



# A health and social profile

FALL 2013



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# 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).

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

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

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](mailto:phsu@vch.ca).

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## Introduction by community partner

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CHA 2 is a rich and diverse area made up of three unique neighbourhoods facing some of the biggest challenges and undergoing some of the most significant changes as Vancouver grows and develops. These neighbourhoods are made up of communities with incredible assets, creativity and innovation, and for those who live and work here, CHA 2 is really the “heart” of our city.

The communities within CHA 2 are also disproportionately affected by social determinants of health such as poverty, discrimination, trauma, and violence. CHA 2 has alarming rates of suicide across the adult population – being the highest in the 25 through 84 age groups. Premature deaths and rates of communicable diseases also reflect the ill health of many in the community, where HIV, infectious disease, accidental poisoning and cardiovascular disease are the highest across the CHAs. Many traditional services do not adequately serve these highly vulnerable populations, and challenges faced include identifying innovative approaches to primary care, specialty medical care, dental care, and mental health care for those populations who are the most vulnerable and marginalized, including seniors, children and families, urban Aboriginal, refugee and newcomer populations and individuals with addictions and mental health issues.

From 2007/09 to 2009-2011, CHA 2 has remained the most vulnerable in all domains of Early Development Instrument for child development, except communication skills and general

knowledge. These numbers have been on the decline thanks to community efforts. CHA 2 has the smallest number of Kindergarten children, but with vulnerability so high it is imperative that CHA 2 focus on place-based strategies addressing the health inequities for these children and their families through social pediatrics, increasing childcare and early learning spaces for children and creating accessible opportunities for learning and care from the prenatal stage through to adolescence.

CHA 2 has the highest percentage of seniors living in low income conditions in Vancouver. Many of these seniors face challenges regarding aging in place and do not have family supports to provide continuity of care as they face increased health issues, safety issues and social isolation. Neighbourhood networks of individuals and organizations play a key role in connecting seniors to much needed health and social supports to reduce the impacts of poverty for some of our most marginalized elders.

Access to affordable housing—both supported housing and affordable rental stock—is a key issue for residents in CHA 2 and is repeatedly identified in community consultations as essential to sense of security, safety and belonging as well as positive health outcomes. “Housing First” is of critical importance to residents here and with increasing economic and development pressures, ensuring there is a diverse range of affordable, safe housing without displacement becomes essential and will be a central issue in the years to come.

# 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)

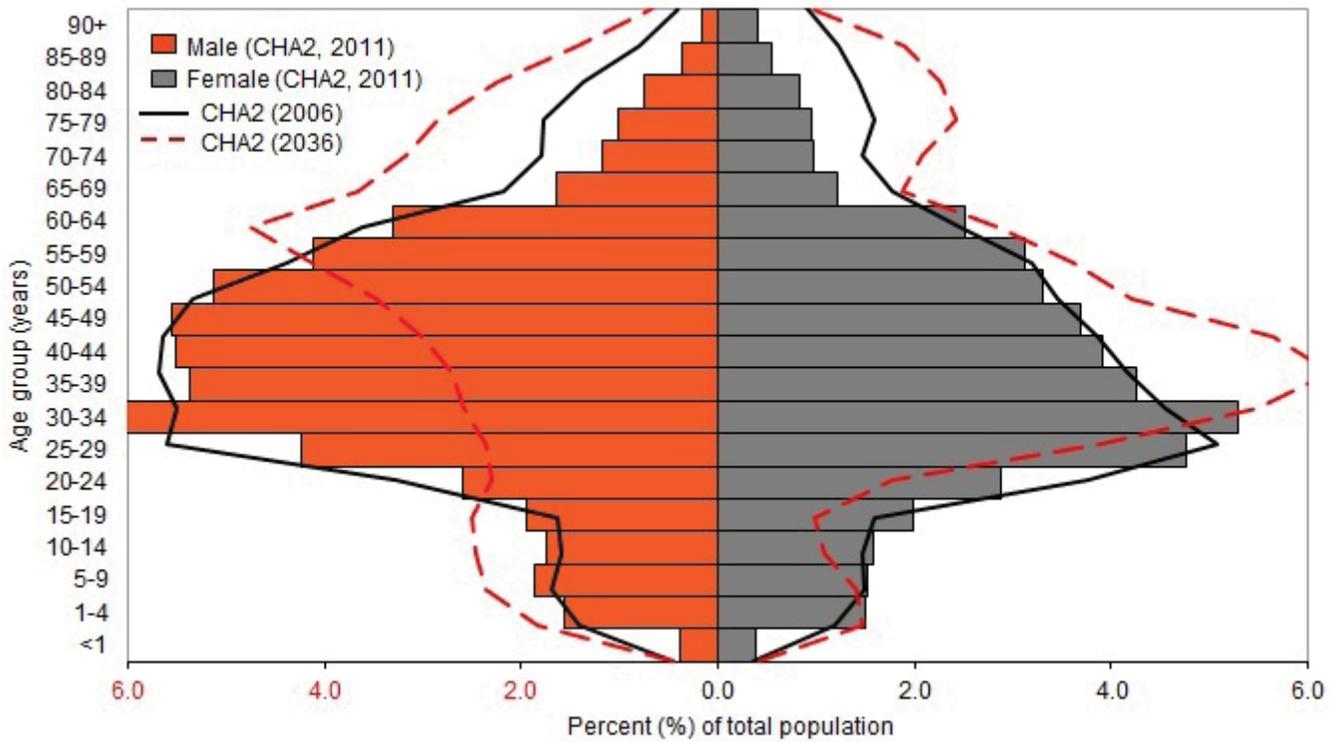
In 2011, the population of CHA 2 was 71,358, the least populated out of the six CHAs, comprising 18.1% of Vancouver’s population. CHA 2 is an adult-oriented community with over 28% aged 35-49 years.

