|---|---|---|---|---|---|---|
| Count | 121,165 | 71,358 | 106,364 | 137,666 | 95,928 | 136,209 | 668,690 | 4,573,321 |
| Total 0-19 years | 8.5% | 14.5% | 20.0% | 20.5% | 20.1% | 19.9% | 17.4% | 21.1% |
| 0-4 years | 3.6% | 3.8% | 5.2% | 4.3% | 5.7% | 4.7% | 4.5% | 4.9% |
| 5-19 years | 5.0% | 10.6% | 14.9% | 16.2% | 14.4% | 15.2% | 12.9% | 16.2% |
| | | | | | | | | |
| Total 20-64 years | 81.2% | 75.5% | 66.8% | 67.3% | 69.7% | 66.3% | 70.7% | 63.6% |
| 20-34 years | 37.6% | 25.8% | 23.2% | 26.2% | 23.8% | 22.8% | 26.7% | 20.9% |
| 35-49 years | 27.0% | 28.3% | 24.2% | 22.9% | 26.9% | 22.7% | 25.0% | 21.5% |
| 50-64 years | 16.6% | 21.5% | 19.5% | 18.1% | 19.0% | 20.8% | 19.1% | 21.2% |
| | | | | | | | | |
| Total 65+years | 10.3% | 10.0% | 13.1% | 12.2% | 10.2% | 13.8% | 11.8% | 15.3% |
| 65-79 years | 7.4% | 7.0% | 9.1% | 8.1% | 7.1% | 9.3% | 8.1% | 11.0% |
| 80+ years | 2.9% | 3.1% | 4.1% | 4.1% | 3.1% | 4.5% | 3.7% | 4.3% |

Source: BC Stats (2012, March)

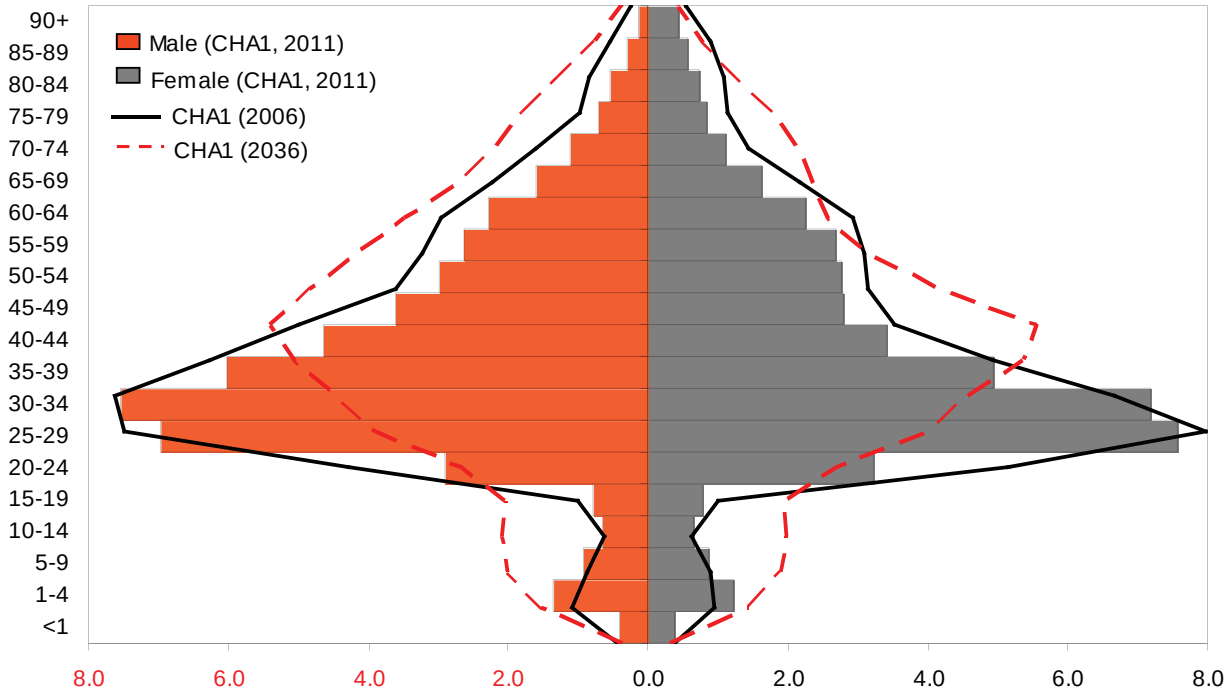
In 2011, the population of CHA 1 was 121,165 the third most populated out of the six CHAs, comprising 18.1% of Vancouver's population. CHA 1 is home to many young adults with over 37% of its population aged 20-34 years, the most amongst the CHAs.

**TABLE 2.** Population projections. Community Health Areas, Vancouver, and British Columbia, 2036

| | CHA 1 | CHA 2 | CHA 3 | CHA 4 | CHA 5 | CHA 6 | Vancouver | BC |
|---|---|---|---|---|---|---|---|---|
| Count | 160,936 | 96,444 | 123,785 | 166,865 | 118,775 | 161,984 | 828,789 | 6,155,588 |
| Total 0-19 years | 15.6% | 14.9% | 16.5% | 18.5% | 14.9% | 16.6% | 16.3% | 19.0% |
| 0-4 years | 3.6% | 4.2% | 3.8% | 3.6% | 4.4% | 3.7% | 3.9% | 4.4% |
| 5-19 years | 12.0% | 10.8% | 12.6% | 14.8% | 10.5% | 12.9% | 12.5% | 14.6% |
| | | | | | | | | |
| Total 20-64 years | 71.0% | 64.5% | 57.6% | 59.9% | 64.6% | 57.0% | 62.4% | 57.3% |
| 20-34 years | 22.2% | 18.4% | 16.9% | 25.3% | 20.5% | 16.8% | 20.3% | 17.0% |
| 35-49 years | 30.4% | 25.3% | 18.7% | 18.1% | 21.9% | 19.1% | 22.1% | 21.1% |
| 50-64 years | 18.4% | 20.9% | 22.0% | 16.6% | 22.3% | 21.2% | 20.0% | 19.2% |
| | | | | | | | | |
| Total 65+years | 13.4% | 20.5% | 25.9% | 21.6% | 20.5% | 26.4% | 21.3% | 23.7% |
| 65-79 years | 10.5% | 15.0% | 18.4% | 15.2% | 15.9% | 18.3% | 15.5% | 16.3% |
| 80+ years | 2.9% | 5.5% | 7.5% | 6.4% | 4.5% | 8.0% | 5.8% | 7.4% |

Source: BC Stats (2012, March)

**FIGURE 1.** Population distribution (%) by sex and age group. Community Health Area 1, 2006, 2011, and 2036




Source: BC Stats (2012, March)

Figure 1 illustrates the sex distribution in CHA 1 with males on the left and females on the right hand side. Overall in 2011, there were 54.4% males and 45.6% females; however, the composition shifts according to the age group.

Figure 1 also shows in more detail the number of people in each five-year age group. The figure shows what the population looked like in 2006 (black line) and 2011 (bars), and what the data is expected to look like in 2036 (red dotted line). In CHA 1 the population distribution has not changed significantly since 2006.

By 2036, the total population of CHA 1 is projected to increase by 32.8% to 160,936 persons. The population of CHA 1 is also expected to age, with 10.2 % fewer people aged 20-64 years and 3.1% more people aged 65 years and over. In 2036, there will be 7.1% more people in the 0-19 year age group.

# Demographic composition

This section draws attention to the demographic composition of Community Health Area 1 and how it relates to diversity, education and childhood development, employment and income, and housing and household characteristics.

# Diversity

**Visible Minorities.** Both Statistics Canada and the Public Service Commission of Canada use the following definition of visible minority: A person in a visible minority group is someone who is non-white in colour/race, regardless of place of birth.

**The immigrant population** is defined as persons who are, or who have been, landed immigrants in Canada. This term does not include non-permanent residents, persons in Canada on employment or student authorizations, refugee claimants or persons born outside Canada who are Canadian citizens by birth (Statistics Canada, 2010, July 6).

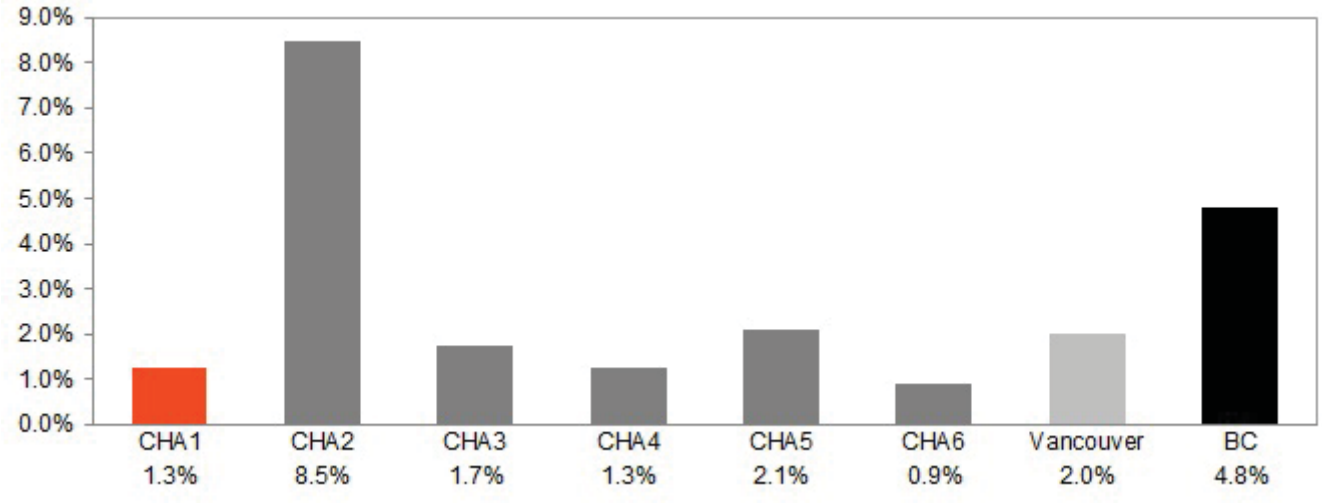
**Recent immigrants** refer to landed immigrants who came to Canada up to five years prior to a given census year. For the 2006 Census, recent immigrants are landed immigrants who arrived in Canada between January 1, 2001 and May 16, 2006 (Statistics Canada, 2010, July 6).

Data Source: Statistics Canada

## Aboriginal Population

Over the past few decades the health status of Aboriginal peoples in Vancouver has improved, particularly in the areas of infant mortality, unintentional injuries and suicide. These improvements can be attributed to changes in the social determinants of health, improved access to health care services and greater emphasis on cultural teachings. Participants at the 2011 Forum for Aboriginal Elders identified many positive impacts that result from preserving Aboriginal cultural traditions. A number of community organizations operate in Vancouver to meet the needs of urban Aboriginal people. These include the Vancouver Aboriginal Council, the Vancouver Aboriginal Friendship Centre, the Urban Native Youth Association, and the Aboriginal Mother Centre Society.

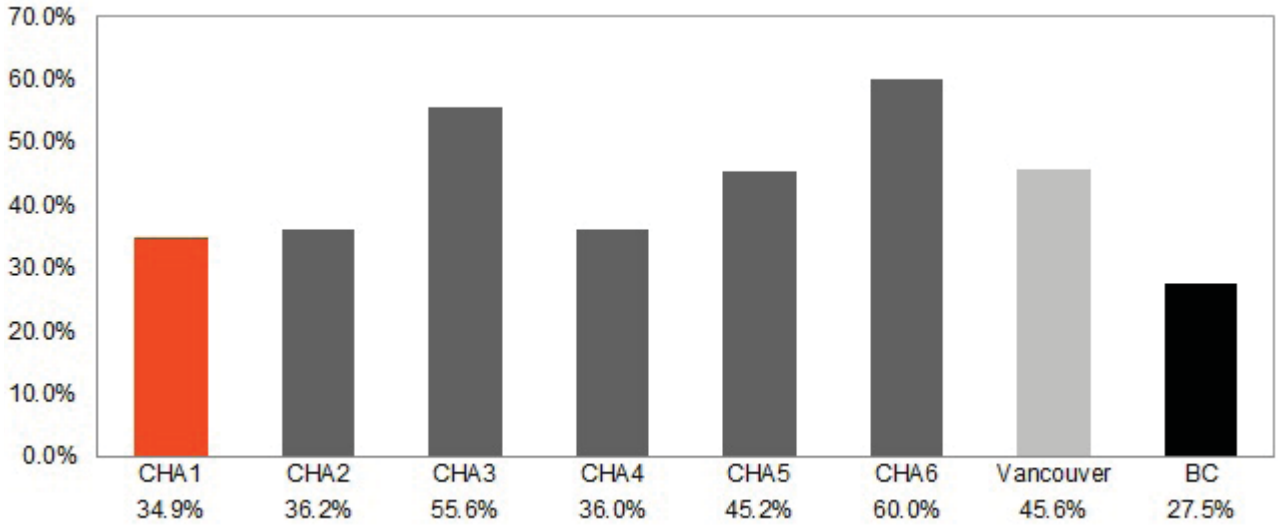
**FIGURE 2.** Aboriginal population as a percentage (%) of the total population. Community Health Areas, Vancouver, and British Columbia, 2006




Source: Statistics Canada, 2006 Census of Population

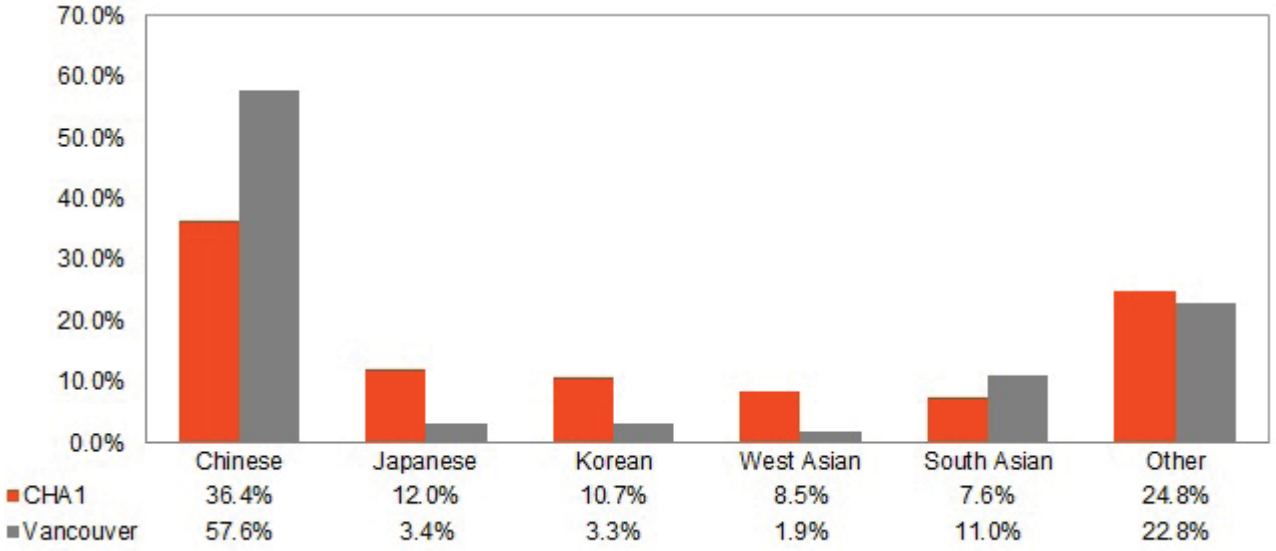
## Immigrant population

**FIGURE 3.** Immigrant population as a percentage (%) of the total population. Community Health Areas, Vancouver, and British Columbia, 2006




Source: Statistics Canada, 2006 Census of Population

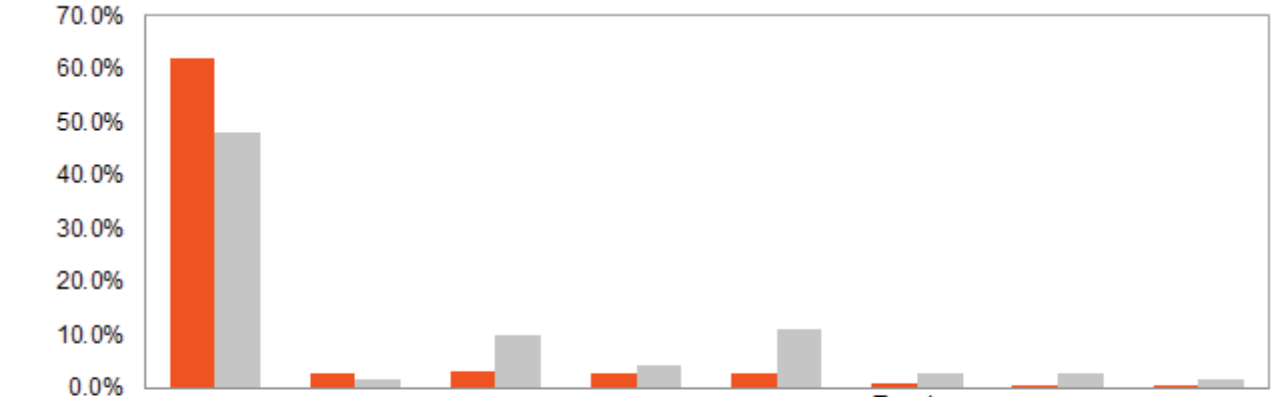
**FIGURE 4.** Select visible minority groups as a percentage (%) of the total visible minority population. Community Health Area 1 and Vancouver, 2006




Source: Statistics Canada, 2006 Census of Population

Visible minorities comprise 30.6% of the total population of CHA 1. Within CHA 1, the Chinese (36.4%) are the most prominent visible minority group; however, this is lower relative to Vancouver (57.6%). Japanese (12.0%), Koreans (10.7%), West Asians (8.5%), and other minority groups (24.8%) make up a greater proportion within CHA 1 relative to Vancouver overall.

**FIGURE 5.** Total population by select mother tongue. Community Health Area 1 and Vancouver, 2006




| | English | French | Chinese n.o.s. | Mandarin | Cantonese | Tagalog (Pilipino, Filipino) | Panjabi (Punjabi) | Vietnamese |
|---|---|---|---|---|---|---|---|---|
| CHA1 | 61.9% | 2.9% | 3.3% | 2.7% | 2.6% | 0.9% | 0.2% | 0.2% |
| Vancouver | 48.0% | 1.6% | 9.8% | 4.1% | 11.0% | 2.8% | 2.7% | 1.8% |

Source: Statistics Canada, 2006 Census of Population

"N.o.s." stands for 'not otherwise specified. This refers to people who reported "Chinese" in their response to the question on language spoken most often at home without specifying Mandarin, Cantonese or other Chinese languages.

# Education and healthy child development

Child care enables parents of young children to work or study on a full or part-time basis. A vast body of research has demonstrated that quality early learning and child care has significant educational, social, and emotional benefits for children.

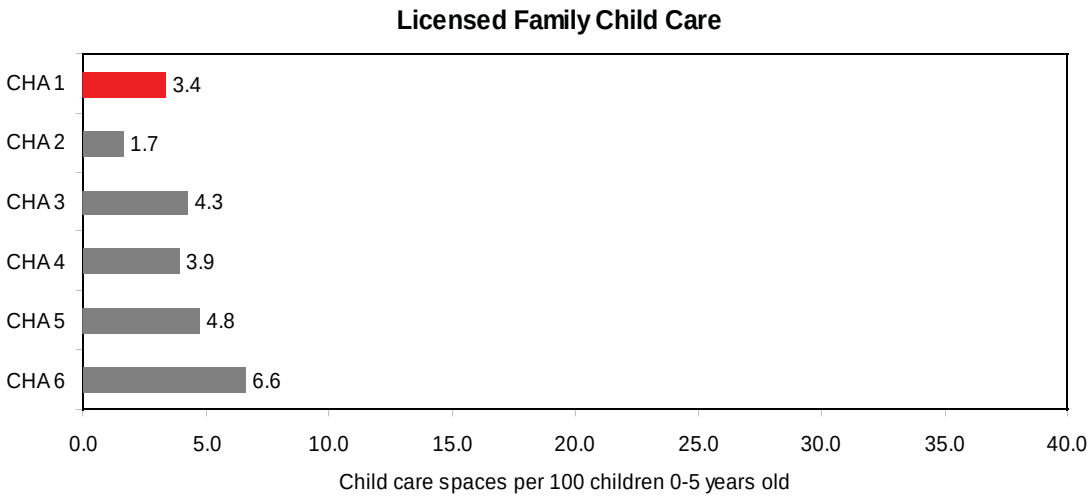
Licensed Family Child Care is offered in a child care provider's own home, and serves a maximum of 7 children from birth to age 12. Group Child Care serves children in two age groupings: from birth to 36 months and from 30 months to school-age. Preschools serve children age 30 months to school entry. Preschools are part-day programs, typically operating on the school-year, September to June (Vancouver Coastal Health, 2009).

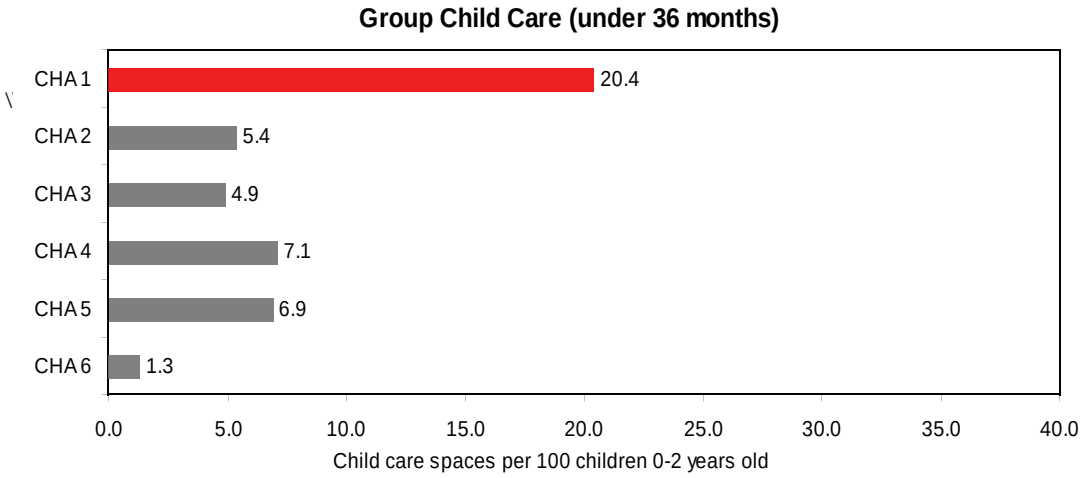
Within Vancouver, the number of child care spaces varies considerably by CHA. While the number of spaces has increased in recent years, the population under age 5 is also increasing and child care availability remains low. Many families rely on informal child care arrangements.