**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 2, 2006, 2011, and 2036



Source: BC Stats (2012, March)

Figure 1 illustrates the sex distribution in CHA 2 with males on the left and females on the right. Overall, there are more males than females in CHA 2, but the sex distribution changes in some of the age groups.

Figure 1 also shows the number of people in each five-year age group. The figure shows what the data was in 2006 (black line), 2011 (bars), and what the data is expected to look like in 2036 (red dotted line).

By 2036, the total population of CHA 2 is expected to increase by 35%. The population of CHA 2 is also expected to age, with older people and fewer younger people in the community. Currently, there is only one defined peak in the 30-34 age group for males and 30-34 age group for females. However, over 25 years as the population ages, these peaks shift into higher age groups. Compared to 2011, there will be a shift towards a greater proportion of males aged 55 and older (38.7% vs. 23.0%) and females aged 35 to 59 years (44.4% vs. 40.1%) and 65 and older (19.5% vs. 10.0%).

# Demographic composition

This section draws attention to the demographic composition of Community Health Area 2 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).

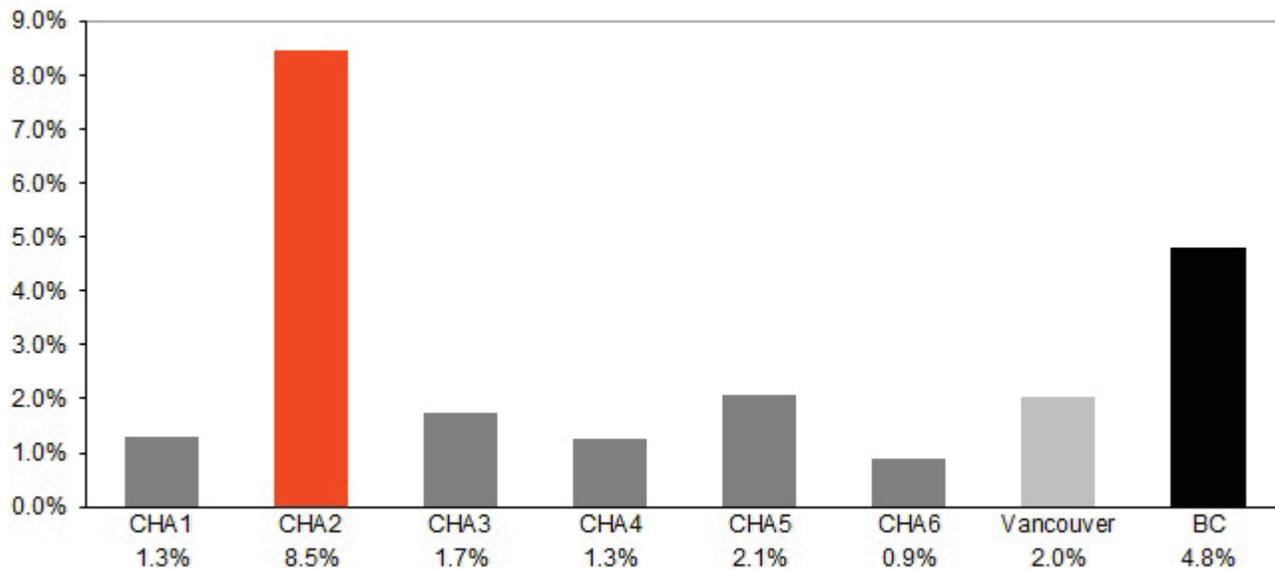
**Recent immigrants** refer to landed immigrants who came to Canada up to five years prior to a given census year. For the 2006 Census, recent immigrants are landed immigrants who arrived in Canada between January 1, 2001 and May 16, 2006 (Statistics Canada, 2010, July 6).

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.

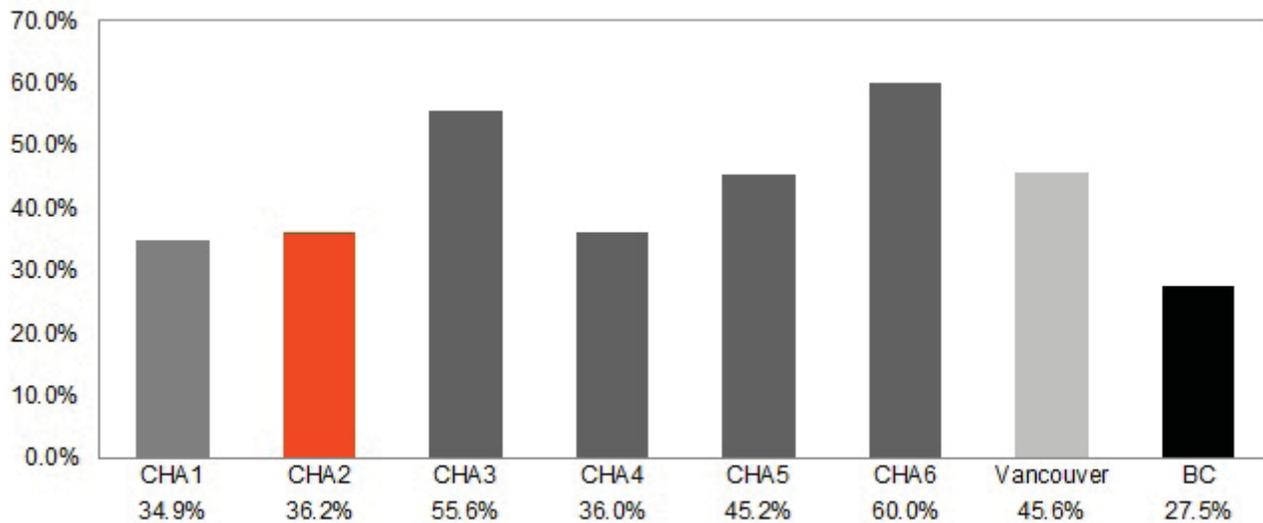
**FIGURE 2.** Aboriginal population as a percentage (%) of the total population. Community Health Areas, Vancouver, and British Columbia, 2006



Source: Statistics Canada, 2006 Census of Population

## Immigrant population

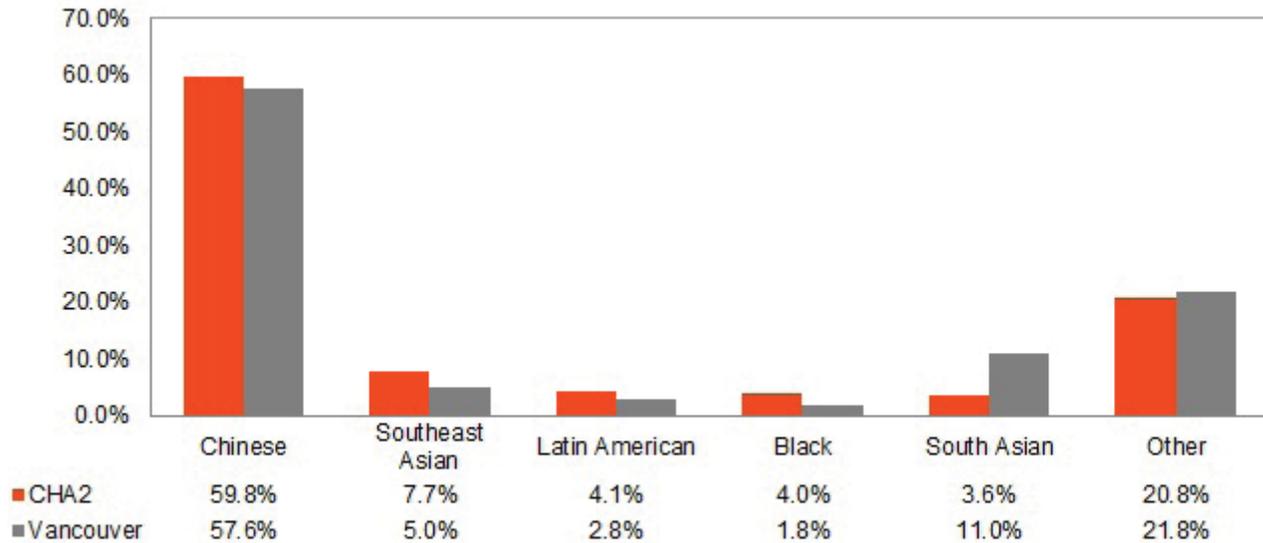
**FIGURE 3.** Immigrant population as a percentage (%) of the total population. Community Health Areas, Vancouver, and British Columbia, 2006



Source: Statistics Canada, 2006 Census of Population

Immigrants make up 36.2% of the total CHA 2 population. However, many of those immigrants that live in CHA 2 have been residing in Vancouver for a while. Among all recent immigrants who immigrated to Vancouver between 2001-2006, the smallest proportion (6.2%) chose to reside within CHA 2.