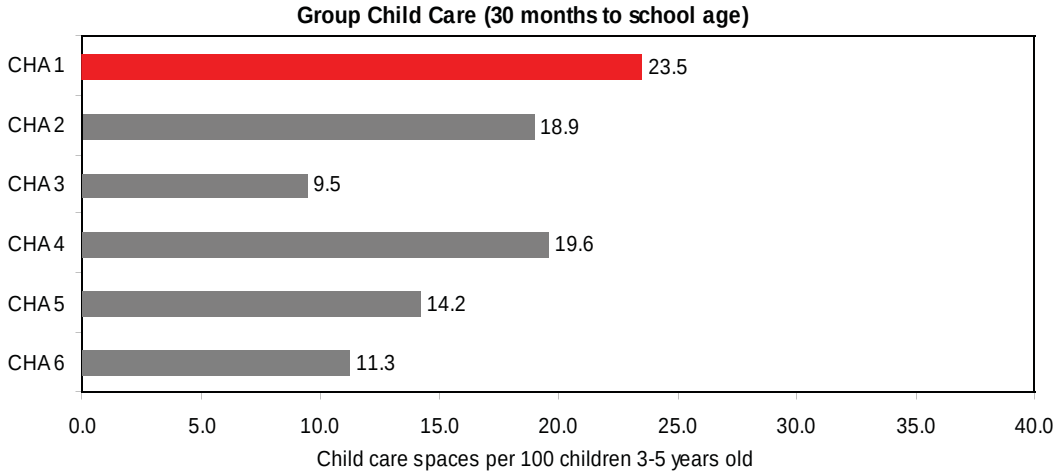
In CHA 1 there are 20.4 licensed group child care spaces for every 100 children under 36 months and 23.5 licensed group child care spaces for every 100 children age 3-5 years. This is the highest rate in the city of Vancouver, yet 75 of every 100 children age 3-5 years do not have access to licensed group child care.

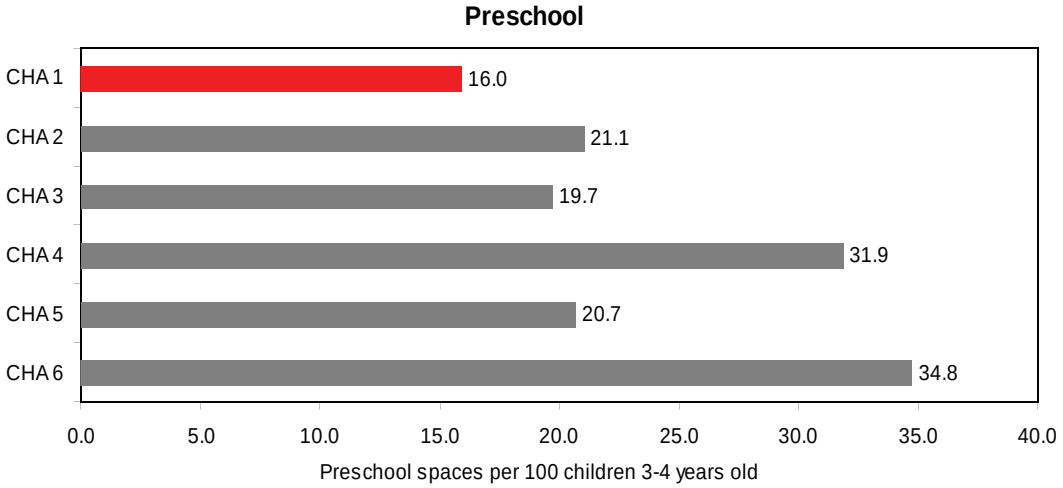
Note: data provided here do not include unlicensed, "licence-not-required" nor informal child care arrangements (e.g. care by relative, nanny).

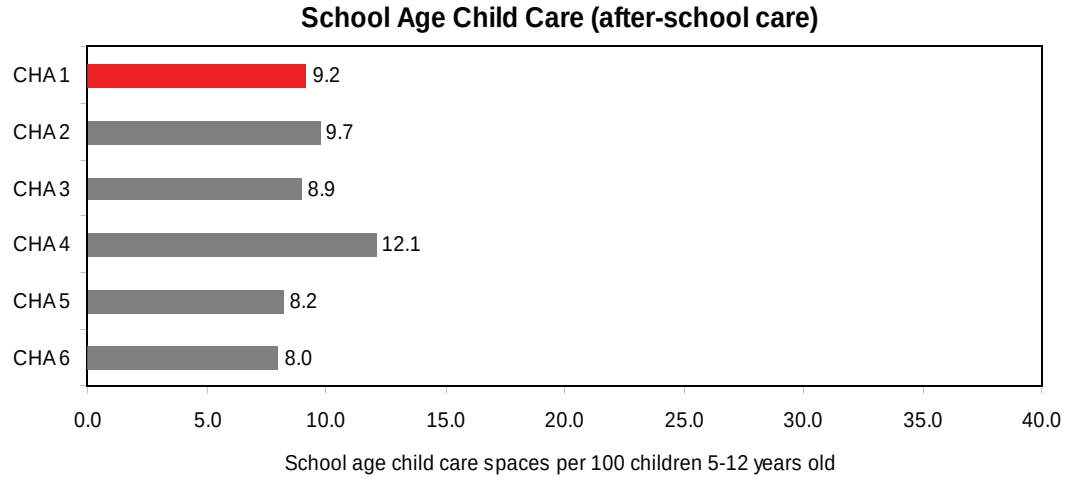
**FIGURE 6.** Child Care spaces per 100 children. Community Health Areas, 2012




Group Child Care (under 36 months)
CHA 1
CHA 2
CHA 3
CHA 4
CHA 5
CHA 6
20.4
5.4
4.9
7.1
6.9
1.3
0.0
5.0
10.0
15.0
20.0
25.0
30.0
35.0
40.0
Child care spaces per 100 children 0-2 years old


Group Child Care (30 months to school age)
CHA 1
CHA 2
CHA 3
CHA 4
CHA 5
CHA 6
23.5
18.9
9.5
19.6
14.2
11.3
0.0
5.0
10.0
15.0
20.0
25.0
30.0
35.0
40.0
Child care spaces per 100 children 3-5 years old


Preschool
CHA 1
CHA 2
CHA 3
CHA 4
CHA 5
CHA 6
16.0
21.1
19.7
31.9
20.7
34.8
0.0
5.0
10.0
15.0
20.0
25.0
30.0
35.0
40.0
Preschool spaces per 100 children 3-4 years old




Source: Westcoast Child Care Resource and Referral and City of Vancouver, 2012

**TABLE 3.** Percentage (%) of Kindergarten children vulnerable on five domains of development as measured by the Early Development Instrument (EDI). Community Health Areas and British Columbia, 2009/11 (compared to 2007/09)

| | Percent (%) vulnerable | | | | | | |
|---|---|---|---|---|---|---|---|
| | CHA 1 | CHA 2 | CHA 3 | CHA 4 | CHA 5 | CHA 6 | BC |
| Total Number of Children | 252 (270) | 210 (254) | 643 (772) | 627 (715) | 557 (623) | 988 (950) | 47,318 (37,398) |
| Physical Health and Well-Being | 19% (14%) | 24% (25%) | 17% (18%) | 8% (7%) | 13% (13%) | 17% (17%) | 14% (12%) |
| Social Competence | 17% (18%) | 24% (24%) | 18% (18%) | 17% (13%) | 17% (12%) | 20% (19%) | 15% (13%) |
| Emotional Maturity | 17% (17%) | 22% (25%) | 13% (15%) | 10% (10%) | 14% (13%) | 18% (19%) | 14% (12%) |
| Language and Cognitive Development | 13% (8%) | 16% (20%) | 12% (4%) | 7% (4%) | 12% (8%) | 14% (13%) | 10% (10%) |
| Communication Skills and General Knowledge | 21% (22%) | 25% (23%) | 27% (28%) | 14% (10%) | 25% (20%) | 27% (26%) | 14% (13%) |
| One or more domain | 39% (39%) | 49% (47%) | 43% (43%) | 29% (25%) | 37% (25%) | 45% (43%) | 31% (29%) |

Source: University of British Columbia, Human Early Learning Partnership, 2011

The quality of a child's early development plays a significant role in lifelong health, social ability and educational achievement. Research has clearly shown that poor early development is associated with a wide range of acute and chronic health issues later in life.

This table shows the percentage of children in each CHA who are considered to be vulnerable in each of the five domains of the EDI. The first row shows the number of children who participated in the EDI in each of 2009/11 and 2007/09 (in parentheses).

In CHA 1, of 252 children who participated in the EDI in 2009/11, 21 percent are considered vulnerable in the domain of "Communication Skills and General Knowledge". 19 percent are considered vulnerable in the domain of "Physical Health and Well Being".

The Early Development Instrument (EDI) is a research tool that measures children's health and well-being as they enter kindergarten in five core developmental domains: physical health and well-being, social competence, emotional maturity, language and cognitive development, and communication skills. These are proven and reliable predictors of later educational outcomes, social capability and adult health.

Reporting EDI data allows us to better understand levels of child "vulnerability." Children are considered to be vulnerable when they receive a low score on EDI in one or more of the domains of development. A child who is vulnerable is at increased risk of encountering difficulties in their school years and beyond. This information is viewed at a population level (e.g. community health area, etc.) and this makes it possible to see the proportion of vulnerable children in a geographic area.

Note: CHA 5 includes neighbourhood data for Cedar Cottage (which is typically included in CHA 3).

TABLE 4. Middle Years Development Instrument Well-Being Index, 2011

| Community Health Area | Number of students | Low | Medium/High | Very High/ Thriving |
|---|---|---|---|---|
| CHA 1 | 143 | 16.2% | 30.9% | 52.9% |
| CHA 2 | 180 | 22.3% | 39.4% | 38.3% |
| CHA 3 | 735 | 31.9% | 35.5% | 32.6% |
| CHA 4 | 600 | 17.3% | 33.2% | 49.5% |
| CHA 5 | 418 | 22.3% | 35.9% | 41.8% |
| CHA 6 | 925 | 31.3% | 30.5% | 38.3% |

Source: University of British Columbia, Human Early Learning Partnership, 2012

The Middle-Years Development Instrument (MDI) measures social and emotional health, and also gathers information about children's perceptions of the community assets available to support their health and development.

The MDI is a self-report questionnaire administered to Grade 4 children. It was used to gather data from all Vancouver School District children starting in 2011. Data from the Vancouver MDI project can be used to provide an overall picture of child well-being. The MDI calculates an overall health and well-being score which is composed of 5 dimensions: optimism, happiness, self-esteem, general health, and sadness (reverse-scored).

Children who scored "high" agreed or strongly agreed with statements like: "I have more good times than bad times," "I am happy with my life," and "the things in my life are excellent."

Children who were considered "medium" on the well-being index responded that these statements were partially or somewhat true for them. Children who responded that they disagreed with these statements were designated as having a "low" level of well-being.

**TABLE 5.** Middle Years Development Instrument percentage (%) of students reporting presence of each asset, 2011

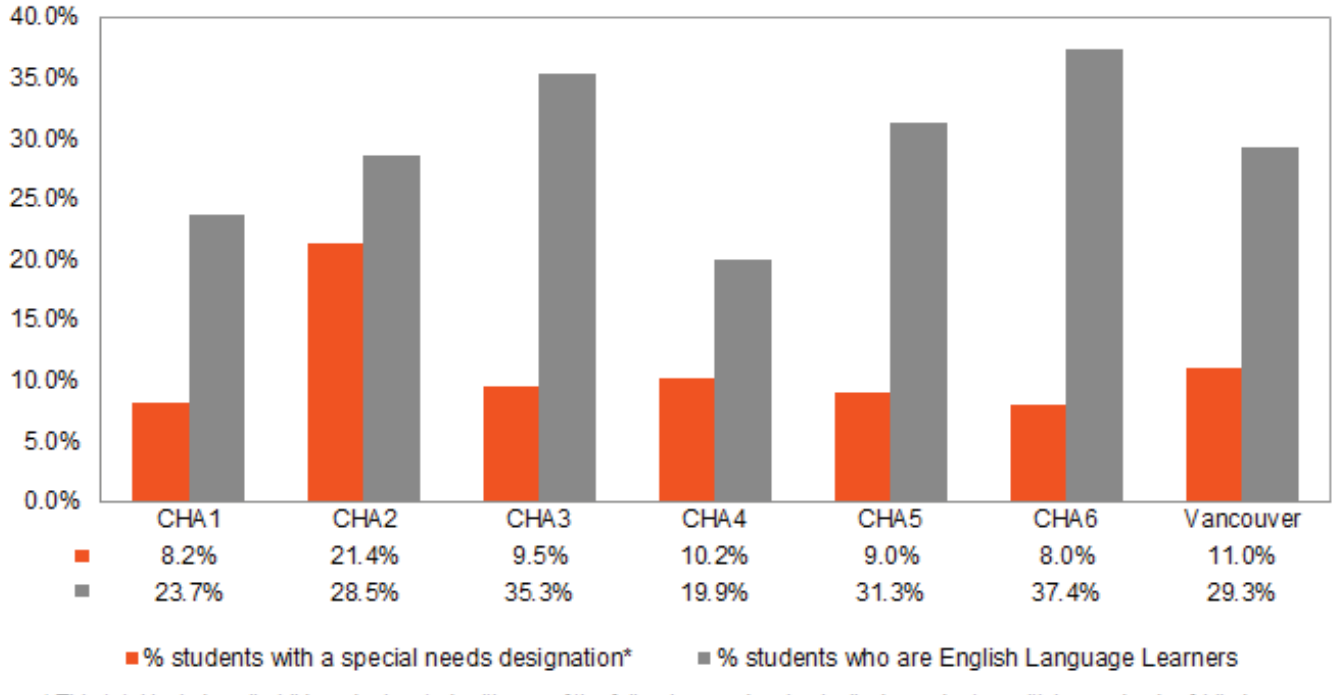
| | Percentage (%) of grade 4 students that report the presence of each asset | | | |
|---|---|---|---|---|
| Community Health Area | After School Activities | Peer Relationships | Nutrition and Sleep | Adult Relationships |
| CHA 1 | 67.4% | 85% | 72% | 83.7% |
| CHA 2 | 76.2% | 74% | 63.3% | 79.5% |
| CHA 3 | 63.5% | 76% | 65.2% | 70.9% |
| CHA 4 | 88.5% | 79.8% | 76.7% | 82.7% |
| CHA 5 | 71.4% | 78.3% | 71.8% | 75.5% |
| CHA 6 | 72.6% | 76.9% | 67.2% | 73.5% |

Source: University of British Columbia, Human Early Learning Partnership, 2012

The MDI also gathers information from children about their perception of the community and school assets they experience. Children were asked about their experiences of connection with adults in their schools, neighbourhoods and at home and with their peers. They were also asked about how often they eat breakfast, how often they get a good night's sleep, and whether they participated in after-school activities.

Table 5 shows that children in CHA 1 report having positive relationships with peers and adults. 72% of children in CHA 1 report that they usually eat breakfast and get a good night's sleep.

**FIGURE 7.** Percentage (%) of students enrolled in the Vancouver School Board with a special needs designation or who are English Language Learners, Community Health Areas and Vancouver, 2010/11 school year




Source: Vancouver School Board, 2011

*The "special needs designation" includes all children designated with any of the following needs: physically dependent – multiple needs, deaf-blind, moderate to profound intellectual disabilities, physical disability or chronic health impairment, visual impairment, deaf or hard of hearing, autism spectrum disorder (ASD), students requiring intensive behaviour intervention or students with serious mental illness, mild intellectual disabilities, gifted, learning disabilities, students requiring behaviour support or students with mental illness. Detailed definitions for these designations can be found here: http://www.vsb.bc.ca/ministry-designations.

In September 2011 there were 55,062 students enrolled in the Vancouver School Board. Of these, about 1 in 10 students had a "special needs" designation and about 1 in 3 students were English Language Learners.

To best understand this information, it is important to consider both the percentages and numbers of children in each category. For example, while CHA 4 has a low percentage of students with a special needs designation (10.2%), it is home to the highest number of children with special needs designations (1,487 children).

Note: this table reports data based on school of enrolment. Some students attend schools in a community health area that is different from their community health area of residence.

**TABLE 6.** Percentage (%) of families with children enrolled in the Vancouver School Board receiving income assistance (IA) and/or with a child in care of the BC Ministry of Children and Family Development. Community Health Areas and Vancouver, 2010/11 school year

| | Total enrolment in Vancouver School Board | % of families on Income Assistance | % of families with a child in care |
|---|---|---|---|
| CHA 1 | 2,265 | 4.6% | 0.2% |
| CHA 2 | 3,319 | 20.9% | 2.2% |
| CHA 3 | 13,365 | 7.3% | 0.9% |
| CHA 4 | 14,548 | 0.8% | 0.2% |
| CHA 5 | 5,919 | 4.1% | 0.6% |
| CHA 6 | 15,646 | 5.2% | 0.5% |
| Vancouver | 55,062 | 7.1% | 0.8% |

Source: Vancouver School Board, Personal Communication, (2011, September 30)

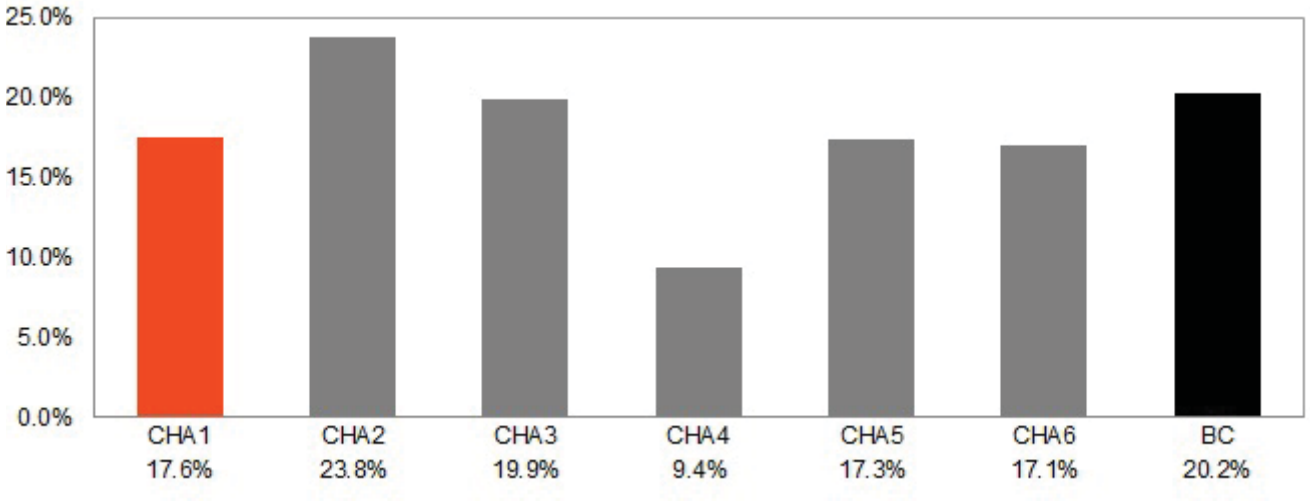
Families in BC who rely on income assistance (IA) may be experiencing temporary unemployment or disability. While income assistance helps these families with the basic costs of living, the support is limited and these families live in poverty.

Children and youth come into foster care with the BC Ministry of Children and Family Development (MCFD) for a variety of reasons including voluntary agreements with parents or guardians who are experiencing difficulties, specialized care for a child who has mental or physical difficulties, or to escape neglect or abuse in their own homes. Whatever the reason for coming into care, for these children, separation from their families is a very difficult experience.

Children and youth in care are highly vulnerable to poor health and poor educational attainment. Within BC, more than half (51.7%) of the children who come into care are Aboriginal (British Columbia Provincial Health Officer, 2006).

Note: this table reports data based on school of enrolment. Some students attend schools in a community health area that is different from their community health area of residence.

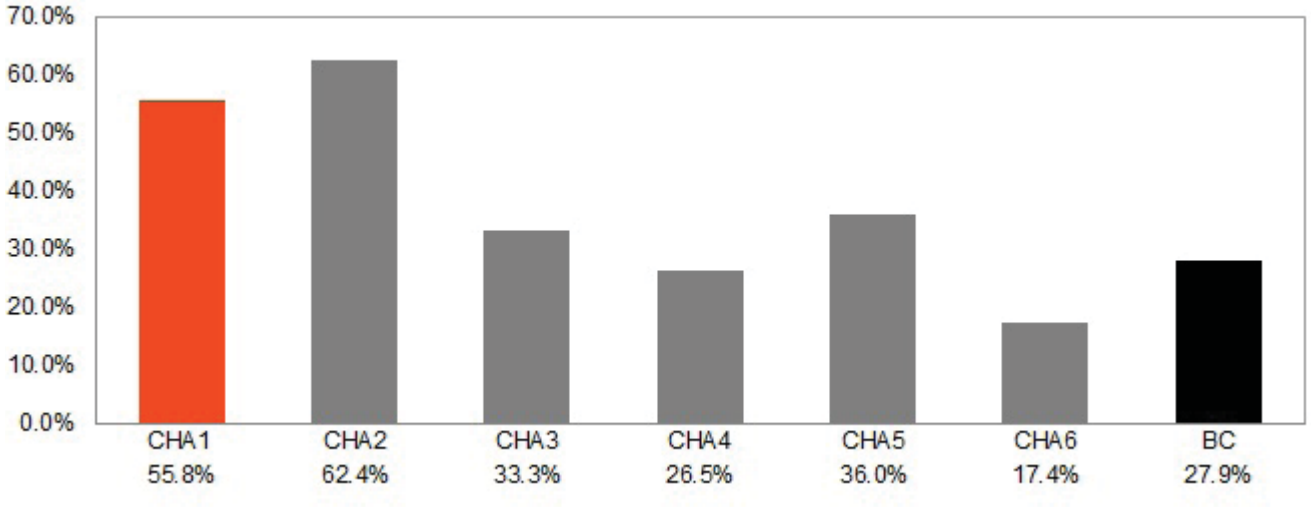
**FIGURE 8.** Percentage (%) of students below the average on the Foundation Skills Assessment reading tests - average of Grade 4 and 7 students. Community Health Areas and British Columbia, average 2008/09-2010/11




Source: BC Stats (2011)

The Foundation Skills Assessment (FSA) is an annual, province-wide assessment of Grade 4 and 7 students' academic skills, providing a snapshot of how well BC students are performing in reading comprehension, writing, and numeracy (BC Ministry of Education). There has been controversy over the meaningfulness and misuse of the data and many parents have opted their children out of writing these exams. As such, these numbers do not reflect all Grade 4 and 7 students.

**FIGURE 9.** Percentage (%) of 18 years olds who did not graduate from high school. Community Health Areas and British Columbia, average 2008/09-2010/11

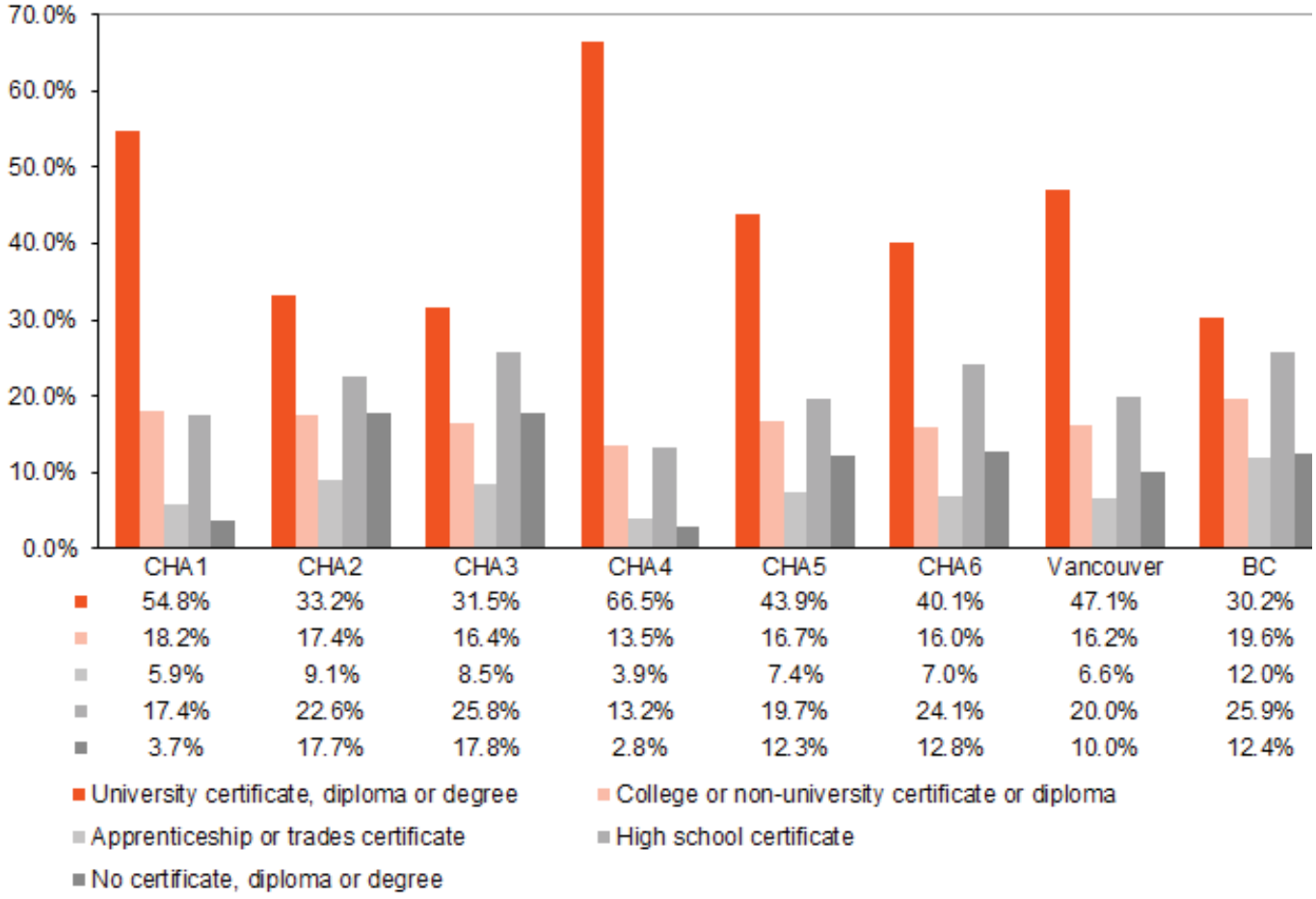



Source: BC Stats, 2011

This figure reports on the percentage of 18 year olds enrolled in the Vancouver School Board who did not graduate at age 18. However, a significant number of youth graduate at age 19 or older. The district-wide average for those who graduated in grade 12 (first time eligible) in 2008/09-2010/11 was 72%. The district average for students graduating within 6 years of starting grade 8 (the "six-year completion rate") for the same time period is higher (81%) (BC Ministry of Education, 2011).

There are various reasons why non-graduation rates for 18 year olds appear high in Vancouver. For example, newcomer students may take extra time to complete required courses. Also, youth with a special needs designation are entitled to an additional year of high school.

**FIGURE 10.** Percentage (%) of population, 25-64 years, by highest level of education attained. Community Health Areas, Vancouver, and British Columbia, 2006

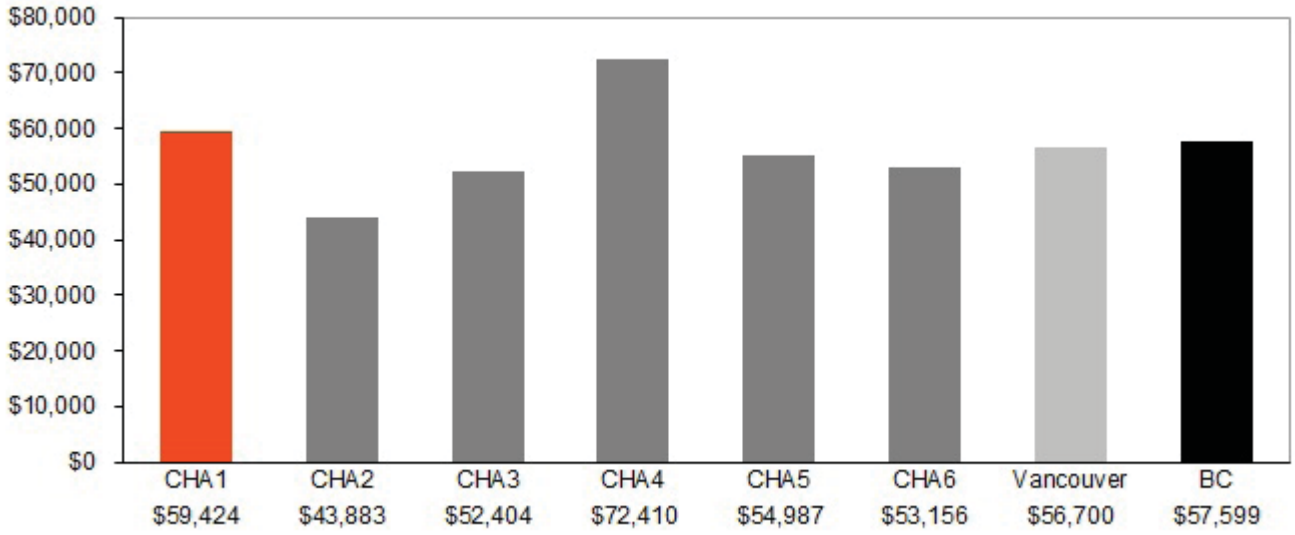



Source: Statistics Canada, 2006 Census of Population

Figure 10 shows the percentage of the population of each CHA that have attained various levels of education. For all CHAs, the percentage of the population that has attained a university certificate, diploma or degree is higher than the percentage in BC overall. CHA 4 is home to the highest percentage of people who have attained a university certificate, diploma or degree, while CHA 3 is home to the highest percentage of people who have not attained any certificate, diploma or degree. 9.1% of residents of CHA 2 have attained an apprenticeship or trades certificate, the highest rate for that certification among all CHAs.

# Employment and income

**FIGURE 11.** Median after-tax incomes of economic families. Community Health Areas, Vancouver, and British Columbia, 2006

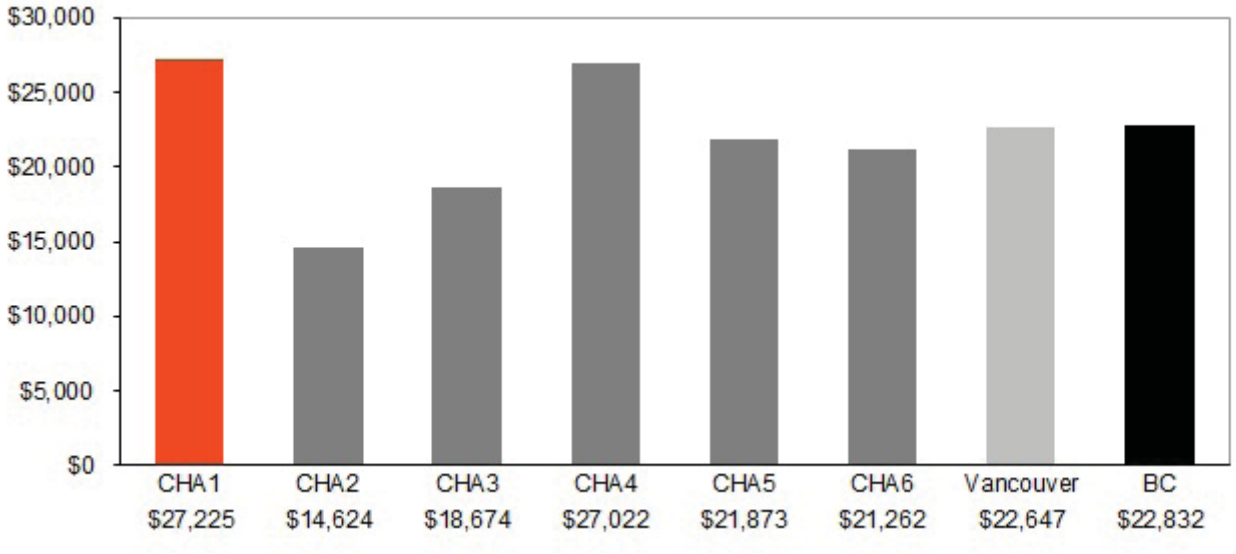



Source: Statistics Canada, 2006 Census of Population

Median income divides income distribution into two groups - half having income above that amount and the other below (Statistics Canada, 2010, July 6). This measure of income is not distorted by the highest and lowest values average income.

Economic families refer to a group of two or more persons who live in the same dwelling and are related to each other by blood, marriage, common law or adoption. A couple may be of opposite or same sex. For 2006, foster children are included (Statistics Canada, 2010).

**FIGURE 12.** Median after-tax income of individuals (aged 15+ years) not in economic families. Community Health Areas, Vancouver, and British Columbia, 2006




Source: Statistics Canada, 2006 Census of Population

**TABLE 7.** Median and average after-tax income of individuals (aged 15+ years) by sex. Community Health Areas, Vancouver, and British Columbia, 2005

| | CHA 1 | CHA 2 | CHA 3 | CHA 4 | CHA 5 | CHA 6 | Vancouver | BC |
|---|---|---|---|---|---|---|---|---|
| Median after-tax income ($) | | | | | | | | |
| Total | $27,624 | $16,309 | $18,916 | $27,831 | $21,334 | $18,952 | $21,840 | $22,785 |
| Male | $29,950 | $16,823 | $21,304 | $31,885 | $23,366 | $21,276 | $24,200 | $28,251 |
| Female | $25,585 | $15,996 | $17,231 | $24,682 | $19,812 | $17,129 | $19,951 | $18,930 |
| Difference (%) | 17.1% | 5.2% | 23.6% | 29.2% | 17.9% | 24.2% | 21.3% | 49.2% |
| Average after-tax income ($) | | | | | | | | |
| Total | $34,233 | $22,230 | $22,719 | $43,746 | $26,229 | $24,340 | $30,107 | $28,908 |
| Male | $39,135 | $22,801 | $25,011 | $56,323 | $28,483 | $27,347 | $34,832 | $34,652 |
| Female | $29,222 | $21,562 | $20,547 | $32,639 | $24,122 | $21,622 | $25,595 | $23,408 |
| Difference (%) | 33.9% | 5.7% | 21.7% | 72.5% | 18.1% | 26.5% | 36.1% | 48.0% |

Source: Statistics Canada, 2006 Census of Population

When looking at median income, males in CHA 1 make 17.1% more than females.

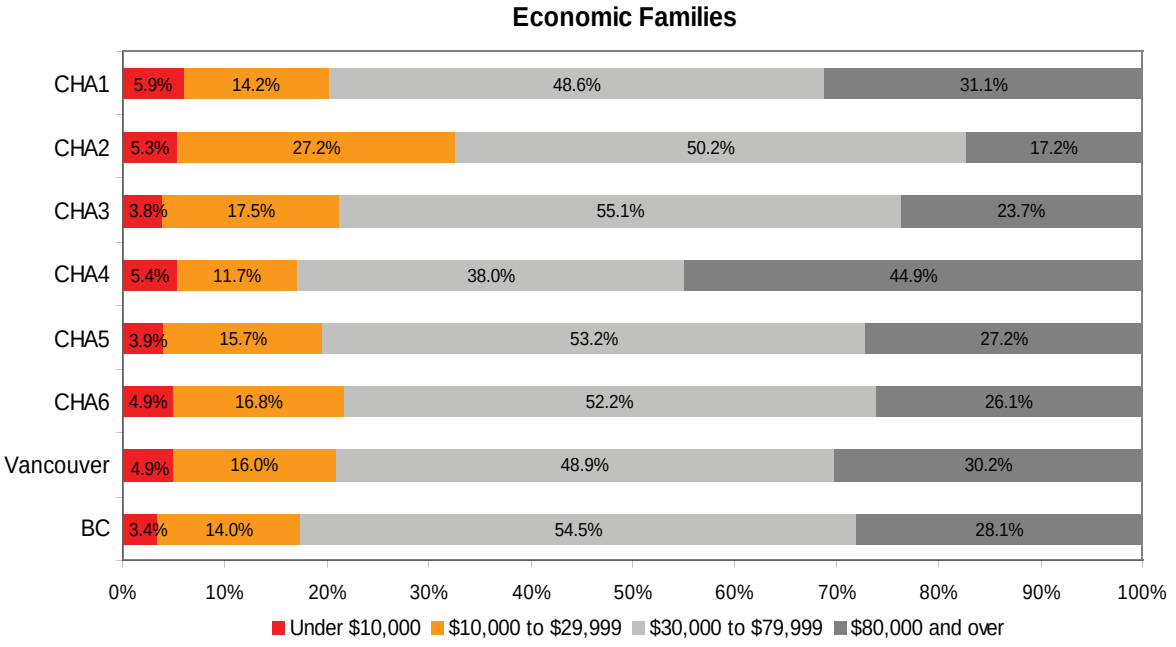
**TABLE 8.** Employment income and unemployment rates for Canadian-born, all immigrants, and recent immigrants. Community Health Areas and British Columbia, 2006

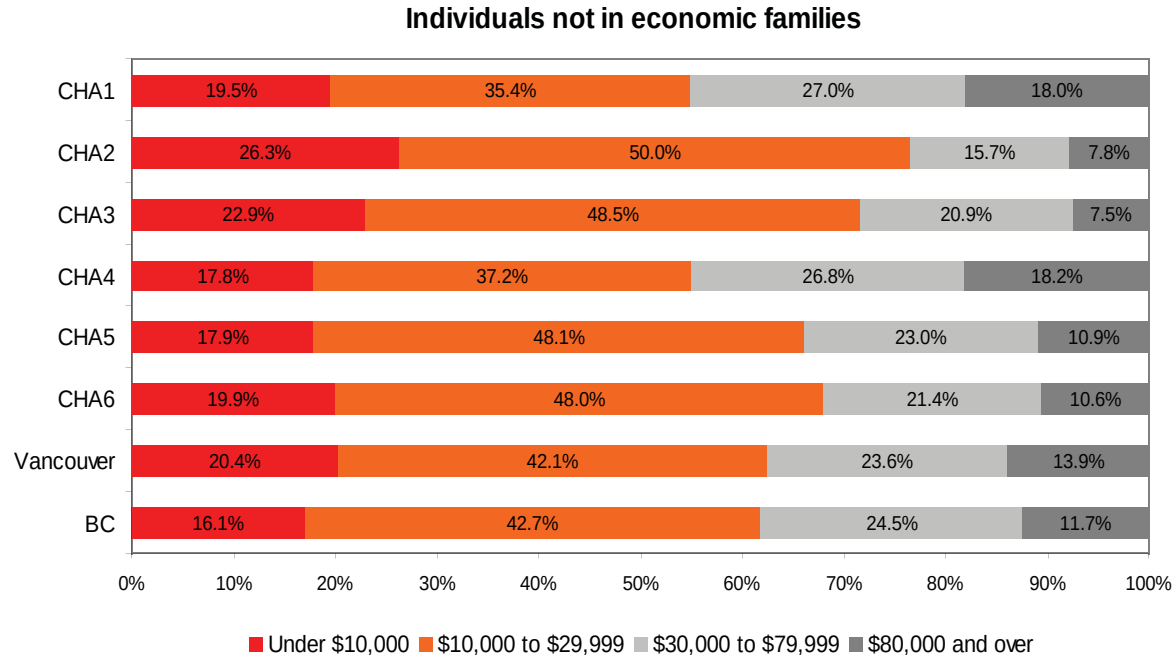
| | Employment Income ($), 2005 | | | Unemployment Rate (%), 2006 | | |
|---|---|---|---|---|---|---|
| | Canadian-Born | All Immigrants | Recent Immigrants | Canadian-Born | All Immigrants | Recent Immigrants |
| CHA 1 | $41,201 | $33,967 | $22,973 | 3.8% | 5.7% | 8.5% |
| CHA 2 | $28,520 | $24,044 | $19,202 | 8.1% | 8.0% | 9.9% |
| CHA 3 | $34,922 | $24,800 | $17,940 | 6.0% | 5.8% | 7.5% |
| CHA 4 | $41,597 | $34,962 | $18,164 | 3.4% | 5.6% | 10.2% |
| CHA 5 | $35,067 | $25,080 | $17,992 | 4.4% | 6.1% | 11.9% |
| CHA 6 | $37,202 | $24,558 | $14,643 | 4.8% | 5.1% | 8.7% |
| BC | $36,053 | $28,009 | $17,994 | 4.8% | 5.5% | 9.7% |

Source: BC Stats (2011)

Immigrants and, in particular, recent immigrants experience a disadvantage in the labour force. Within CHA 1, recent immigrants earn $18,228 less than the average Canadian-born worker. This group also experiences greater rates of unemployment (8.5% vs. 3.8%).

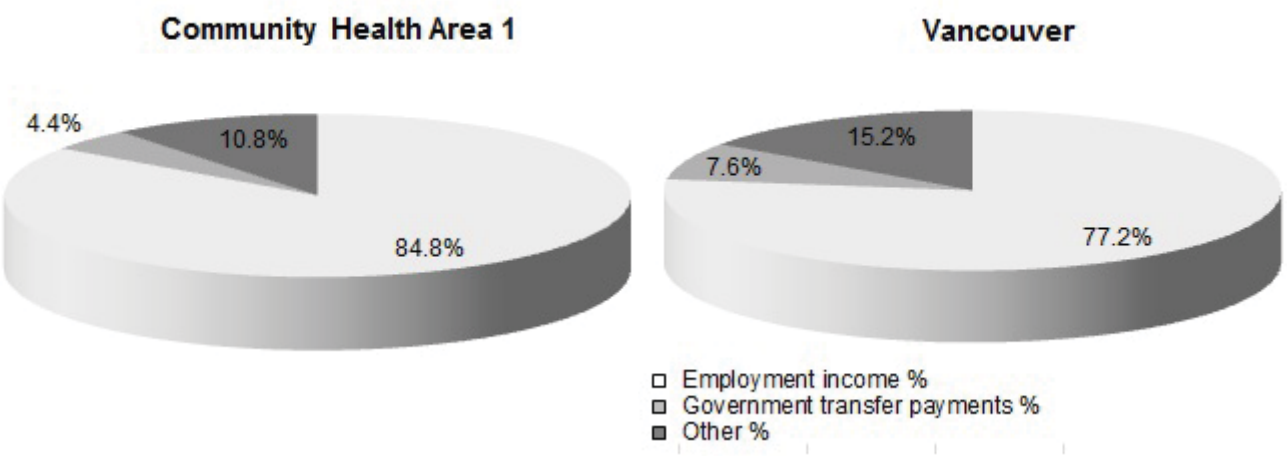
**FIGURE 13.** Income distribution (%), after-tax. Community Health Areas, Vancouver, and British Columbia, 2006




Source: Statistics Canada, 2006 Census of Population

**FIGURE 14.** Composition of family income of economic families. Community Health Area 1 and Vancouver, 2006




Source: Statistics Canada, 2006 Census of Population

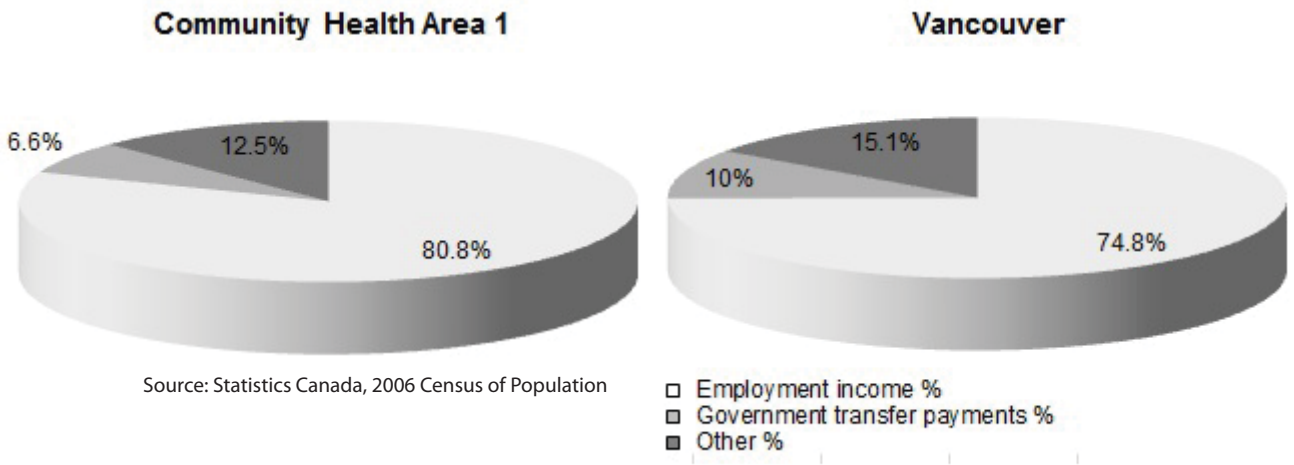
The previous figures break down income source (employment, government transfer payments and other sources) as a percentage of the total income of economic families in CHA 1 compared to that of Vancouver.

Government transfer payments include the Old Age Security pension and Guaranteed Income Supplement, benefits from the Canada Pension Plan, benefits from Employment Insurance, and child benefits.

Other money income includes dividends, interests, other investment income, retirement pensions, superannuation and annuities, and income from abroad (Statistics Canada, 2010).

Note: see page 29 for definition of economic families.