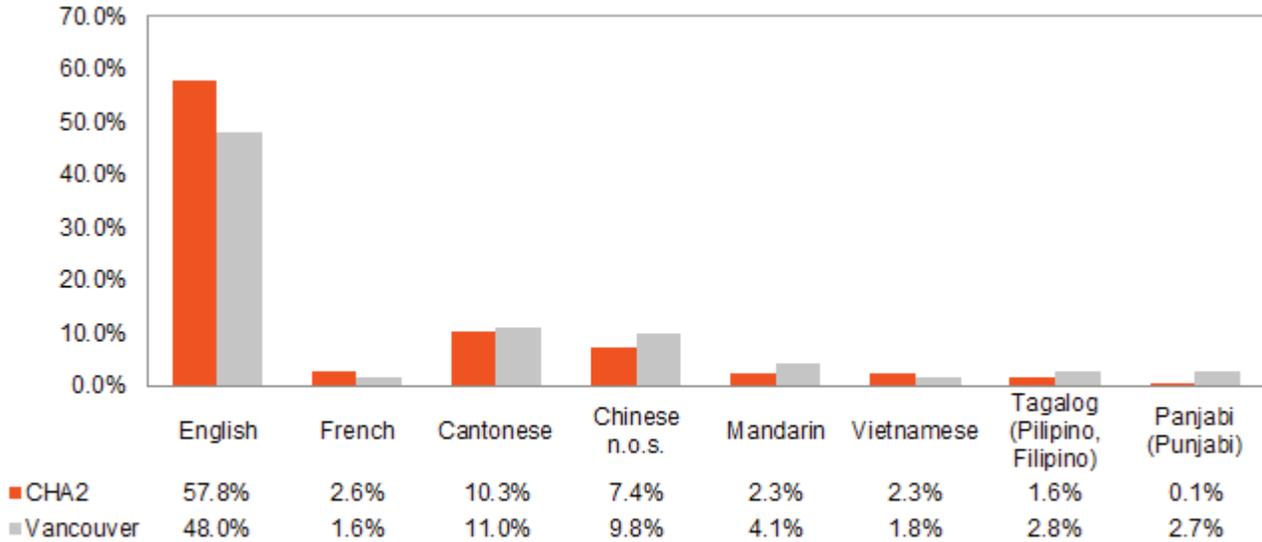
**FIGURE 4.** Select visible minority groups as a percentage (%) of the total visible minority population. Community Health Area 2 and Vancouver, 2006



Source: Statistics Canada, 2006 Census of Population

Visible minorities comprise 38.2 % of the total population of CHA 2. The Chinese population is the most prominent visible minority group making up 59.8% of the total visible minority population.

**FIGURE 5.** Total population by select mother tongue. Community Health Area 2 and Vancouver, 2006



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.

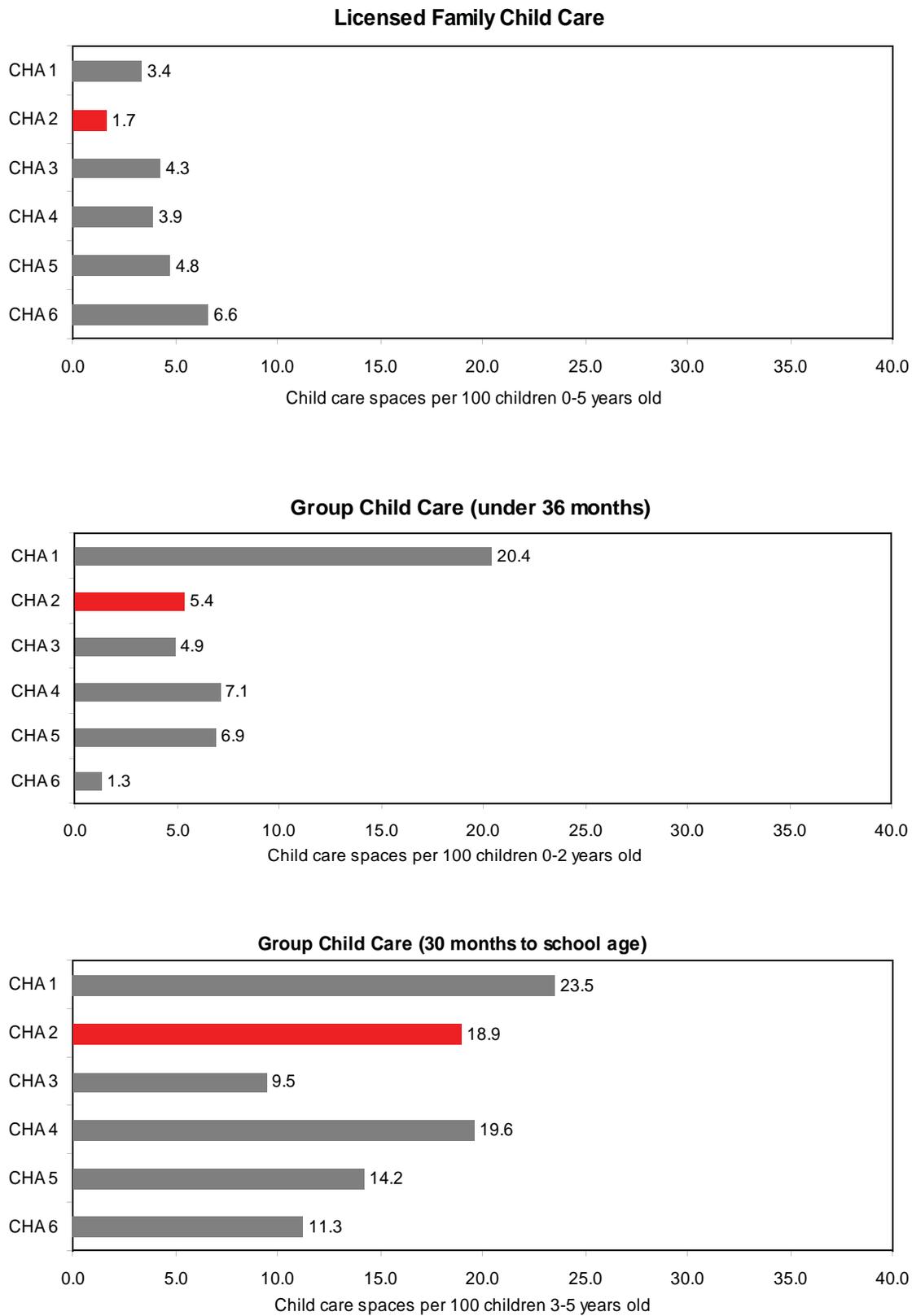
Licensed Family Child Care is offered in a child care provider's own home, and serves a maximum of 7 children from birth to age 12. Group Child Care serves children in two age groupings: from birth to 36 months and from 30 months to school-age. Preschools serve children age 30 months to school entry. 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.