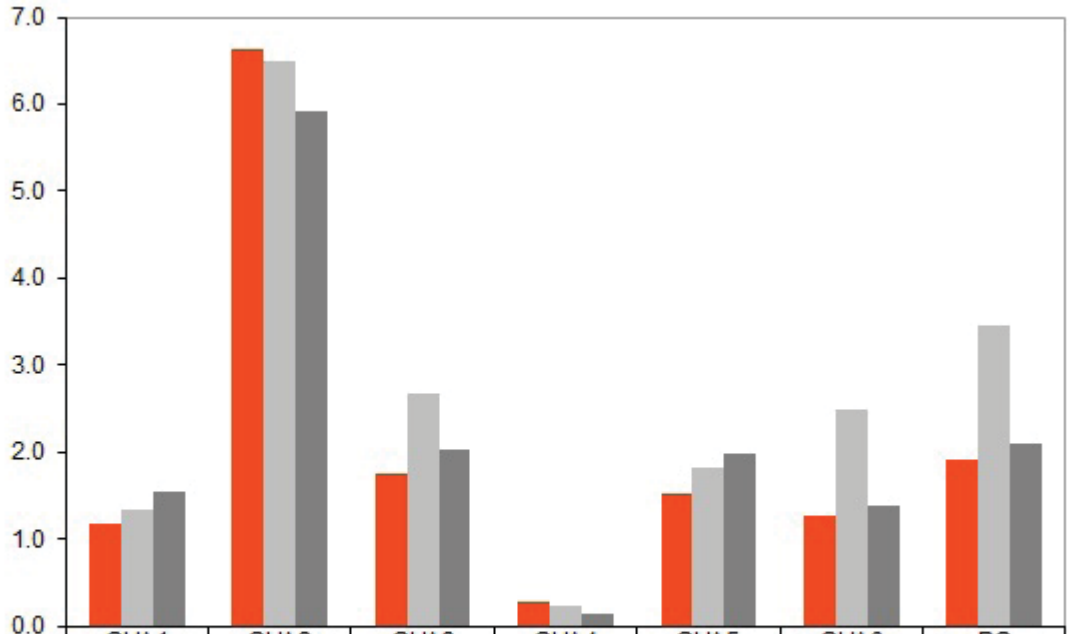
**FIGURE 15.** Composition of individual income of persons (aged 15+ years) not in economic families. Community Health Area 1 and Vancouver, 2006




Source: Statistics Canada, 2006 Census of Population

When it comes to composition of individual income in CHA 1, the relative share of employment income is 80.8%, while the relative share of government transfer payments is 6.6%.

**FIGURE 16.** Percentage of population (%) receiving income assistance. Community Health Areas and British Columbia, 2010

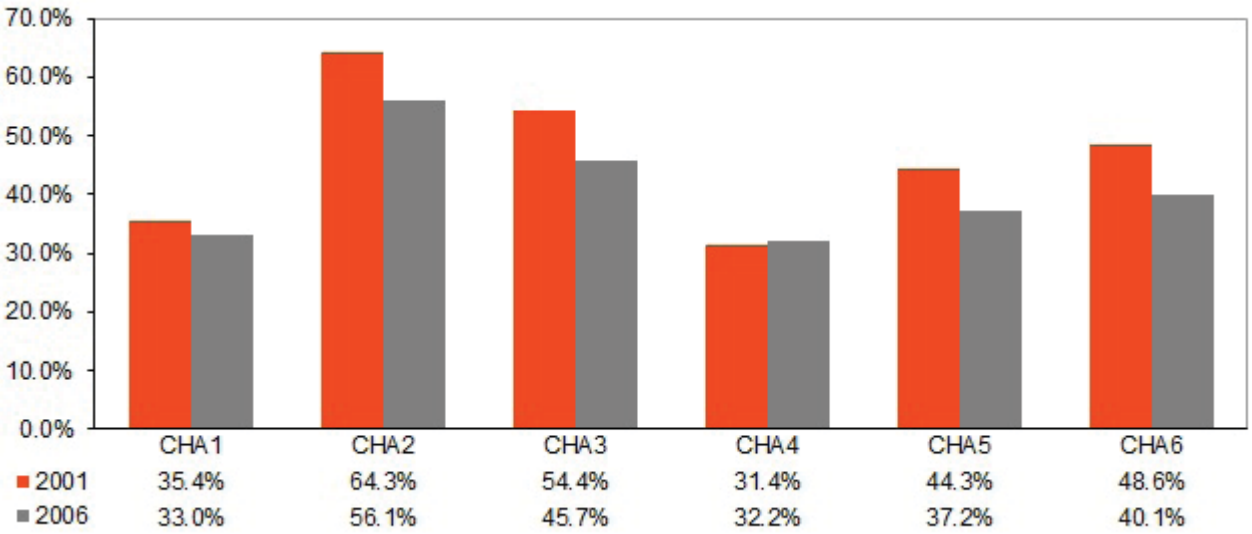



| | CHA1 | CHA2 | CHA3 | CHA4 | CHA5 | CHA6 | BC |
|---|---|---|---|---|---|---|---|
| Total | 1.2 | 6.6 | 1.8 | 0.3 | 1.5 | 1.3 | 1.9 |
| Children (0-14 years) | 1.3 | 6.5 | 2.7 | 0.2 | 1.8 | 2.5 | 3.5 |
| Youth (15-24 years) | 1.5 | 5.9 | 2.0 | 0.1 | 2.0 | 1.4 | 2.1 |

Source: BC Stats (2011)

The BC Employment and Assistance program is meant to help British Columbians move from income assistance to sustainable employment. Applicants are expected to take advantage of all other sources of income and assets before qualifying and to actively seek work and participate in employment programs while receiving assistance (BC Ministry of Social Development, 2010, May 28). Included are those on temporary assistance: expected to work, expected to work - medical condition, temporarily excused and persistent multiple barriers. Excluded are those on continual assistance who have access to other forms of assistance: persons with disabilities, children in the home of a relative, and Old Age Security/seniors (BC Stats, n.d.).

**FIGURE 17.** Incidence of low-income among individuals (aged 15+ years) after-tax. Community Health Areas, 2001 and 2006.

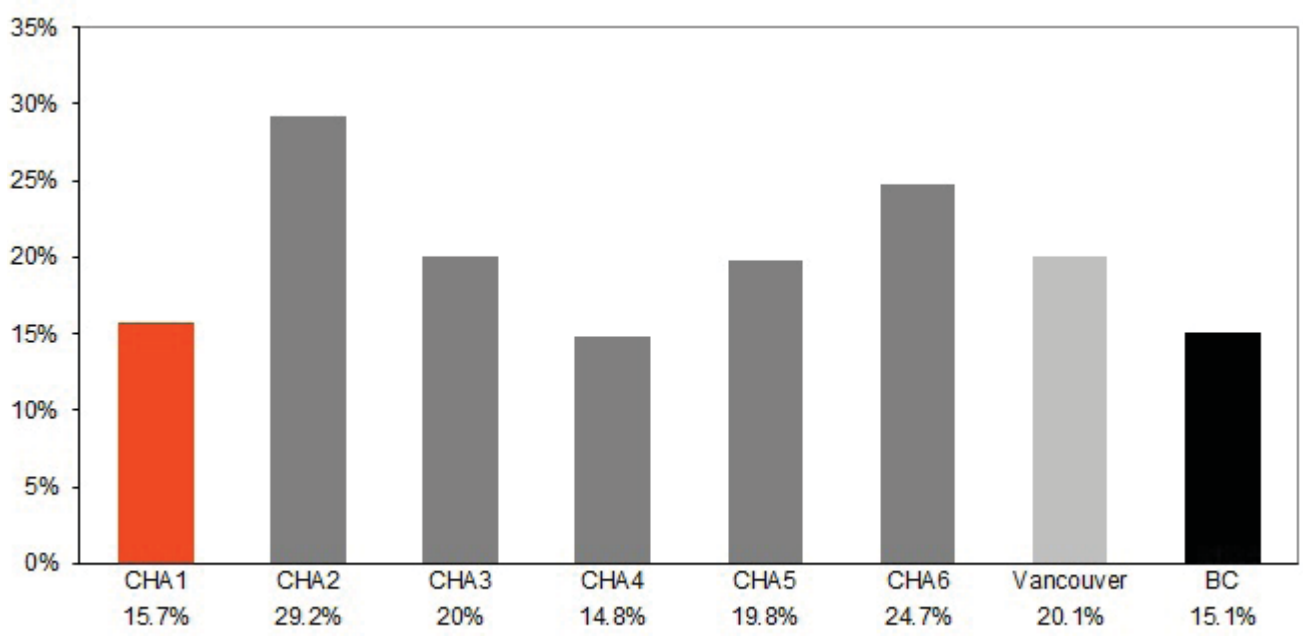



Source: Statistics Canada, 2001 Census of Population and 2006 Census of Population

The most widely recognized approach to understanding poverty is the "Low Income Cut Off" (LICO) calculated by Statistics Canada: "A LICO is an income threshold below which a family will likely devote a larger share of its income to the necessities of food, shelter and clothing than an average family would." Statistics Canada calculates different LICOs for families of various sizes living in rural and urban communities. For example, in 2006 the LICO, after tax, for a single person living in a city with a population over 500,000 was $17, 568. The LICO, after tax, for a family of four in a similar sized city was $33, 216 (Statistics Canada. 2012, December 20).

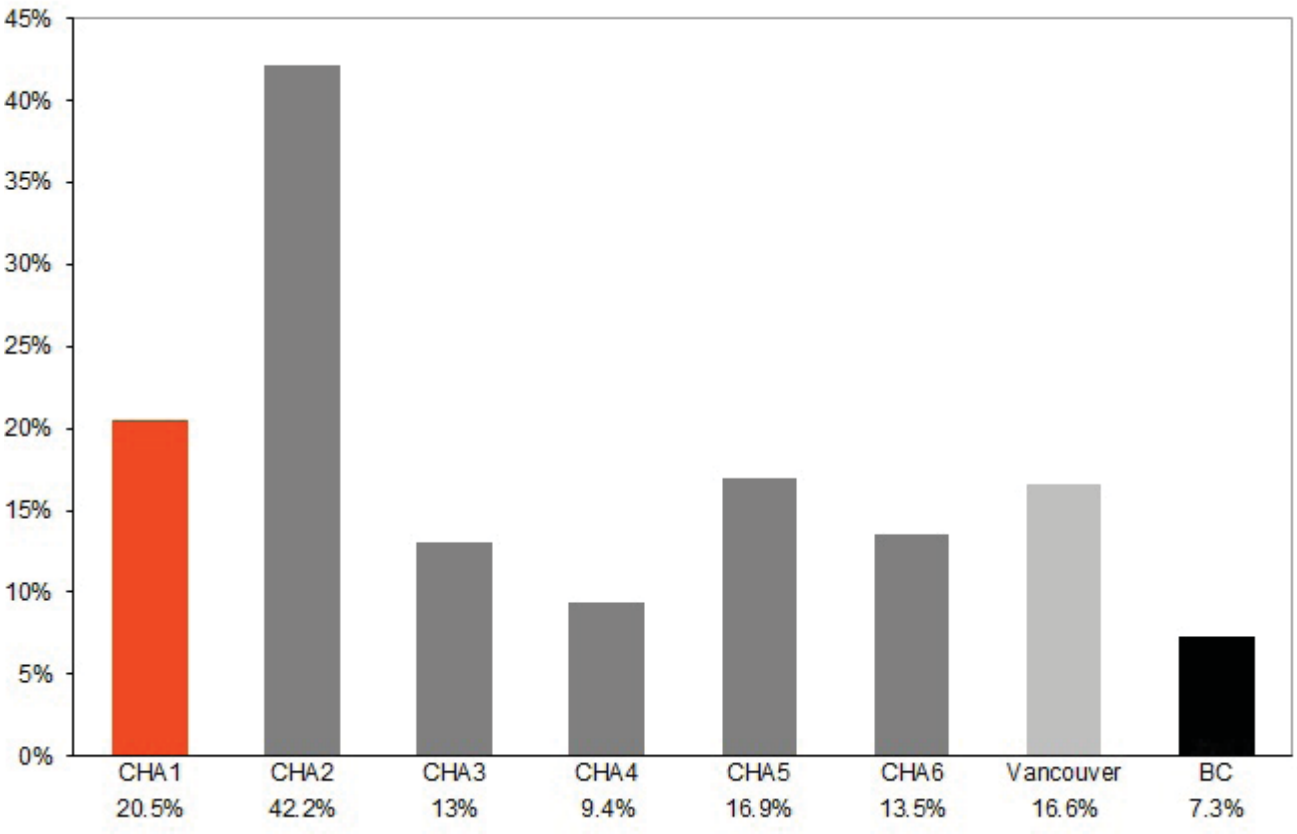
From 2001 to 2006, the percentage of low-income among individuals over the age of 15 decreased in all CHAs with the exception of CHA 4 (Westside), which showed a very small increase.

**FIGURE 18.** Children, aged less than 6 years, (%) living in low income conditions, after-tax. Community Health Areas, Vancouver, and British Columbia, 2006




Source: Statistics Canada, 2006 Census of Population

**FIGURE 19.** Seniors, aged 65 years and over, (%) living in low income conditions, after-tax. Community Health Areas, Vancouver, and British Columbia, 2006

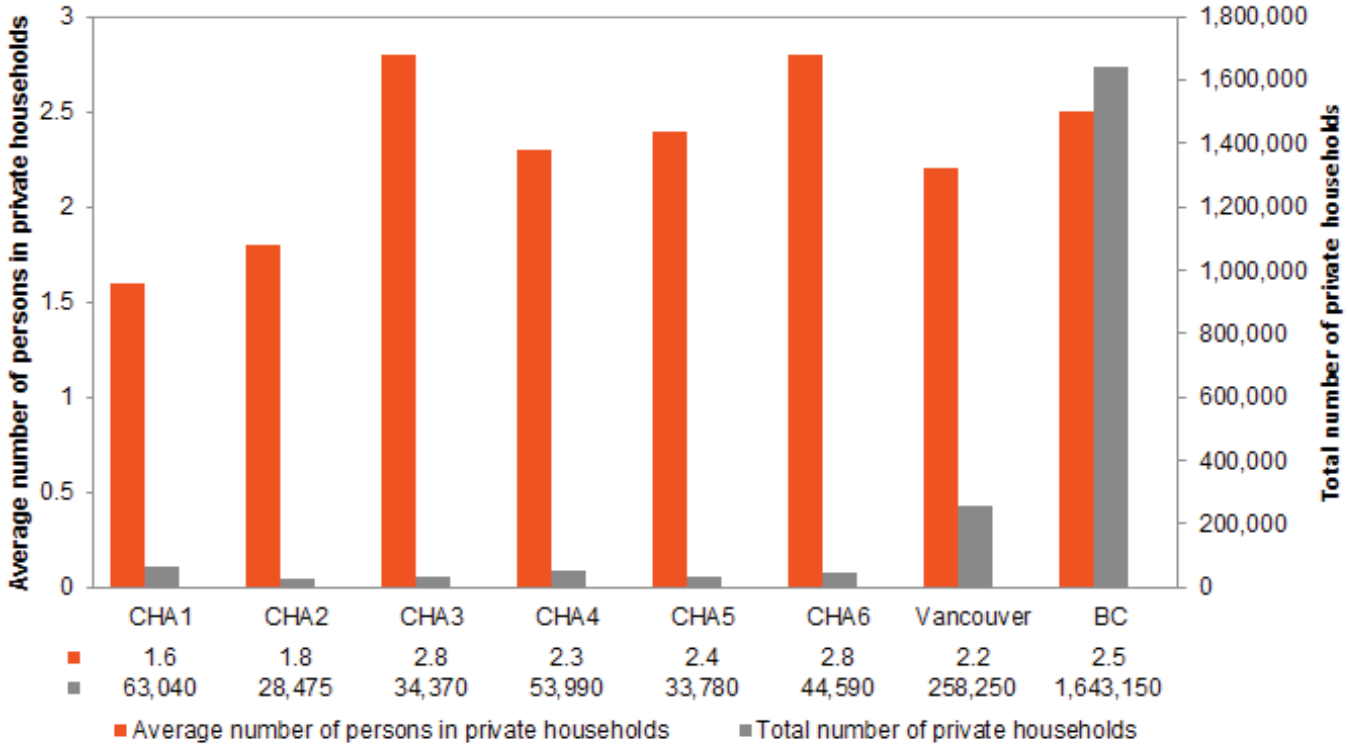



Source: Statistics Canada, 2006 Census of Population

CHA 1 has the second lowest percentage of its total population (33.0%) and children (15.7%) that are considered to be living in low income conditions. However, it has the second highest percentage of seniors (20.5%) living in low income conditions.

# Housing and household characteristics

**FIGURE 20.** Average number of persons in households. Community Health Areas, Vancouver, and British Columbia, 2006




Source: Statistics Canada, 2006 Census of Population

CHA 1 has the fewest number of people per household averaging at 1.6 people.

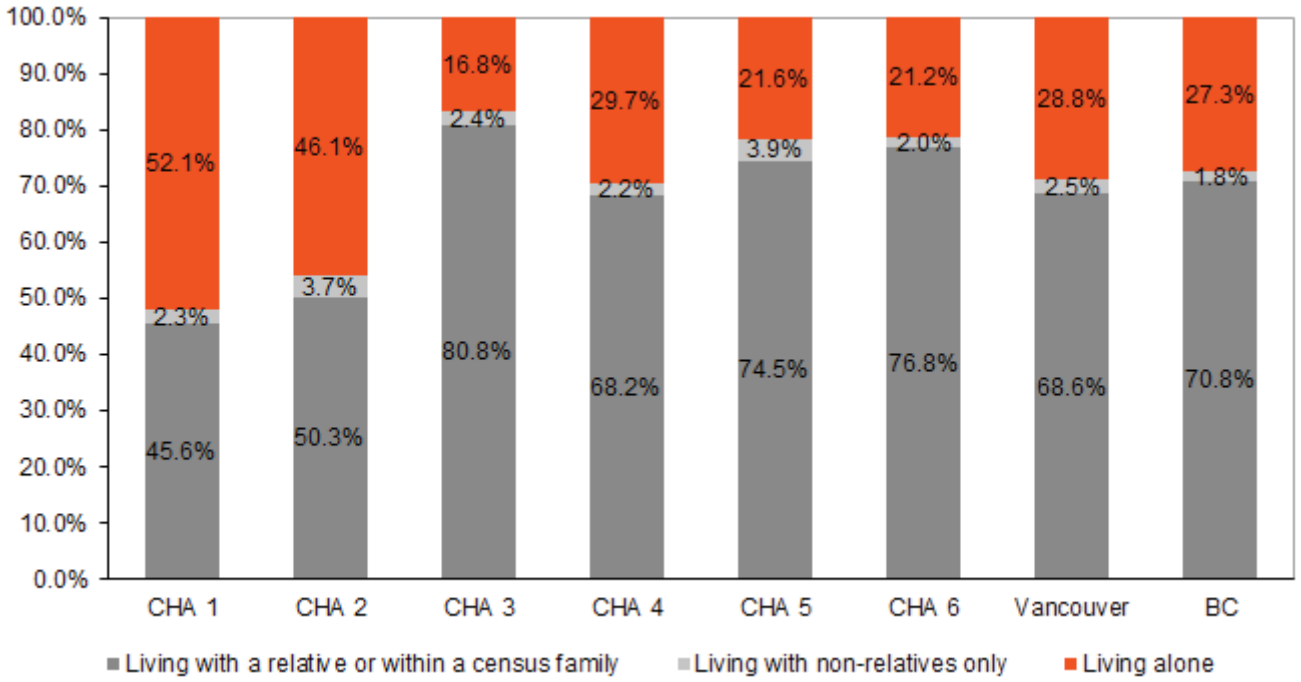
**TABLE 9.** Total lone parent families as a percentage of all census families by sex of parent. Community Health Areas, Vancouver, and British Columbia, 2006

| | CHA 1 | CHA 2 | CHA 3 | CHA 4 | CHA 5 | CHA 6 | Vancouver | BC |
|---|---|---|---|---|---|---|---|---|
| Total lone-parent families | 11.3% | 22.4% | 18.5% | 13.1% | 17.6% | 17.5% | 16.2% | 15.1% |
| Female parent | 81.4% | 81.0% | 81.0% | 83.0% | 78.0% | 83.4% | 81.6% | 79.8% |
| Male parent | 18.6% | 19.0% | 19.0% | 17.0% | 22.1% | 16.6% | 18.4% | 20.2% |

Source: Statistics Canada, 2006 Census of Population

Lone parent families, over 80% of whom are led by women, are often at a disadvantage economically. With housing costs so high and women's incomes typically lower than men's, children in lone parent families may live in poorer quality housing and have less access to enrichment programs than their counterparts in two-income households. Of all the CHAs in Vancouver, CHA 1 is home the smallest percentage of lone parent families (11.3% of all census families).

**FIGURE 21.** Living arrangements of seniors age 65 years and over. Community Health Areas, Vancouver and British Columbia, 2006




Source: Statistics Canada, 2006 Census of Population

The majority of seniors within CHA 1 (52.1%) live alone while another 45.6% live with a partner or relative. This is the highest and lowest, respectively, amongst the CHAs .

These figures cover seniors living in private homes and do not include those living in facilities or hospitals.