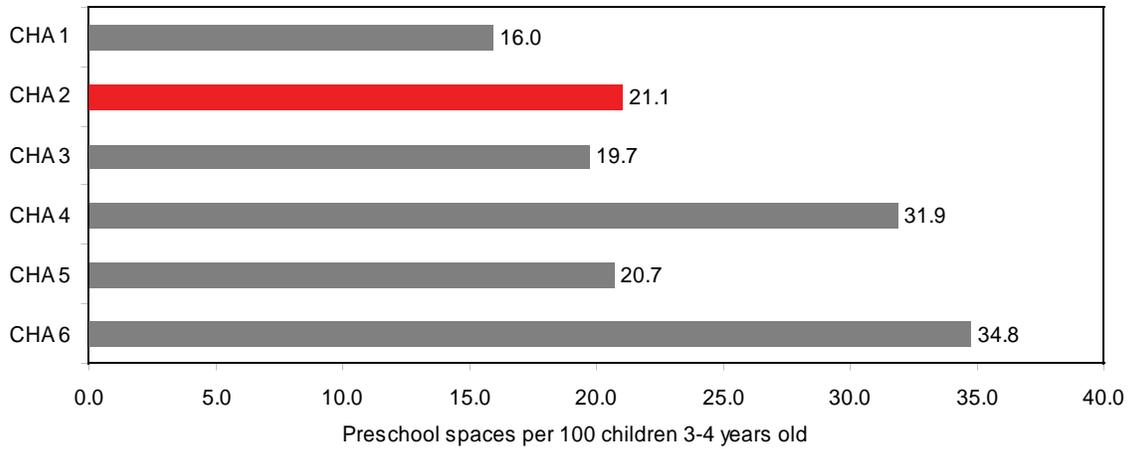
In CHA 2 there are 5.4 licensed group child care spaces for every 100 children under 36 months and 18.9 licensed group child care spaces for every 100 children age 3-5 years. More than 80 of every 100 children age 3-5 years do not have access to licensed group child care.

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

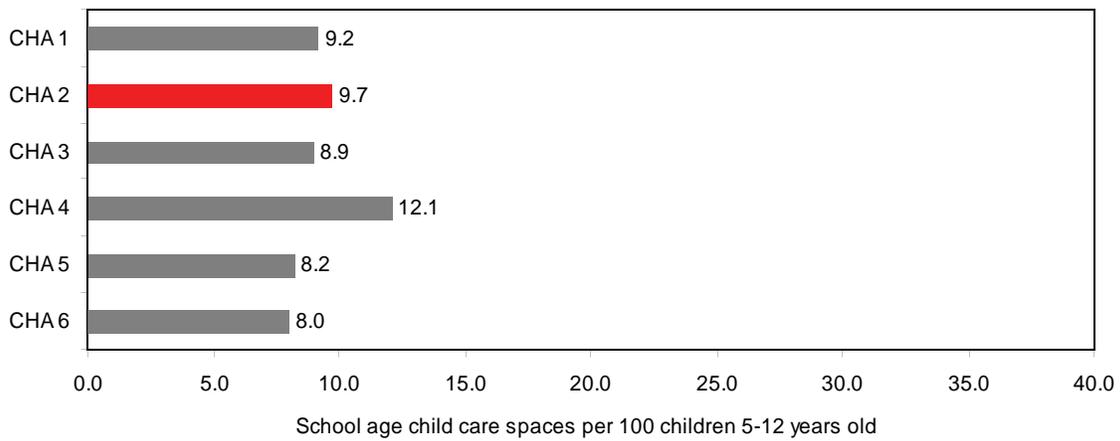
**FIGURE 6.** Child Care spaces per 100 children. Community Health Areas, 2012



**Preschool**



**School Age Child Care (after-school care)**



Source: Westcoast Child Care Resource and Referral and City of Vancouver, personal communication, (2012, August 16).