**TABLE 10.** Percentage of population 15 years and older by hours of unpaid care/assistance to seniors. Community Health Areas, Vancouver, and British Columbia, 2006.

| | Total population 15 years and older | Hours unpaid care/assist. to seniors | Less than 5 hrs unpaid care/ assist. to seniors | 5 – 9 hrs unpaid care/assist. to seniors | 10+ hrs unpaid care/assist. to seniors |
|---|---|---|---|---|---|
| CHA 1 | 95,705 | 88.9% | 7.2% | 2.2% | 1.6% |
| CHA 2 | 46,560 | 88.4% | 6.4% | 2.6% | 2.6% |
| CHA 3 | 82,015 | 81.6% | 10.3% | 4.2% | 3.9% |
| CHA 4 | 107,290 | 83.5% | 10.7% | 3.3% | 2.5% |
| CHA 5 | 69,110 | 83.4% | 10.0% | 3.4% | 3.1% |
| CHA 6 | 107,165 | 80.3% | 11.0% | 4.5% | 4.2% |
| Vancouver | 507,850 | 84.0% | 9.6% | 3.4% | 3.0% |
| BC | 3,394,910 | 82.5% | 10.3% | 3.9% | 3.3% |

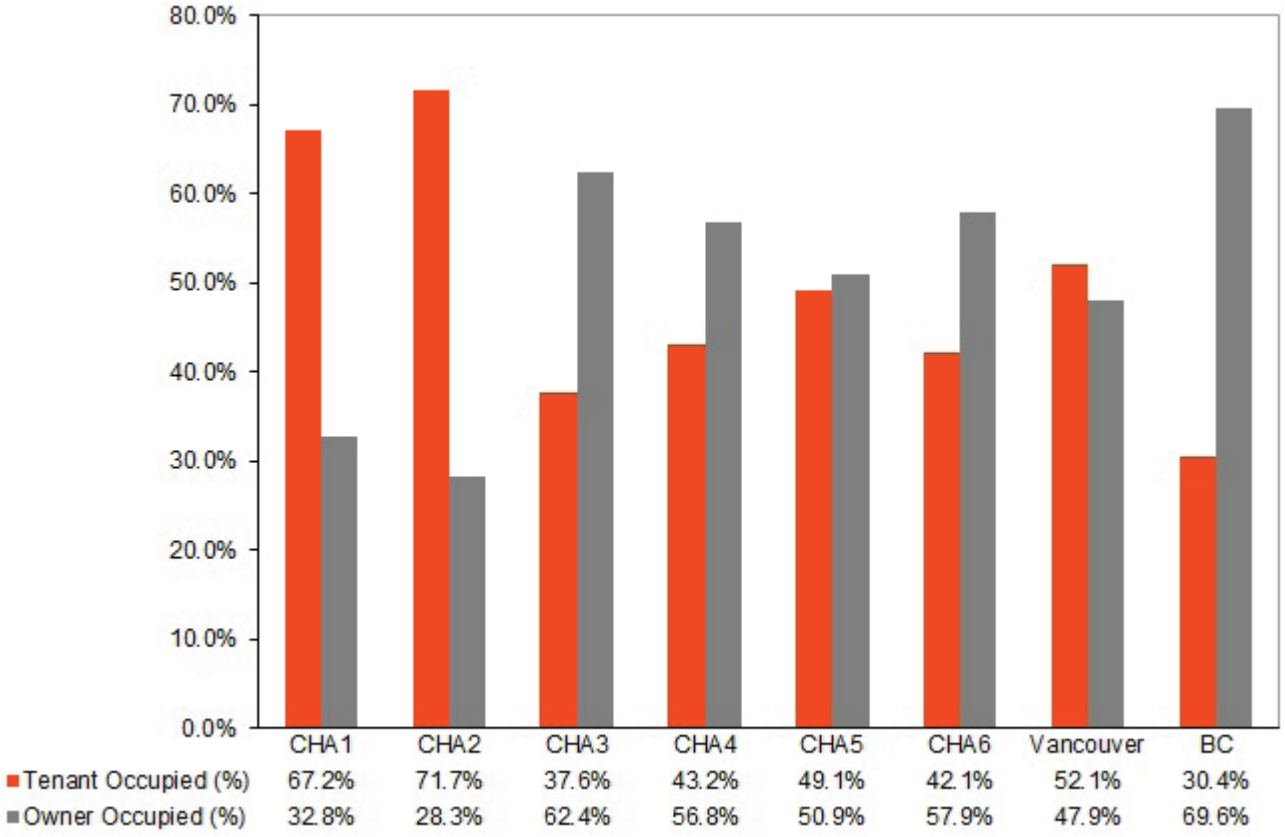
Source: Statistics Canada, 2006 Census of Population

Table 10 shows the percentage of the adult population that is providing unpaid care to seniors. These caregivers are most often relatives or spouses.

It also refers to the number of hours persons spent providing unpaid care or assistance to seniors of one's own household, to other senior family members outside the household, and to friends or neighbours in the week (Sunday to Saturday) prior to Census Day (May 16, 2006).

Unpaid care or assistance to seniors does not include volunteer work for a non-profit organization, religious organization, charity or community group, or work without pay in the operation of a family farm, business or professional practice. (2006 Census Dictionary).

**FIGURE 22.** Tenant and owner occupied dwellings. Community Health Areas, Vancouver, and British Columbia, 2006

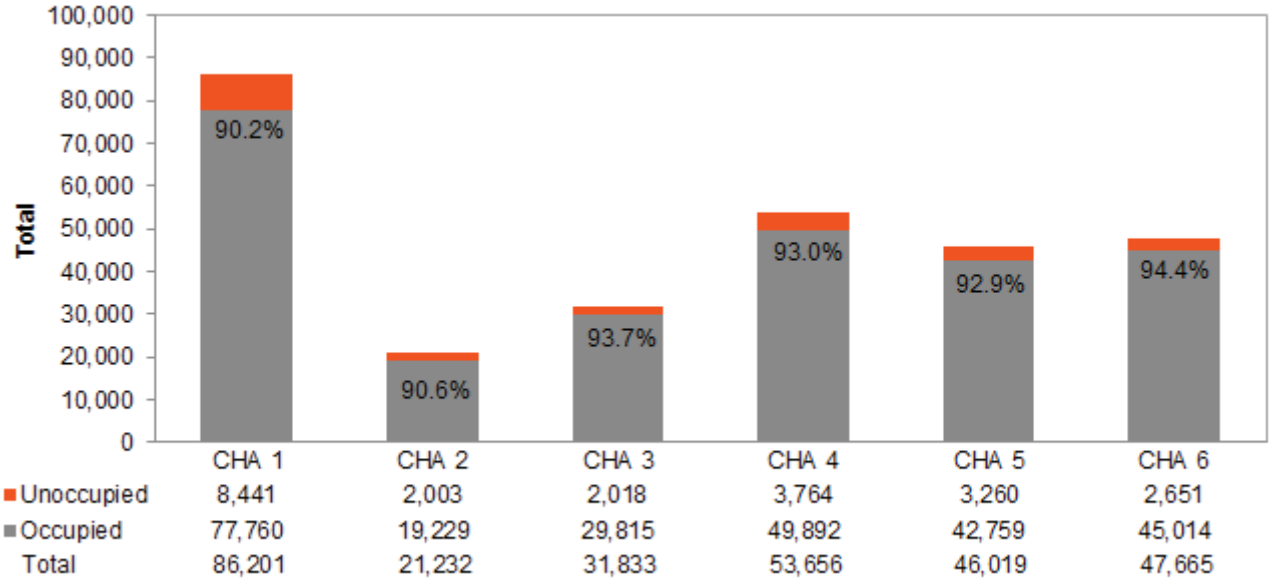



| | CHA 1 | CHA 2 | CHA 3 | CHA 4 | CHA 5 | CHA 6 | Vancouver | BC |
|---|---|---|---|---|---|---|---|---|
| Tenant Occupied (%) | 67.2% | 71.7% | 37.6% | 43.2% | 49.1% | 42.1% | 52.1% | 30.4% |
| Owner Occupied (%) | 32.8% | 28.3% | 62.4% | 56.8% | 50.9% | 57.9% | 47.9% | 69.6% |

Source: Statistics Canada, 2006 Census of Population

Similar to Vancouver, CHA 1 has more tenant-occupied versus owner-occupied dwellings (67.2% vs. 32.8%). CHA 1 has the second highest percentage of rented dwellings in Vancouver.

**FIGURE 23.** Total number of dwellings and the percentage that are occupied. Community Health Areas, 2011




| | CHA 1 | CHA 2 | CHA 3 | CHA 4 | CHA 5 | CHA 6 |
|---|---|---|---|---|---|---|
| Unoccupied | 8,441 | 2,003 | 2,018 | 3,764 | 3,260 | 2,651 |
| Occupied | 77,760 | 19,229 | 29,815 | 49,892 | 42,759 | 45,014 |
| Total | 86,201 | 21,232 | 31,833 | 53,656 | 46,019 | 47,665 |

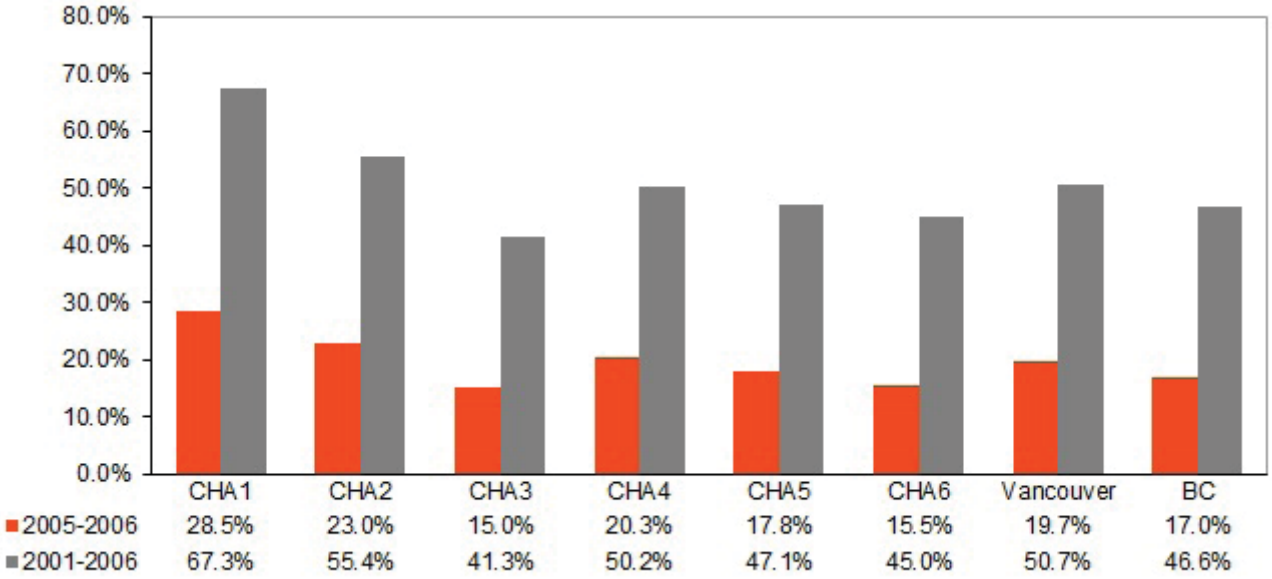
Source: City of Vancouver, 2012

A dwelling may be considered as "unoccupied" if there was someone living there who was not counted in the census (overseas visitors, etc.) or someone living there who the census didn't find, or a part-time resident. It also includes housing that is empty due to being renovated, those vacant and for sale, or those in-between tenants (City of Vancouver, Personal Communication, 2012, July 5).

A high number of unoccupied dwellings in an area may have an impact on feelings of community vibrancy and safety. The above figure shows the total number of dwellings in each CHA and the percentage of dwellings that were occupied at the time of the 2011 Census.

Note: The neighbourhood of Cedar Cottage spans across CHAs 3 and 5. In this figure, data for Cedar Cottage is included in CHA 5 only.

**FIGURE 24.** Percentage of population who have moved recently (between 2005-2006 or 2001-2006). Community Health Areas, Vancouver, and British Columbia, 2006

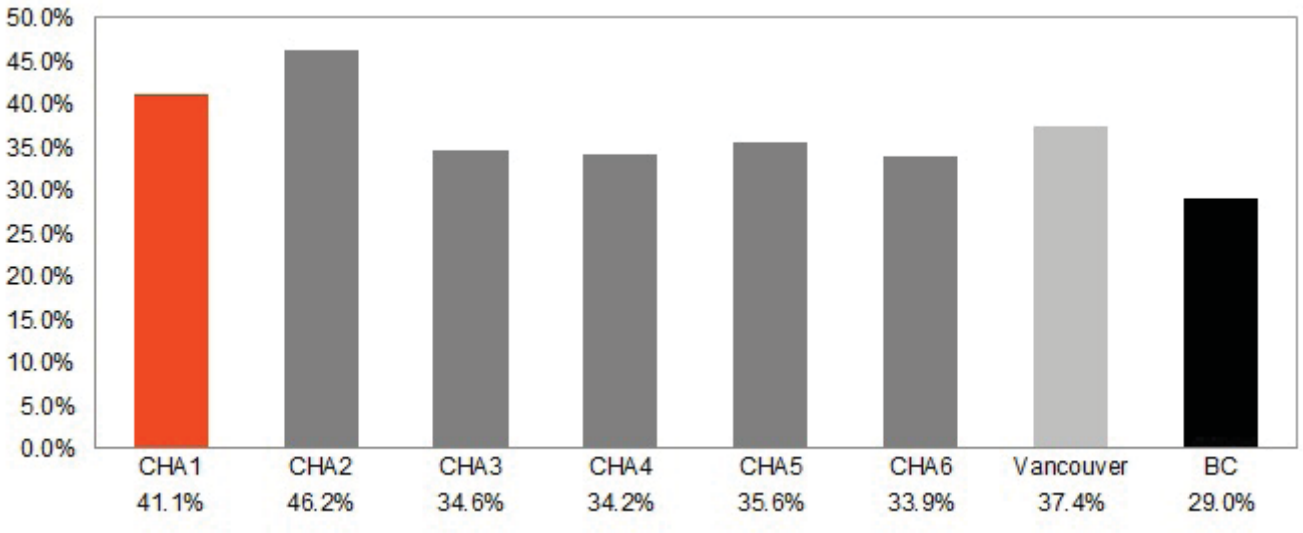



Source: Statistics Canada, 2006 Census of Population

Mobility refers to the number of people who have changed addresses within the last year (2005-2006) or last 5 years (2001-2006) before the Census Day. It takes into account the level of in-migration, nature of the population (i.e. students), and cost of housing (Statistics Canada, 2010).

A more stable community with lower mobility may imply a closer social support network with higher social capital and consequent positive health effects. CHA 1 is home to the most mobile population, with 67.3% of residents having changed addresses between 2001-2006 and 28.5% having changed addresses between 2005-2006. This is higher relative to both Vancouver and BC.

**FIGURE 25.** Percentage of households paying 30% or more of their income on housing costs. Community Health Areas, Vancouver, and British Columbia, 2006

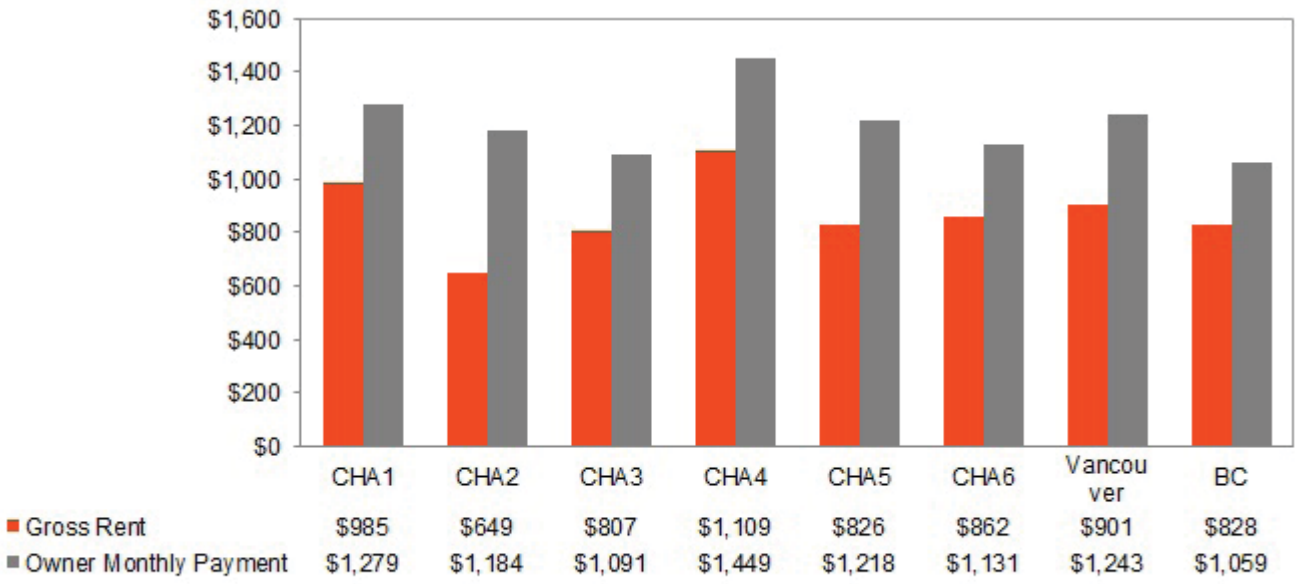



Source: Statistics Canada, 2006 Census of Population

A household paying more than 30% of their annual income on housing is considered to be living in unaffordable conditions. This cost burden makes it difficult to pay for other necessities such as food, clothing, education, transportation, and health care.

Forty-one percent of the CHA 1 population is paying 30% or more of their income on housing costs, the second highest amongst the CHAs.

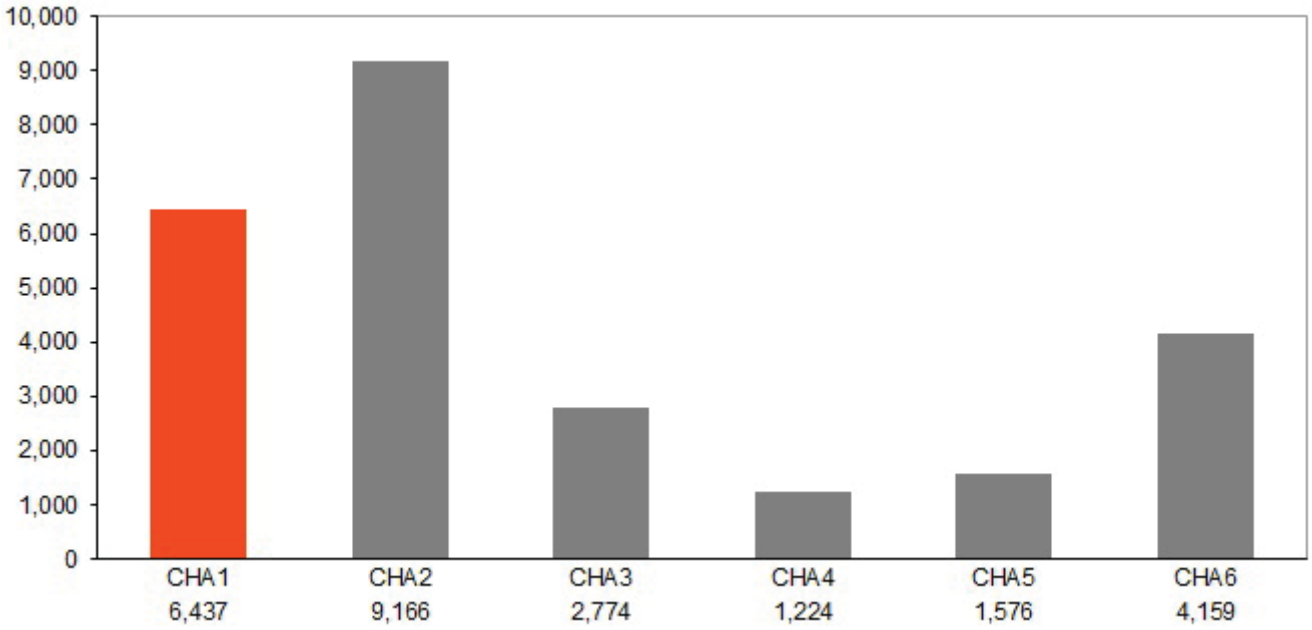
**FIGURE 26.** Average gross rent and owner monthly payment ($). Community Health Areas, Vancouver, and British Columbia, 2005




| | CHA1 | CHA2 | CHA3 | CHA4 | CHA5 | CHA6 | Vancouver | BC |
|---|---|---|---|---|---|---|---|---|
| Gross Rent | $985 | $649 | $807 | $1,109 | $826 | $862 | $901 | $828 |
| Owner Monthly Payment | $1,279 | $1,184 | $1,091 | $1,449 | $1,218 | $1,131 | $1,243 | $1,059 |

Source: Statistics Canada, 2006 Census of Population

**FIGURE 27.** Number of non-market housing units. Community Health Areas, 2011




Source: City of Vancouver, 2012

Non-market housing provides housing mainly for those who cannot afford to pay market rents. It is housing owned by government, a non-profit, or co-operative society where rents are determined not by the market but by the residents' ability to pay (City of Vancouver, 2010). Non-market housing is designed for independent living. In 2010, non-market housing accounted for 8.4% of Vancouver's total housing stock.

**TABLE 11.** Number of permanent and temporary shelter spaces. Community Health Areas, 2011/2012

| | Permanent Shelter Spaces | Temporary Shelter Spaces | Sheltered Homeless Population | Street Homeless Population |
|---|---|---|---|---|
| CHA 1 | 261 | 80 | 533 | 127 |
| CHA 2 | 298 | 216 | 461 | 134 |
| CHA 3 | 0 | 0 | no data available | no data available |
| CHA 4 | 18 | 0 | 19 | no data available |
| CHA 5 | 103 | 140 | 128 | 6 |
| CHA 6 | 0 | 0 | no data available | no data available |

Source: City of Vancouver, 2012

According to the City of Vancouver 2012 Homeless Count, CHA 1 has a sheltered homeless population of 533 people and street homeless population of 127 people, mostly concentrated near the West End, Downtown South and its border with CHA 2 by the Downtown Eastside.

In CHA 1, there are 261 "year-round" and 80 "temporary" shelter spaces to accommodate this need for housing.

Note: For permanent shelters, three facilities that serve particularly vulnerable populations (e.g. youth safe houses) do not publish their locations and/or number of spaces due to safety concerns and have been excluded from these profiles.

For temporary shelter spaces, these include all HEAT or Winter Response shelters that were open at any point during 2011/2012. These figures do not include Extreme Weather Alert shelter spaces.

Note: all homeless counts underestimate the number of homeless people at one time and do not take into account the mobility of this population.

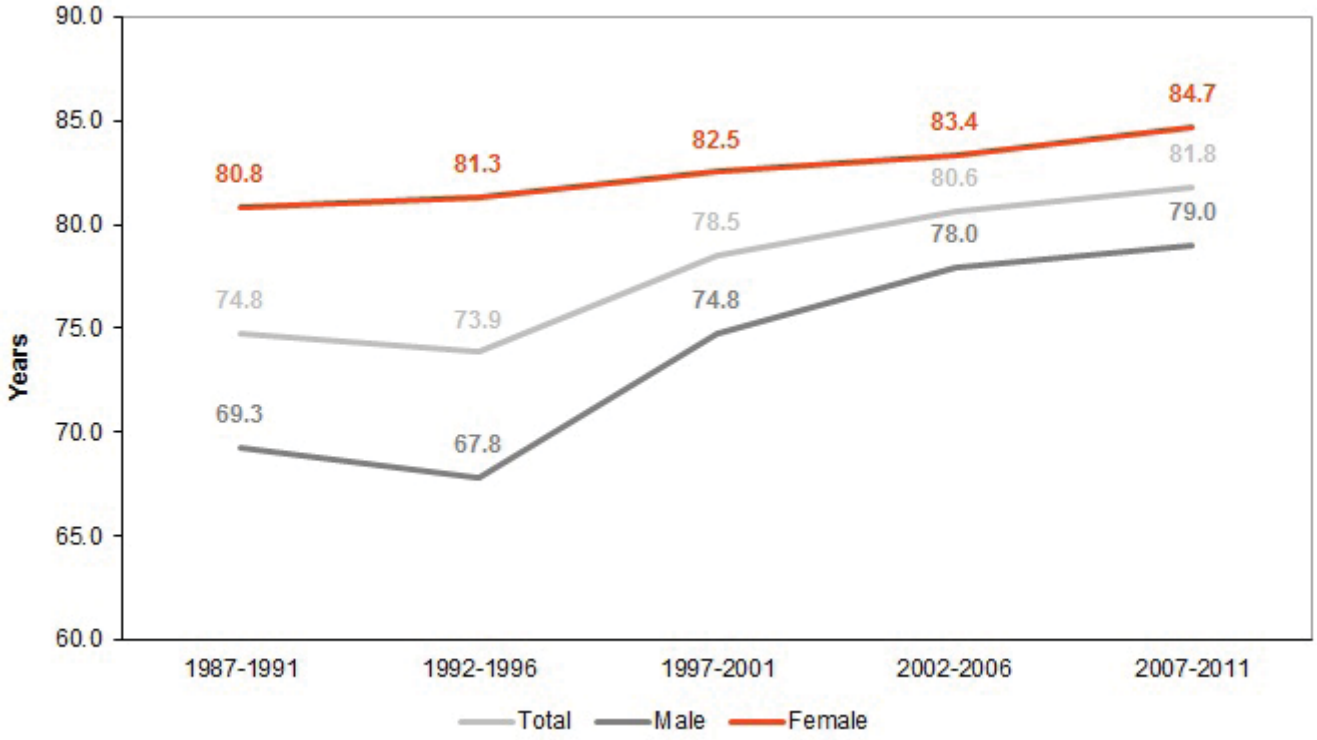
# Health status

This section details the type of data used to profile the health of communities and illustrates the interaction between the determinants of health, illness and injury.

Understanding the health status of a population provides an opportunity to evaluate current health programs, and to be proactive in planning future health initiatives and tailoring interventions to meet community needs.

# Life expectancy

**FIGURE 28.** Life expectancy at birth. Community Health Area 1, 1987-2011

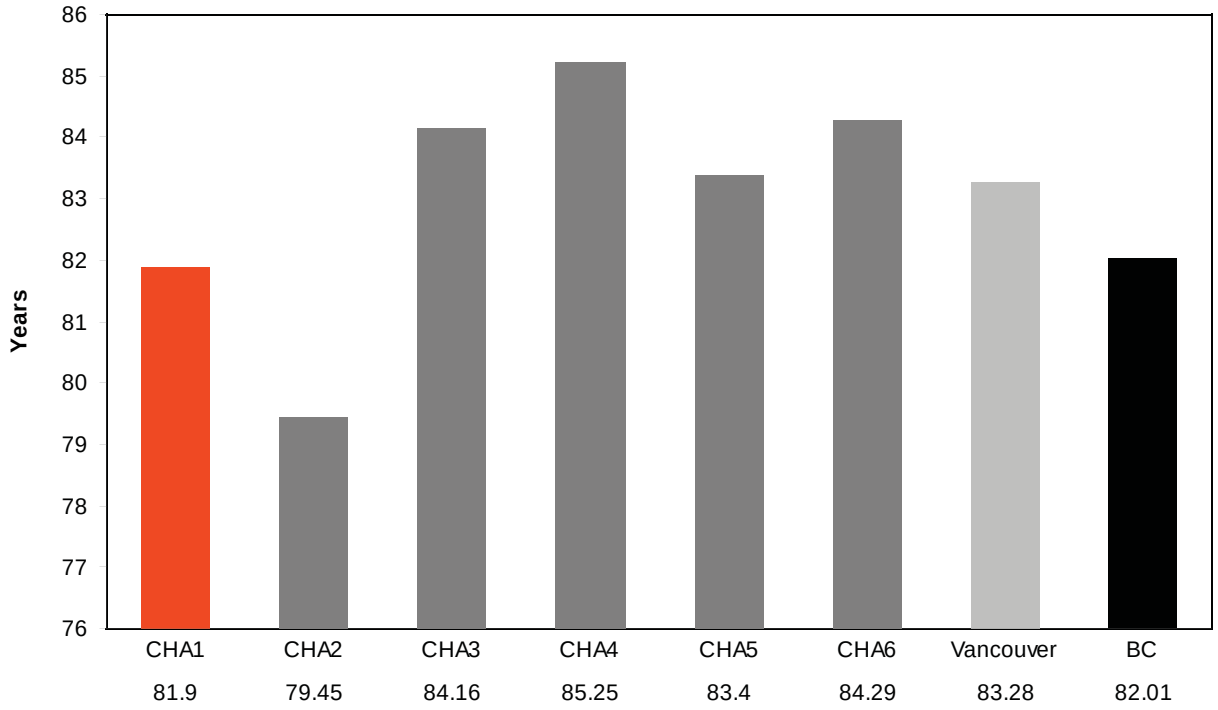



Source: BC Stats, 2012

Life expectancy at birth represents the mean number of years a birth cohort (persons born in the same year) may expect to live given the present mortality experience of a population. Life expectancy is an internationally accepted indicator of the health status of a population (British Columbia Vital Statistics Agency, 2008).

Within CHA 1, life expectancy has been steadily increasing, reaching a high of 81.8 years in 2007-2011, with females living 5.7 years longer than males.

**FIGURE 29.** Life expectancy at birth. Community Health Areas, Vancouver, and British Columbia, 2007-2011



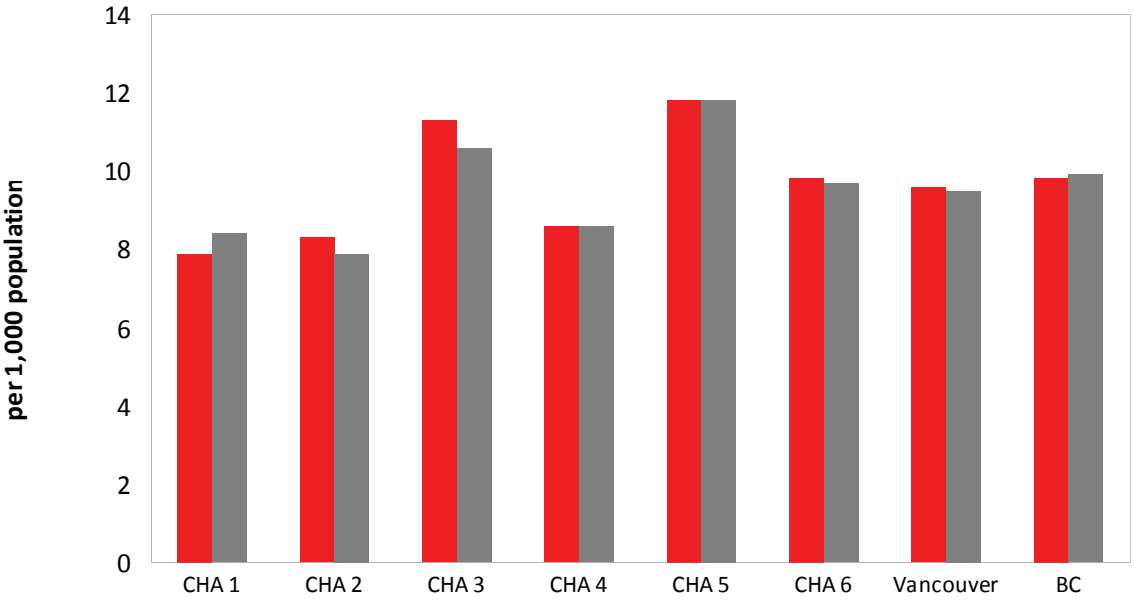

Source: BC Stats, 2012

Figure 29 shows the average life expectancy for the total population (males and females together) within each CHA. Life expectancy in CHAs 3, 4, 5, and 6 is higher than the provincial average. While life expectancy in CHA 2 is the lowest among all CHAs, it is steadily increasing.

Between 2002-2006 and 2007-2011, CHA 2 residents experienced a 3.9 year improvement in life expectancy, which is greater than that of Vancouver (1.7 year improvement). Females in CHA 2 live an average of 8.5 years longer than their male counterparts; the largest discrepancy in gendered life expectancy amongst the CHAs.

# Births

**FIGURE 30.** Crude live birth rate per 1,000 population. Community Health Areas, Vancouver, and British Columbia, 2001-2005 vs. 2006-2010



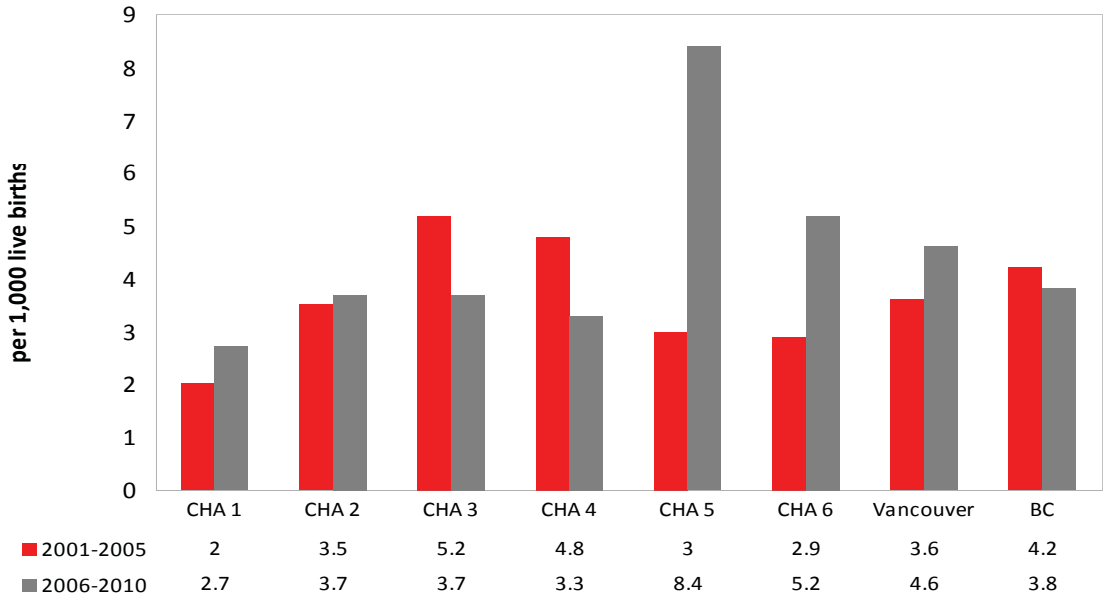

| | CHA 1 | CHA 2 | CHA 3 | CHA 4 | CHA 5 | CHA 6 | Vancouver | BC |
|---|---|---|---|---|---|---|---|---|
| 2001-2005 | 7.9 | 8.3 | 11.3 | 8.6 | 11.8 | 9.8 | 9.6 | 9.8 |
| 2006-2010 | 8.4 | 7.9 | 10.6 | 8.6 | 11.8 | 9.7 | 9.5 | 9.9 |

Source: BC Vital Statistics Agency (VISTA), June 16, 2011

The crude live birth rate is the number of births divided by the mid-year population and converted to a rate per 1,000 population. Crude rates allow for comparisons to be made between different time periods or geographic areas where the populations are not identical (BC Vital Statistics Agency, 2009).

From 2001-2005 to 2006-2010, the live birth rate within CHA 1 has increased from 7.9 per 1,000 population to 8.4 per 1,000 population.

**FIGURE 31.** Infant mortality rate per 1,000 live births. Community Health Areas, Vancouver, and British Columbia, 2001-2005 vs. 2006-2010




Source: BC Vital Statistics Agency (VISTA), 2011

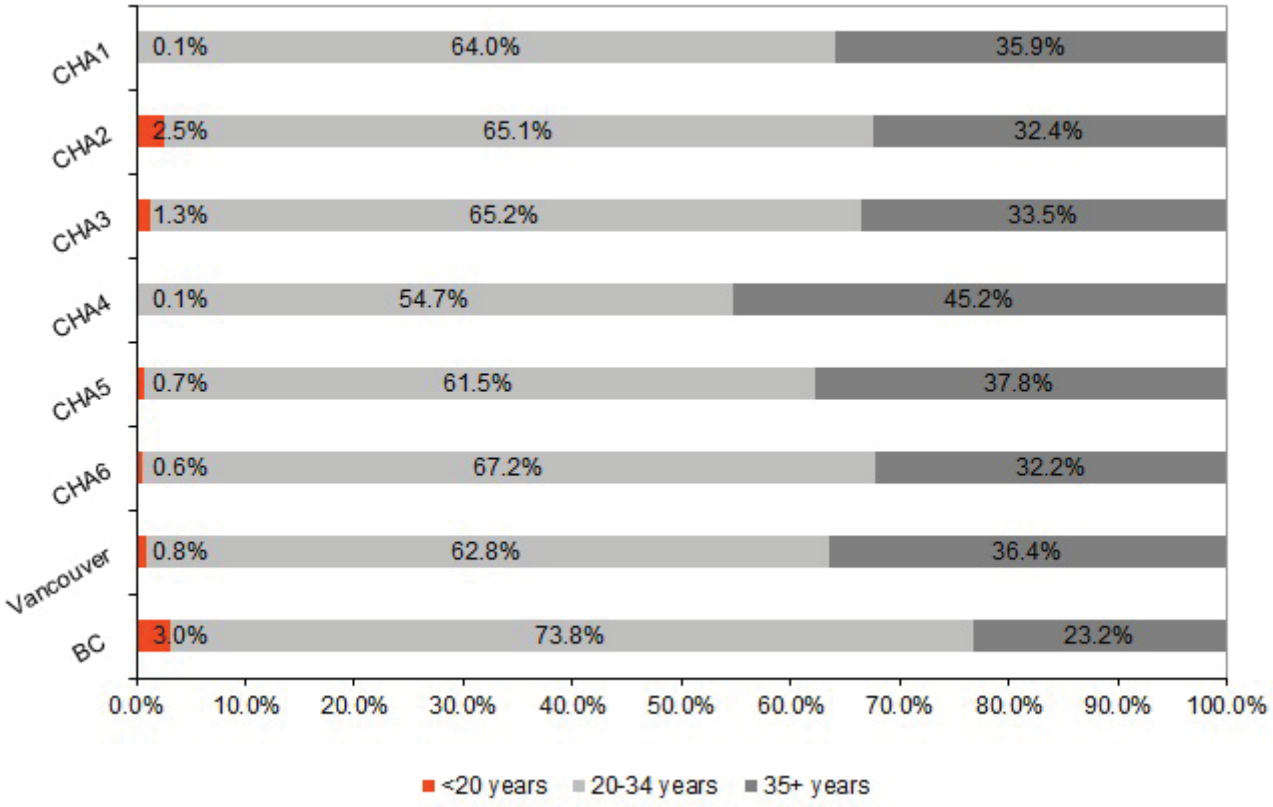
The infant mortality rate is calculated as the number of deaths of children less than one year of age per 1,000 live births in the same year. Infant mortality is an internationally accepted indicators of maternal and child health. "They reflect not only on the state of health care within a jurisdiction, but also on the social environments, the policy supports, and the priority that a society places on childbearing. Our societal goal is to improve infant health and reduce infant mortality to the lowest level possible". (British Columbia Provincial Health Officer, 2003).

The infant mortality rate in Vancouver increased slightly between 2001-2005 and 2006-2010. The rate in Vancouver is slightly higher than the provincial average. Figure 31 shows that infant mortality rates increased in some CHAs between 2001-2005 and 2006-2010, notably CHAs 1, 2, 5 and 6. However, these rates need to be interpreted with caution as the population size is small, giving rise to tremendous variability.

In 2003 the BC Provincial Health Officer published a review of infant mortality rates in BC. The review sought to determine whether increases in the number and rate of deaths in infants are long term trends or random fluctuations. It concluded that there is an overall trend in BC toward declining rate of infant mortality, though random fluctuations may occur in any given year. Major causes of infant mortality include perinatal conditions (where the fetus or newborn is affected by maternal factors and complications of pregnancy, labour and delivery), respiratory and cardiovascular disorders specific to the perinatal period, congenital anomalies (such as defects of the heart and circulatory system), Sudden Infant Death Syndrome (SIDS) and pneumonia/influenza.

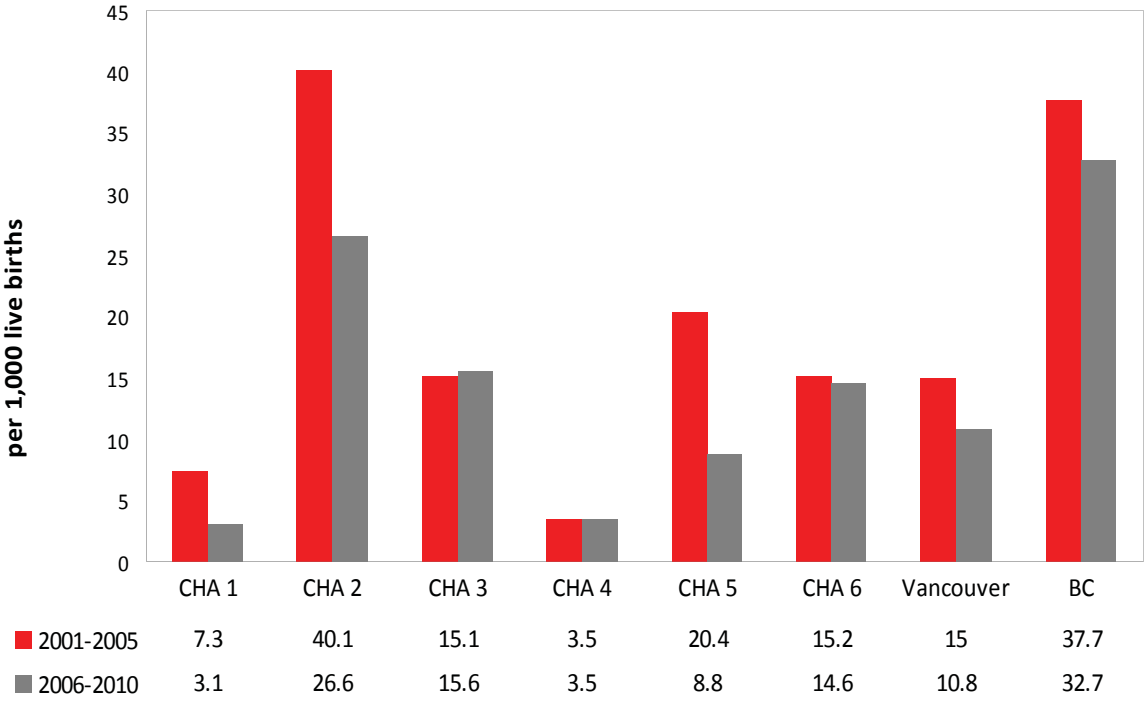
Infant mortality can be reduced by ensuring access to maternal and newborn care as well as by attending to the environments in which infants live (e.g. via immunization, injury prevention, and measures to reduce the risk of SIDS).

**FIGURE 32.** Live births by age of mother (%). Community Health Areas, Vancouver, and British Columbia, 2010



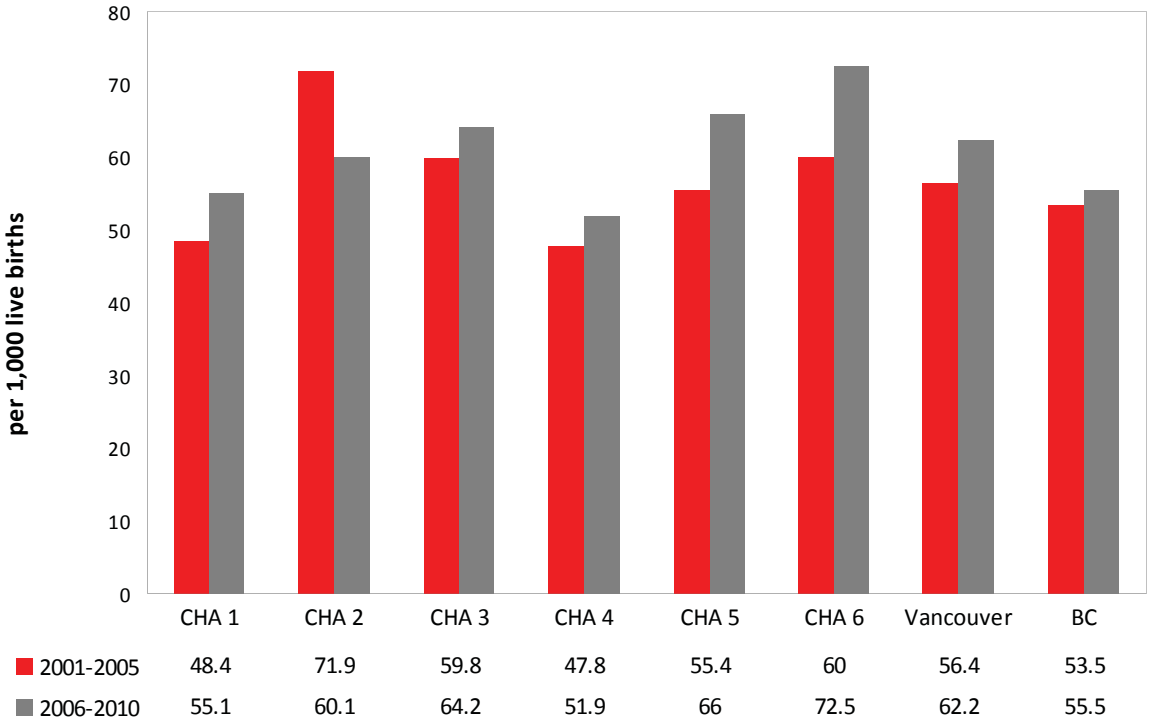

Source: BC Statistical Agency (VISTA), 2011

**FIGURE 33.** Teenage mother (females aged less than 20 years) birth rates per 1,000 live births. Community Health Areas, Vancouver, and British Columbia, 2001-2005 vs. 2006-2010




Source: BC Vital Statistics Agency (VISTA), June 16, 2011

**FIGURE 34.** Low birth weight (less than 2,500 grams) rate per 1,000 live births. Community Health Areas, Vancouver, and British Columbia, 2001-2005 vs. 2006-2010




Source: BC Vital Statistics Agency (VISTA), June 16, 2011

Birth weight is an indicator of the general health of newborns, and a key determinant of infant survival, health and development. Low birth weight infants are at a greater risk of dying during the first year of life, and of developing chronic health problems (Human Resources and Skills Development Canada, 2012).

Figure 34 shows the number of low birth weight births for every 1,000 births in each CHA. For example, in CHA 1 there were 54.9 babies born with low birth rate for every 1,000 babies born in that CHA between 2006 and 2010. This figure can also be expressed as a percentage: 5.49% of babies born in CHA 1 between 2006 and 2010 had low birth weight. This is comparable to the national rate in Canada.

This figure also shows, the rate of low birth weight is increasing in every CHA except in CHA 2. In CHA 2, between 2001-2005 and 2006-2010 the rate of low birth weight babies decreased from 71.7 to 59.3 of every 1,000 babies born.

There are many factors that contribute to low birth weight, and these factors tend to overlap. Risk factors for low birth weight include multiple births, pre-term births (less than 259 days gestation), maternal infections, maternal use of alcohol, tobacco, cocaine or narcotics, maternal experience of violence/abuse and fertility/IVF treatments. Efforts to address low birth weight need to be multidisciplinary and include substance use prevention and prenatal medical care.