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

	Percentage (%) 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, September 22).

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 2, of 210 children who participated in the EDI in 2009/11, 25% are considered vulnerable in the domain of “Communication Skills and General Knowledge.” In the domain of “Physical Health and Well-Being”, 24 percent are considered vulnerable.

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 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, Personal Communication (2012, August 13)

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) (UBC Human Early Learning Partnership, personal communication, August 13, 2012).

Table 4 shows that 180 grade 4 children from CHA 2 participated in the MDI questionnaire in 2011, and of these almost 78% are doing well (i.e. scored "medium/high" or "very high/thriving"). 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

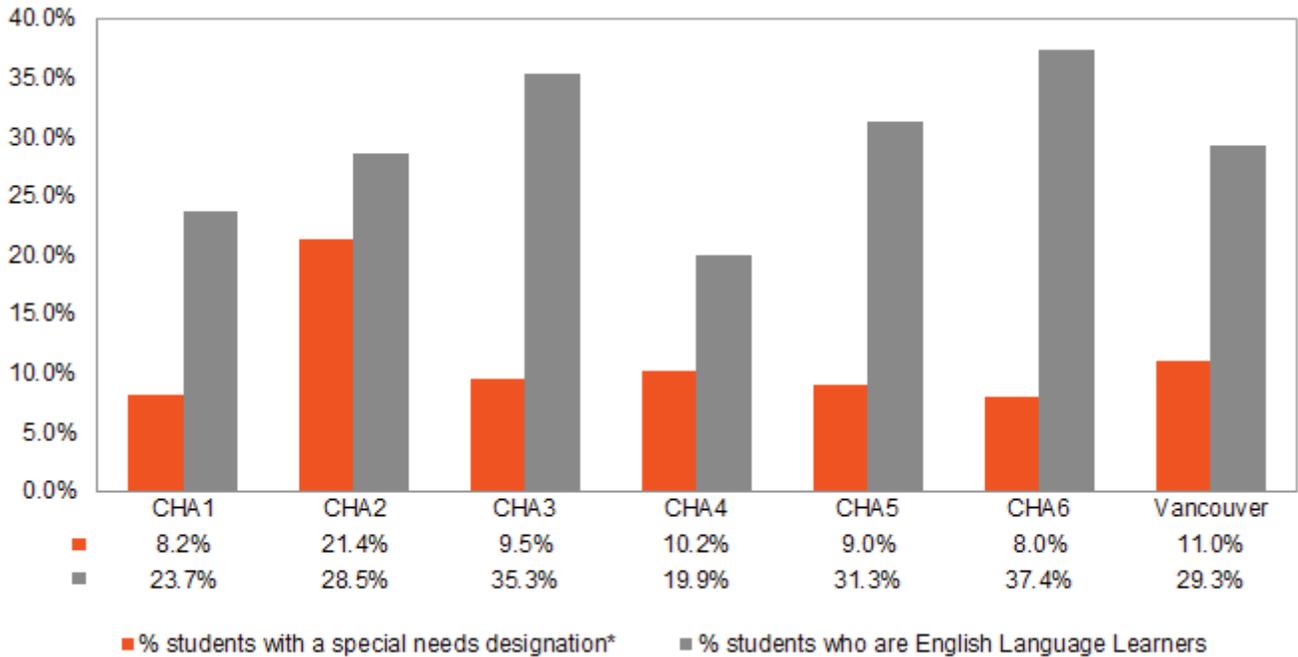
Community Health Area	Percentage of grade 4 students that report the presence of each asset			
	After School Activities	Peer Relationships	Nutrition and Sleep	Adult Relationships
CHA 1	67.4%	85%	72%	83.7%
CHA 2	76.2%	74%	63.3%	79.5%
CHA 3	63.5%	76%	65.2%	70.9%
CHA 4	88.5%	79.8%	76.7%	82.7%
CHA 5	71.4%	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, Personal Communication, (2012, August 13).

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 2 report having positive relationships with peers and adults. Over 76% of children in CHA 2 participate in after-school activities. This is the second-highest rate of participation in after-school activities among all of the CHAs. However, only 63% of children in CHA 2 report that they usually eat breakfast and get a good night's sleep – the lowest rate among all CHAs.

**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, Personal Communication, (2011, September 30)

\*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’s 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)

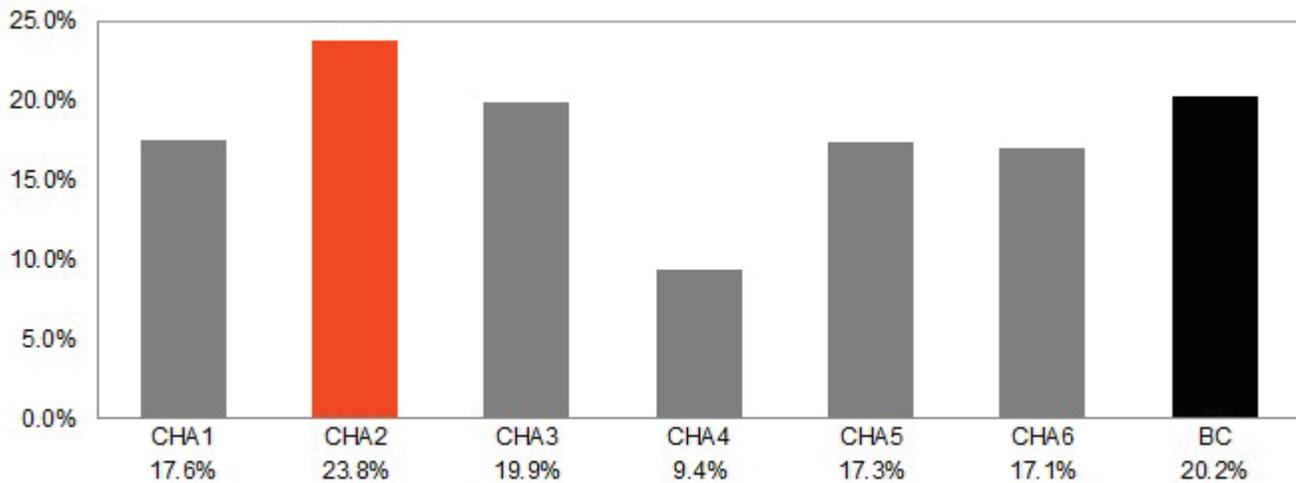
Families in BC who rely on income assistance (IA) may be experiencing temporary unemployment or disability. While income assistance helps these families with the basic costs of living, the support is limited and these families live in poverty.

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.

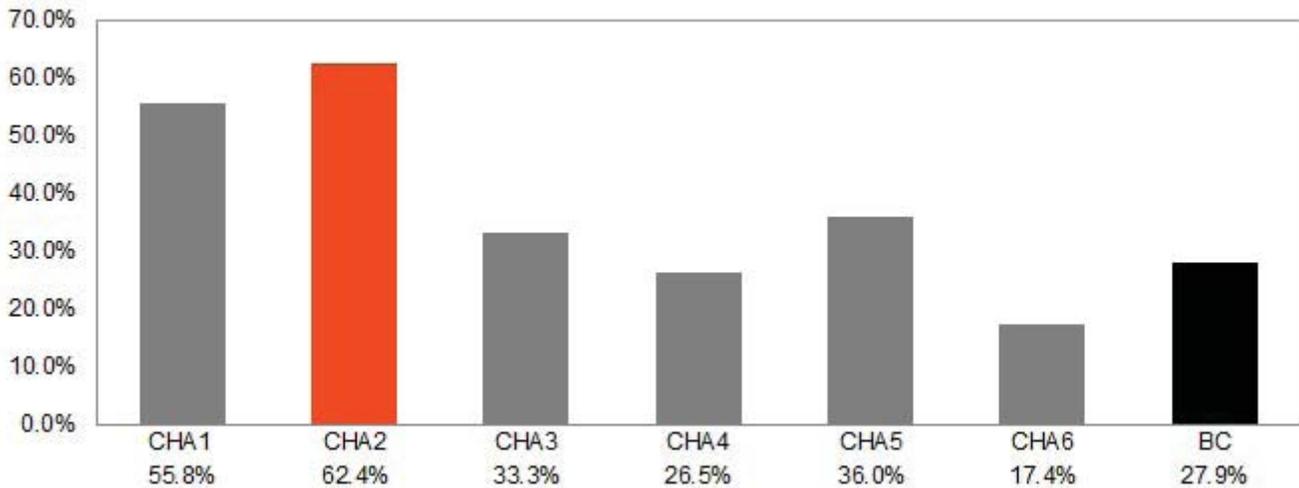
**FIGURE 8.** Percentage of students below the average on the Foundation Skills Assessment reading tests - average of Grade 4 and 7 students. Community Health Areas and British Columbia, average 2008/09-2010/11