# Mortality

Cancer mortality includes deaths from all forms of malignant tumours (neoplasms).

Cardiovascular disease mortality includes deaths from coronary heart disease, heart failure, hypertensive heart disease, and more.

Cerebrovascular disease mortality includes deaths from ischemic or hemorrhagic stroke as a result of blood clots or bleeding inside the head.

Chronic pulmonary disease mortality includes deaths from emphysema or chronic bronchitis.

Infectious disease mortality includes deaths from Human Immunodeficiency Virus (HIV), viral hepatitis, bacterial intestinal infectious, and other viral and bacterial infections. These are largely preventable and mortality is rare in most cases.

Unintentional ("accidental") injuries includes injuries due to causes such as motor vehicle collisions, falls, drowning, burns, and poisoning, but not medical misadventures/complications.

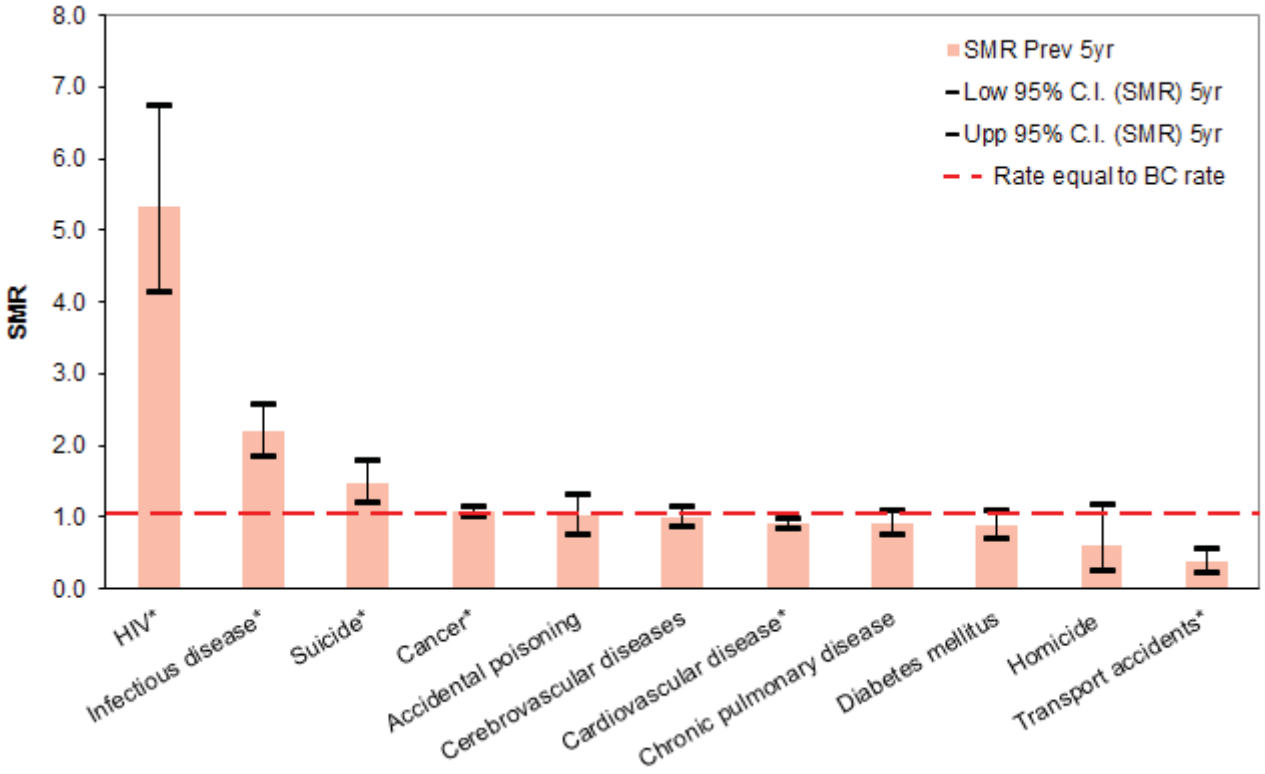
**Table 12.** Leading causes of death per 10,000 population. Community Health Areas, Vancouver, and British Columbia, 2006-2010

| Cause of death | CHA 1 | CHA 2 | CHA 3 | CHA 4 | CHA 5 | CHA 6 | Vancouver | BC |
|---|---|---|---|---|---|---|---|---|
| Malignant neoplasms | 15.8 | 19.2 | 18.0 | 14.5 | 13.8 | 16.4 | 16.1 | 20.2 |
| Cardiovascular disease | 10.1 | 14.6 | 9.9 | 12.1 | 10.0 | 13.8 | 11.7 | 15.4 |
| Cerebrovascular diseases | 3.8 | 4.6 | 4.6 | 4.6 | 4.8 | 5.2 | 4.6 | 5.3 |
| Unintentional injuries | 1.9 | 7.3 | 1.8 | 1.6 | 2.0 | 1.8 | 2.3 | 3.1 |

Souce: BC Vital Statistics Agency (VISTA), October 2012.

With the exception of CHA-2, the top three leading causes of death for each region are malignant neoplasms, cardiovascular disease and cerebrovascular diseases. For CHA-2, the top three leading casues of death are malignant neoplasms, cardiovascular disease, unintentional injuries.

**FIGURE 35.** Standardized mortality ratio (SMR) by specific cause of death. Community Health Area 1, 2007-2011



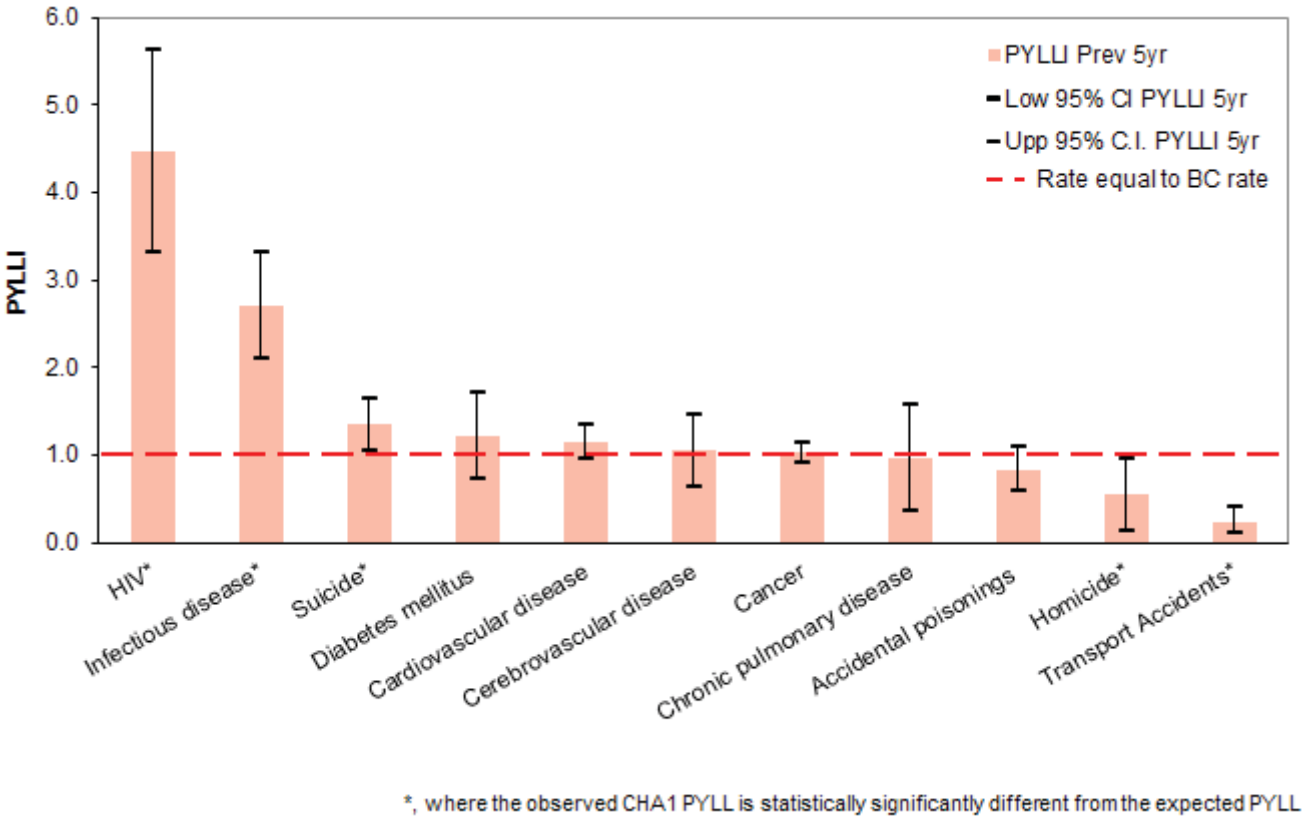

Source: BC Vital Statistics Agency (VISTA), 2011

Within CHA 1, there are significantly more people experiencing mortality from infectious disease (2.20), HIV (5.33), and suicide (1.48) than what is expected based on provincial rates. CHA 1 also has the highest SMR for cancer amongst all the CHAs. Fewer people are dying from deaths related to cardiovascular disease (0.92) and transport accidents (0.37) than what is expected based on provincial rates.

The standardized mortality ratio (SMR) is a ratio of the number of deaths occurring to residents of a geographic area to the expected number of deaths in that area based on provincial age-specific mortality rates (BC Vital Statistics Agency, 2009).[1]

1 SMR=1, the observed deaths in the area are as would be expected based on provincial rates ; SMR>1, observed deaths are higher than expected; SMR<1, observed deaths are lower than expected; The black bars show the 95% confidence interval (CI) or range of accuracy of the SMR.

**FIGURE 36.** Potential years of life lost index (PYLLI) by specific cause of death. Community Health Area 1, 2007-2011




*, where the observed CHA1 PYLL is statistically significantly different from the expected PYLL

Source: BC Vital Statistics Agency (VISTA), July 28, 2011

Within CHA 1, there are significantly more premature deaths related to infectious disease and suicide and significantly less related to unintentional injuries and homicide than what is expected based on provincial rates. CHA 1 also has the highest PYLLI for diabetes amongst the CHAs. [2]

The potential years of life lost (PYLL) is the number of years of life lost when a person dies before a specified age (75 years). It is an indicator of premature death and highlights the causes of death that occur at younger ages.

2 The PYLL index (PYLLI) is the ratio of the geographic area's observed PYLL to its expected PYLL. The black bars show the 95% confidence interval (CI) or range of accuracy of the PYLLI.

**TABLE 13.** Age specific suicide rates per 10,000 people. Community Health Areas, Vancouver, and British Columbia, 2006-2010 (compared to 2001-2005)

| | CHA 1 | CHA 2 | CHA 3 | CHA 4 | CHA 5 | CHA 6 | Vancouver | BC |
|---|---|---|---|---|---|---|---|---|
| < 24 years | 2.3 (2.5) | 1.7 (2.6) | 2.3 (0.6) | 0.7 (0.8) | 1.6 (1.1) | 1.4 (1.0) | 1.5 (1.1) | 1.6 (1.9) |
| 25-44 years | 1.4 (1.2) | 2.7 (3.5) | 0.8 (1.4) | 0.6 (0.8) | 0.7 (1.5) | 0.8 (0.7) | 1.1 (1.4) | 1.2 (1.5) |
| 45-64 years | 3.3 (3.1) | 3.5 (4.3) | 0.7 (1.7) | 1.6 (1.3) | 1.4 (1.7) | 1.0 (0.8) | 1.8 (1.9) | 1.4 (1.6) |
| 65-84 years | 1.4 (1.8) | 2.5 (2.2) | 1.4 (0.9) | 1.0 (1.2) | 0.5 (1.5) | 1.0 (1.2) | 1.2 (1.4) | 1.2 (1.2) |
| 85+ years | 2.4 (5.3) | 0.0 (0.0) | 0.0 (7.9) | 2.0 (1.5) | 1.5 (1.8) | 1.3 (0.0) | 1.4 (2.4) | 1.3 (1.8) |

Source: BC Vital Statistics Agency (VISTA), 2011

Table 13 shows the suicide rates for five age groupings for the periods 2006-2010 compared with 2001-2005. Overall in Vancouver the highest rate is within the age group of 45-64 years.

The BC Crisis Centre reports various statistics about suicide. While suicide deaths include people from all socioeconomic, age, gender, culture and ethnic groups, some groups experience higher rates. Suicide rates tend to be higher among youth, Aboriginal people and people who identify as lesbian, gay, bisexual, transgender and two-spirit. It is estimated that in more than 70 percent of suicides, the person was suffering from one or more unmanaged mental health issues.

In CHA1 the highest suicide rate in 2006-2010 is within the 45-64 age group.

**TABLE 14.** Lifestyle related deaths, Community Health Area 1, 2006-2010

| | Standardized Mortality Ratio (SMR) | Potential Years of Life Lost (PYLL) | PYLL Index (PYLLI) |
|---|---|---|---|
| Alcohol-related | 0.73* | 2673 | 0.6* |
| Medically treatable | 1.26 | 648 | 1.04 |
| Drug induced | 1.31* | 2308 | 1.06 |
| Smoking attributable | 1 | 3187 | 1.02 |

*significantly different from expected values based on provincial rates
Source: BC Vital Statistics Agency (VISTA), March 2011

Alcohol-related deaths include deaths where alcohol was a contributing factor (indirectly related) as well as those due to alcohol (directly related). Alcohol-related and drug overdose deaths are the only cause of death categories that are not based entirely upon underlying causes of death.

Deaths due to drug-induced causes excludes unintentional injuries, homicides, and other causes that could be indirectly related to drug use and are based on those used by the National Center for Health Statistics.

Medically treatable disease deaths are ones for which mortality could potentially have been avoided through appropriate medical intervention. The incidence of deaths from medically treatable diseases can be used by public health professionals as a way of monitoring the effect of health promotion programs.

The absence on death certificates of complete and reliable data on smoking requires the use of estimation techniques to approximate the extent of smoking-attributable deaths. These are derived by multiplying a smoking-attributable mortality percentage by the number of deaths aged 35+ years in smoking-related categories including cancers, circulatory system diseases, and respiratory system diseases (BC Vital Statistics Agency, 2009).

Within CHA 1, significantly more people are dying from deaths related to drugs than what is expected based on provincial rates.

# Chronic and communicable disease

Chronic diseases are typified by long duration and slow progression. They are by far the leading cause of death across Canada.

Human Immunodeficiency Virus (HIV) is a virus that attacks the immune system, resulting in a chronic progressive illness that leaves people vulnerable to opportunistic infection. HIV is transmitted from person to person through unprotected sexual intercourse, shared needles or equipment for injection drug use, or perinatally (from mother to her baby) (Public Health Agency of Canada, 2012). Hepatitis C is a virus that results in chronic liver disease and is transmitted in the same ways as HIV, i.e. sharing of sharp instruments or unsterilized personal hygiene equipment with an infected person, sharing of drug-use equipment, unprotected sexual intercourse, or perinatally.

**TABLE 15.** Chronic and communicable disease new diagnosis rates per 100,000 people. Community Health Area 1, Vancouver and British Columbia

| | CHA 1 | Vancouver | BC |
|---|---|---|---|
| Chronic disease new diagnosis rates per 100,000 population, 2010/11 (compared to 2008/09) | | | |
| Arthritis (osteoarthritis and rheumatoid arthritis) | 476.2 (394.5) | 487.2 (447.6) | 690.5 (642.8) |
| Cardiovascular disease | 347.5 (357.5) | 358.5 (364.8) | 421.7 (469.6) |
| Chronic obstructive pulmonary disease (COPD) (aged 45+ years) | 255.0 (464.6) | 298.0 (476.1) | 424.7(643.5) |
| Diabetes | 503.4 (409.9) | 641.0 (561.3) | 644.6 (650.4) |
| Communicable disease new diagnosis rates per 100,000 population, 2009/11 (compared to 2006/08) | | | |
| HIV (males) | 84.3 (112.4) | 42.0 (51.0) | 11.1 (13.7) |
| HIV (females) | 3.9 (4.8) | 5.2 (7.9) | 2.6 (3.3) |
| Hepatitis C | 51.4 (63.4) | 58.4 (75.7) | N/A (64.3) |

Sources: BC Primary Health Care Disease Registries, November 2011, BC Centre for Disease Control, Annual Report 2011, VCH Public Health Surveillance Unit (PARIS), July 16 2012

CHA 1 has amongst the lowest chronic disease new diagnosis rates for all categories, which may be explained by the younger age demographic of CHA 1 as compared to the rest of Vancouver. The rates for arthritis and diabetes have increased, while the rates for cardiovascular disease and COPD have decreased from 2008/09 to 2010/11. The highest HIV new diagnosis rates for males are found within CHA 1. The rates for both HIV and Hepatitis C have decreased from 2006-2008 to 2009-2011, with HIV rates decreasing by 23.5%.

Note: Chronic disease cases are notified to various registries by primary care physicians and therefore these numbers may not truly reflect rates of new diagnoses. Communicable disease data are collected by primary care physicians, laboratories, hospitals and institutions and reported to the local public health unit through a mandatory notification system. Even though the reporting of diseases is mandatory under legislation, the number of cases may be underreported for a number of reasons: 1) not all diseases present signs and symptoms, 2) not all individuals who experience illness seek care, and 3) health care providers do not always conduct laboratory tests.

# School-age immunization coverage

Immunization is one of the most effective methods to protect adults and children from communicable disease illness or deaths. Widespread immunization reduces the number of susceptible people making it difficult for disease to spread from person to person (British Columbia Centre for Disease Control, 2011).

The figures in this section report on two indicators for school immunization coverage. Meningococcal C immunization protects against meningoccal infection that affects the lining around the spinal cord and brain often resulting in death or permanent brain damage to those who survive. The Tdap immunization protects against the potentially lethal diseases of diphtheria, tetanus, and pertussis (British Columbia Centre for Disease Control, 2011).

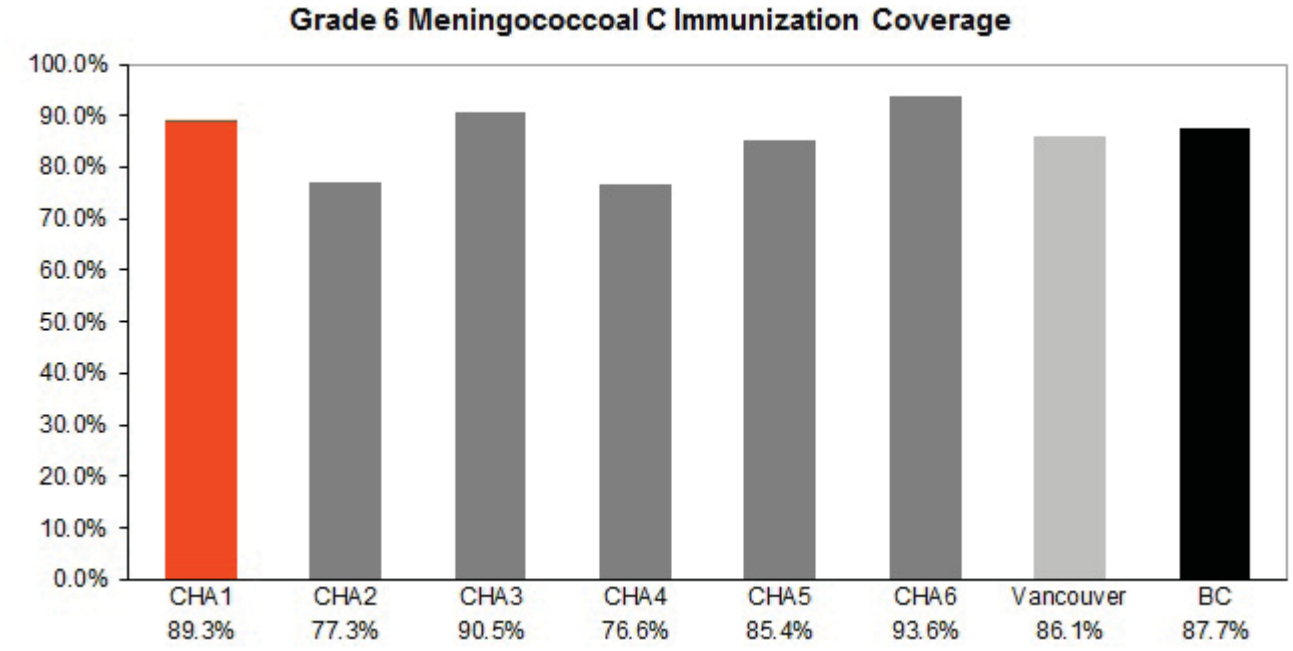
BC's publicly funded immunization program offers many vaccinations free of charge. VCH is the public health authority in Vancouver responsible for providing these vaccinations in the school setting, however, private practice general practitioners may also provide the vaccine (British Columbia Centre for Disease Control, 2011).

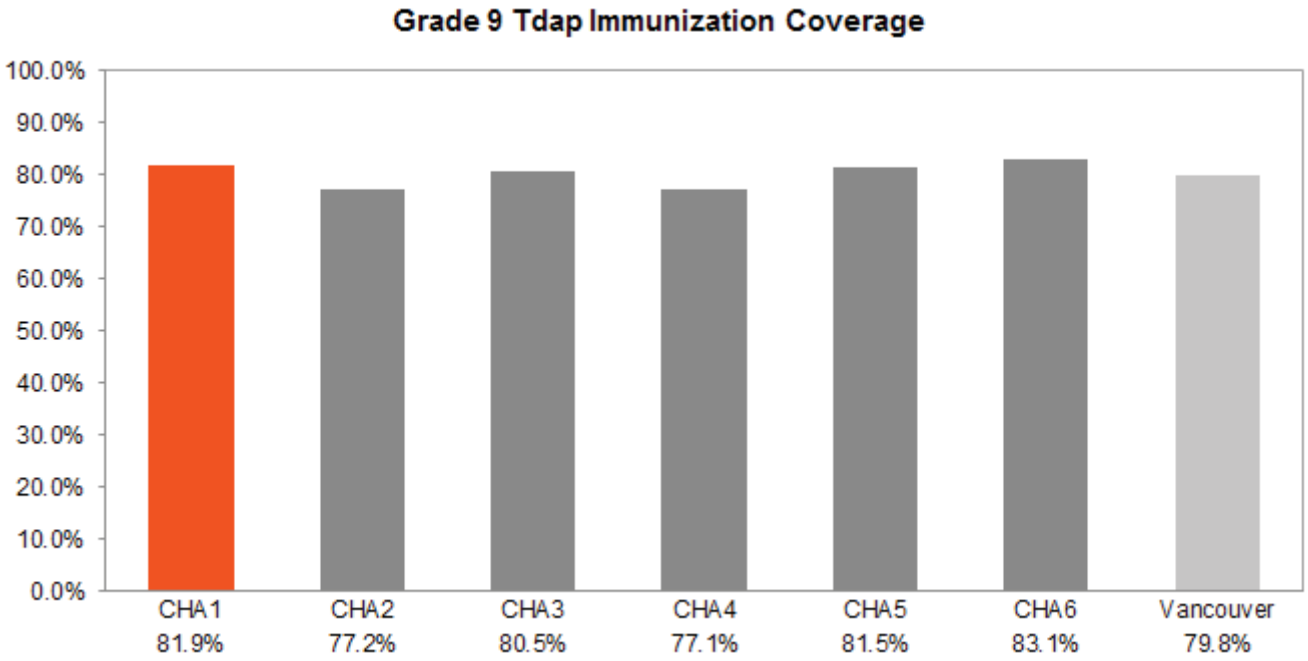
Immunization coverage in CHA 1 is comprehensive, with almost 90% of grade 6 students having been vaccinated against Meningococcal C and almost 82% of grade 9 students having been vaccinated against tetanus, diphtheria and pertussis.

Immunization coverage may be lower in certain CHAs for several reasons. Although vaccines are demonstrated to be safe, some families do not consent to their children receiving vaccinations. Some children may receive vaccinations via their primary care practitioner and not through the VCH public health.

Newcomer students also tend to have lower rates of immunization. They may have been vaccinated in their home countries but have incomplete records or they may be living with sponsors or in home-stay situations with adults who are unable to authorize vaccination for minors.

**FIGURE 37.** Grade 6 Meningococcal C and Grade 9 Tdap (diphtheria, tetanus, and pertussis) immunization coverage, Community Health Areas, Vancouver, and British Columbia, 2010/11 school year




Source: Vancouver Coastal Health Public Health Surveillance Unit, August 18, 2011

Immunize BC, 2011

Primary Access Regional Information System (PARIS) for Vancouver, August 18, 2011 via Vancouver Coastal Health, Public Health Surveillance Unit

# Health service utilization

Health care utilization has evolved as the population's need for care has changed over time. Factors which have influenced the population's need for care include: aging, socio-demographic population shifts and changes in the prevalence and incidence of different diseases.

The prevalence of chronic health conditions has resulted in the emergence of both residential and community-based health services designed to promote functional independence and hence, keep people out of institutional settings.

Health service utilization data provide valuable insight into the health of a population and can be used to help determine the allocation of health prevention efforts and resources.

# Acute care services

This section refers to acute care hospital admissions related to the:

- Circulatory system include heart disease, hypertensive disease, and diseases of the arteries or veins
- Digestive system include diseases of the oral cavity, esophagus, stomach, small intestine, liver, gallbladder, appendicitis, hernia, enteritis and colitis
- Respiratory system include pneumonia, influenza, COPD, and acute respiratory infections
- Mental disease and disorders include organic brain disorders, mental and behavioural disorders due to psychoactive substance use, schizophrenia, mood disorders, and more

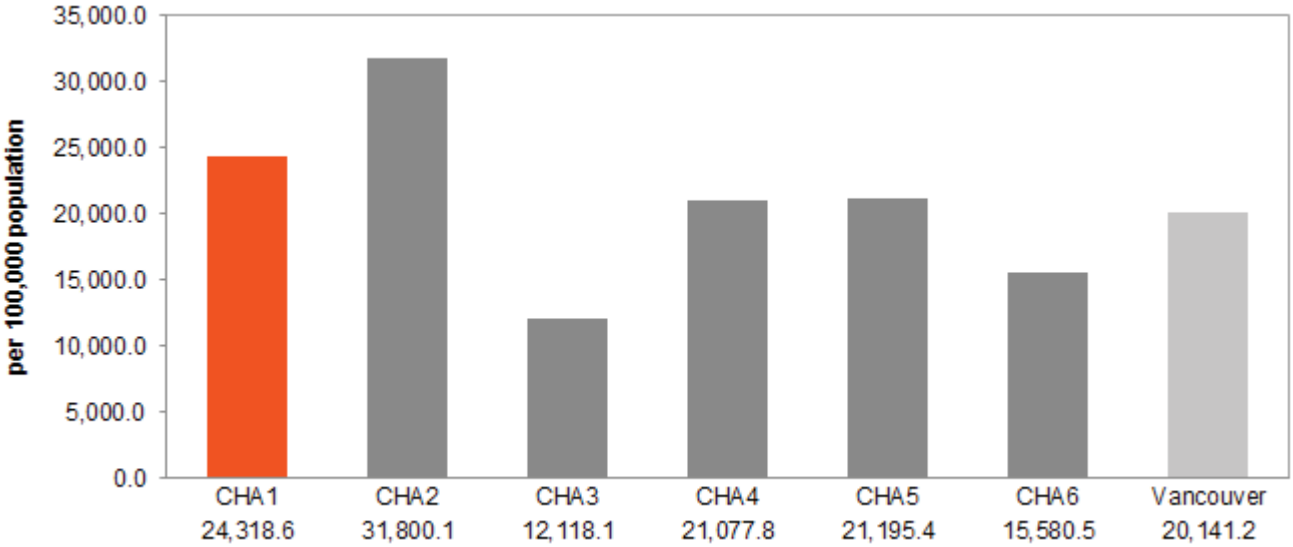
**TABLE 16.** Acute care hospital admissions (inpatient) by clinical category per 100,000 population. Community Health Areas, Vancouver and British Columbia, 2007/08

| | CHA1 | CHA 2 | CHA3 | CH4 | CH5 | CHA 6 | Vancouver | BC |
|---|---|---|---|---|---|---|---|---|
| Circulatory system | 500.7 | 717.8 | 595.4 | 557.8 | 582.4 | 682.6 | 598.0 | 1049.5 |
| Mental disease and disorders | 666.4 | 1669.1 | 504.5 | 426.8 | 514.2 | 477.0 | 645.8 | 645.2 |
| Respiratory system | 329.7 | 992.5 | 488.9 | 514.2 | 687.1 | 508.7 | 495.6 | 622.3 |
| Significant trauma, injury, poisoning, and toxic effect of drugs | 417.1 | 688.6 | 447.8 | 457.4 | 470.6 | 458.1 | 471.9 | 705.2 |
| Pregnancy and childbirth | 962.5 | 882.6 | 1221.2 | 993.0 | 1353.1 | 1175.4 | 1102.3 | 1184.9 |

Source: BC Ministry of Health Services, Management Information Branch (Discharge Abstract Database), December 2008 via Vancouver Coastal Health Authority Knowledge Base

Among all CHAs, CHA 1 residents have the lowest acute care hospital admission rates for three out of four reported major clinical categories. These include admissions related to the circulatory system, respiratory system, and significant trauma, injury, poisoning and toxic effects of drugs.

**FIGURE 38.** Emergency room visits per 100,000 population. Community Health Areas and Vancouver, 2010




Source: Vancouver Coastal Health, Emergency Department Systems (CareCast, Eclipsys and McKesson)

# Home and community care services

Adult day centres (ADCs) are community based services for seniors and people with disabilities that provide health care supports such as medication management, personal care such as bathing, health education, and therapeutic social and recreational programs such as meal programs, fitness, and out trips. The purpose of ADCs is to support people to remain at home and provide respite for their caregivers.

Assisted living provides housing plus supportive health services for seniors or people with physical disabilities who need extra help with meals and personal care (i.e. bathing, grooming, dressing and medication management).

Physical and occupational therapy, also known as community rehabilitation services, provides assessment, consultation, treatment and education to clients and their families in home or community clinics to help clients improve or maintain physical and functional abilities.

People are eligible for home nursing if they have been released from hospital and need short-term care, have an ongoing or chronic health issue requiring more complex care, or have a worsening health issue and need help to continue living at home. Services provided by home care nurses include assessment, education, counselling, medical and post surgical care, and palliative care.

Home support provides care for those just released from hospital or as a means of prevention from going to the hospital by providing services such as personal grooming, special exercises, and support and relief for the primary caregiver to help people remain independent and safe in their own home as long as possible.

Residential care is for people who have complex care needs and can no longer remain safely in their own home. RC clients require 24 hour nursing care in a supervised and secure environment (Vancouver Coastal Health, 2011).

**TABLE 17.** Home and community care utilization rates per 1,000 people. Community Health Area 1 and Vancouver, 2010/11

| | CHA 1 | Vancouver |
|---|---|---|
| Adult Day Service | 0.8 | 1.4 |
| Assisted Living Service | 0.9 | 1.0 |
| Case Management Services | 8.0 | 8.3 |
| Community Rehabilitation Services | 9.6 | 10.2 |
| Home Nursing Services | 8.1 | 8.6 |
| Home Support Services – Long Term | 6.0 | 7.9 |
| Home Support Services - Short Term | 2.5 | 2.6 |
| Residential Care Services | 10.3 | 8.1 |

Source: Vancouver Coastal Health, June 28, 2012

People aged 65 years and over represent 10.3% of the CHA 1 population and this age group is projected to increase to 13.4% of the population over the next 25 years. One of the main goals of the health care system is to ensure that there is an adequate supply of home and community care services so that people do not have to resort to institutional care. The volume of clients receiving these services is determined both by the demand for the service (reflecting the proportion of the CHA that is elderly and their health status) and the resources available.

As compared to Vancouver, CHA 1 has slightly lower utilization rates for all services except residential care services.

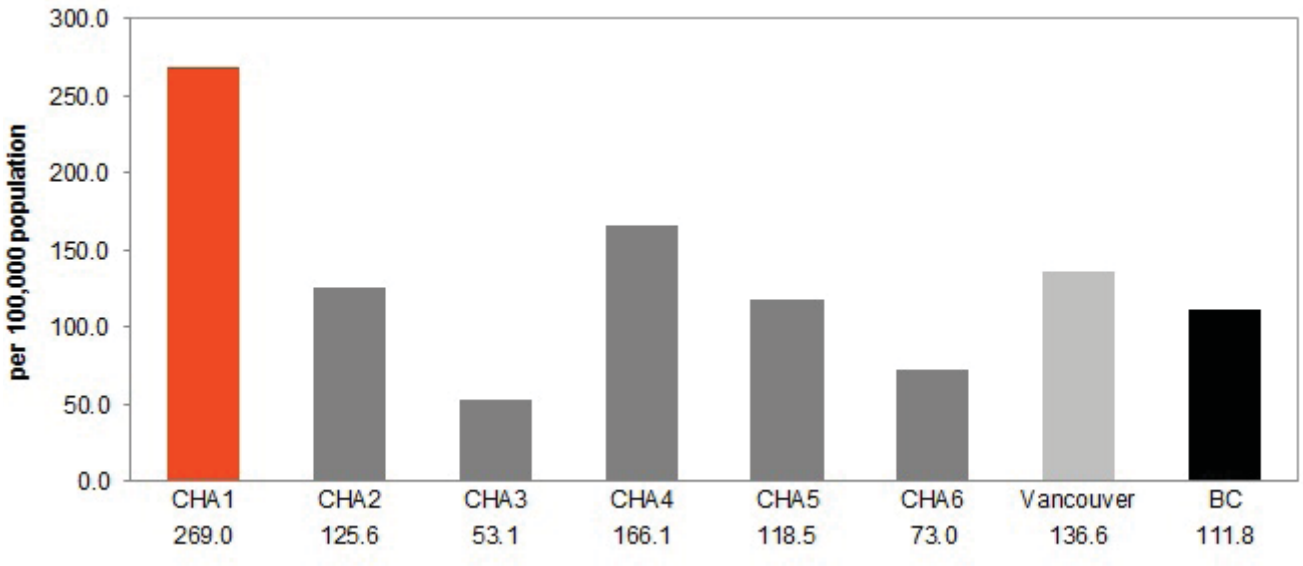
**TABLE 18.** The number of publicly funded assisted living, hospice, and residential care beds. Community Health Areas and Vancouver, 2010/2011

| | Assisted Living | Hospice | Residential Care |
|---|---|---|---|
| CHA 1 | 113 | 12 | 917 |
| CHA 2 | 105 | 6 | 185 |
| CHA 3 | 96 | 10 | 474 |
| CHA 4 | 15 | 0 | 888 |
| CHA 5 | 75 | 0 | 387 |
| CHA 6 | 199 | 0 | 1035 |
| Vancouver | 603 | 28 | 3886 |

Source: Vancouver Coastal Health, 2010

CHA 1 is home to roughly 20% of Vancouver's assisted living beds and 25% of Vancouver's residential care beds. It is one of three community health areas that includes hospice beds and is home to just under half of them.

**FIGURE 39.** General Physicians per 100,000 people. Community Health Areas, Vancouver, and British Columbia, 2009




Source: BC Ministry of Health Services Health System Planning Division, Medical Services Plan Information Resource Manual, 2008/2009

CHA 1 has the greatest number of general physicians per 100,000 population relative to the other CHAs. Such high rates may be explained by CHA 1 encompassing both St. Paul's and Vancouver General Hospital.

# Neighbourhoods within CHA 1

The dynamic and densely populated Vancouver City Centre (CHA 1) is comprised of three main areas: the West End, Downtown Core, and Fairview.

## West End

Boundaries: Burrard Street to Stanley Park and Georgia Street to English Bay

Area (hectares): 204

Population: 44,560

The West End is the most densely populated neighbourhood in Vancouver. It lies adjacent to Stanley Park and encompasses English Bay, the Robson and Denman Street shopping areas, and Davie Street Village, which is known for its active lesbian, gay, bisexual, and transgendered (LGBT) communities.

The West End has a high population of persons aged 20-39 years (48.6%), 40-64 years (33.3%), and seniors aged 65 years and over (11.4%). While 61.3% of its residents report English as their mother tongue, 5.2% report Chinese, 4.2% report Japanese, 3.8% report Korean, and 2.9% report Spanish. The median household income, after-tax is $38,581, the lowest within City Centre. The West End is primarily composed of high-rise (76.9%) and low-rise (22.2%) apartments, with 80.5% being rented dwellings, the highest amongst the City Centre neighbourhoods (City of Vancouver, 2009).

## Downtown Core

Boundaries: a triangular area, nestled between Burrard Inlet and False Creek, Stanley Park, the West End and Cambie Street.

Area (hectares): 375

Population: 43,415

Downtown Vancouver is a transportation terminus, business centre, tourist destination, entertainment district, and home to many.

Since 1991, there has been a transformation of the inner-city Downtown South neighbourhood into a high-density residential and mixed-use community. By 2020 this area is expected to be home to 10,000 people. Since 1986, property redevelopment has resulted in the emergence of several new City Centre neighbourhoods including Coal Harbour, Triangle West, False Creek North, Yaletown, and Granville Slopes. Along with this redevelopment, there has been an increase in the number of city parks, community centres and services, and non-market housing units. Northeast False Creek remains the largest undeveloped area on the downtown peninsula and is expected to be developed into high-rise apartments.

Within Vancouver City Centre, Downtown has the highest percentage of persons aged 19 years and under (9.6%), which includes many young children residing in the Yaletown community. While 56.2% of Downtown residents report English as their mother tongue, another 14.4%

report Chinese, 4.2% report Farsi, 3.4% report Korean, and 2.0% report Spanish as their mother tongue. Downtown is composed primarily of high-rise apartment buildings (89.3%) and is home to the most mobile CHA 1 population, with 73.9% of its residents having changed addresses within 2001 and 2006 (City of Vancouver, 2009).

## Fairview

Boundaries: stretching from Cambie to Burrard Street and from South False Creek to 16th Avenue

Area (hectares): 333

Population: 29,295

Fairview includes the neighbourhoods of South False Creek, Fairview Slopes, Burrard Slopes, and Fairview Heights. It is home to Vancouver City Hall, the Granville Island Public Market, and South Granville with its upscale shops, restaurants, and art galleries.

Fairview is a family-oriented neighbourhood. Within Vancouver City Centre, Fairview has the highest percentage of persons aged 40-64 years (34.6%) and 65 years and over (13.4%), with the second highest percentage of persons aged 19 years and under (9.3%). 70.5% of residents report English as their mother tongue, while another 8.1% report Chinese. Fairview residents have the highest median household income, after-tax ($52,458) of all CHA 1 neighbourhoods. The majority of dwellings are low- (67.3%) or high-rise (23.0%) apartments. The average gross rent is $987 (City of Vancouver, 2009a).

# CHA 1 community resources

## Public elementary schools

5 in total

2 in the West End (Lord Roberts and Lord Roberts Annex)

1 in the Downtown Core (Elsie Roy)

2 in Fairview (False Creek, L'ecole Bilingue)

## Public secondary schools

1 in total, located in the West End (King George)

## Post secondary schools and colleges

British Columbia Institute for Technology's Downtown campus

Columbia College

Emily Carr Institute of Art and Design

Simon Fraser University's satellite university campus

University of British Columbia Robson Street Campus

Vancouver Community College- International Education

Vancouver Film School

## Family resource programs

Vancouver Society of Children's Centres

Several family resource programs operated by community centres and neighbourhood houses

Note: Family Places / family resource programs are parent / child interactive programs for families with children 0-6 years. Family resource programs are unique from other early childhood development programs in that parent and child attend together. Family resource programs have five core areas of service which include: family support, play-based learning, early literacy, learning and care, parent education, and information and referrals. They are low cost or free with subsidies readily available. Family Places may be independent stand-alone organizations or embedded in a multi-service agency such as a neighbourhood house.

## Non-market housing complexes

109 in total

44 in the West End: 27 are for low income singles and families, 4 are co-operative, 8 are for seniors, 1 is for persons living with mental illness, and 1 is for persons living with HIV/AIDS

35 in the Downtown Core: 3 co-operative, 5 for seniors, 7 for low income singles or families, 3 for persons living with a disability, and 2 for persons living with HIV/AIDS

30 in Fairview: 14 housing co-operatives, 4 for seniors, 4 for families, 2 for persons with a mental illness

## Adult homeless shelters

Belkin House- Salvation Army

Catholic Charities Men's Hostel

Covenant House

First Baptist Church

## Seniors Centres and Adult Day Centres

Barclay Manor

Health & Home Care Society of BC

South Granville Seniors Centre

West End Seniors Network

## Publicly funded VCH assisted living facilities

Haro Park Centre and Millennium Tower

Harmony House

Terraces on 7th

## Publicly funded VCH residential care facilities

Broadway Pentecostal Lodge

Central City Lodge

Haro Park Centre

Simon KY Lee Seniors Home

VCH-Banfield Pavillion

Windermere Care Centre

Yaletown House

### Public parks

37 in total, including Stanley Park

### Libraries

Joe Fortes Branch Library
The Outreach Library
Central Branch Library

### Community centres

Coal Harbour Community Centre
False Creek Community Centre
Robert Lee YMCA
Roundhouse Community Centre
The Gathering Place Community Centre
West End Community Centre
YWCA

### Neighbourhood houses

Gordon Neighbourhood House

### Community policing centres

West End - Coal Harbour Community Policing Centre

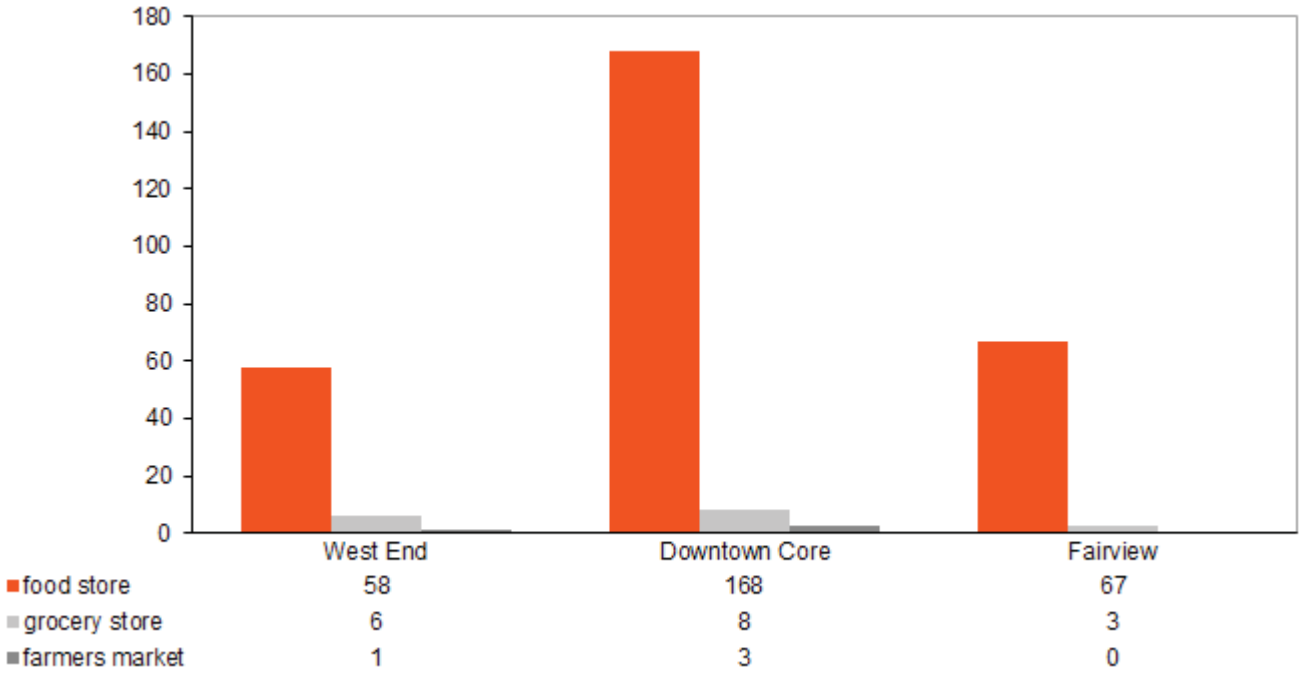
### Business improvement areas

7 (Cambie Village, Downtown Vancouver, Kitsilano Fourth Ave, Robson Street, South Granville, West End, and Yaletown)

### Community and social services that support members of LGBT communities

A Loving Spoonful
AIDS Vancouver
Dr. Peter AIDS Foundation
Positive Living BC
Positive Women's Network
Qmunity
Vancouver PRIDE Society
YouthCO AIDS Society

FIGURE A. Number of food stores by type, Community Health Area 1, 2009




Source: Food Secure Vancouver, 2009

Food stores (pre-package food) include stores identified by subtypes including "convenience store," "vitamins/health food," "pharmacy", and "other", and includes non-food stores that may have some food.

## CHA 1 Vancouver Coastal Health Community Resources

Three Bridges Community Health Centre
1292 Hornby Street
Vancouver, B.C. V6Z 1W2
Tel: 604-736-9844

West End Mental Health Team
1555 Robson Street
Vancouver, B.C. V6G 1C3
Tel: 604-687-7994

Kitsilano-Fairview Mental Health Team
1212 West Broadway
Vancouver, B.C. V6H 3V1
Tel: 604-736-2881

For mental health services, addiction services, youth clinics, and other health related information, please contact your local community health centre.

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