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

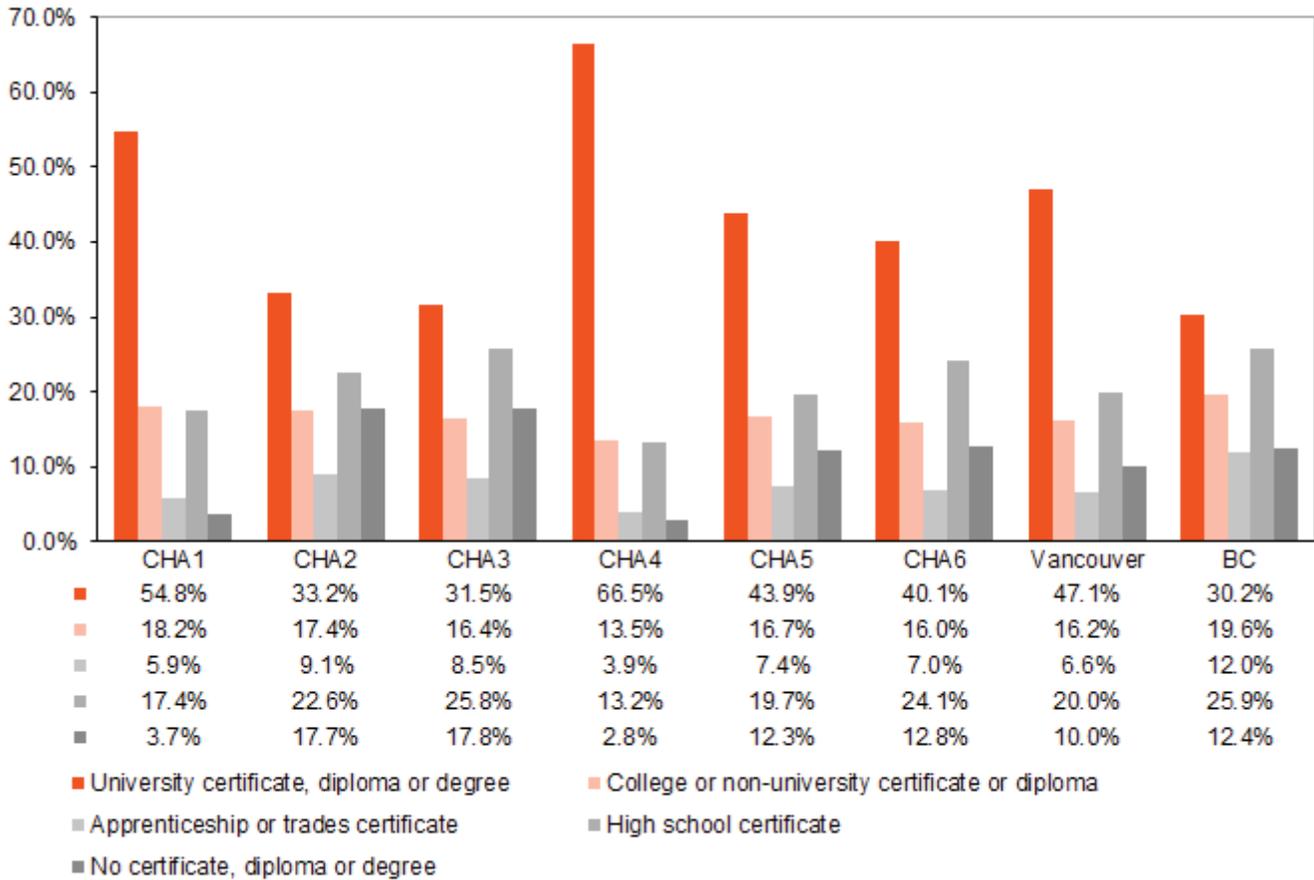


Source: BC Stats (2011)

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

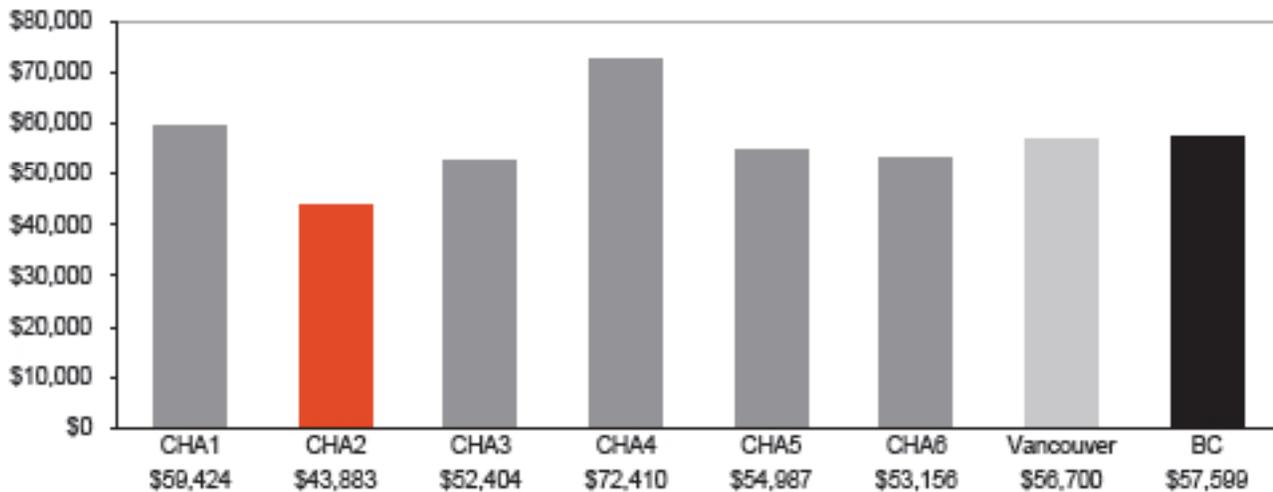


Source: Statistics Canada, 2006 Census of Population

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

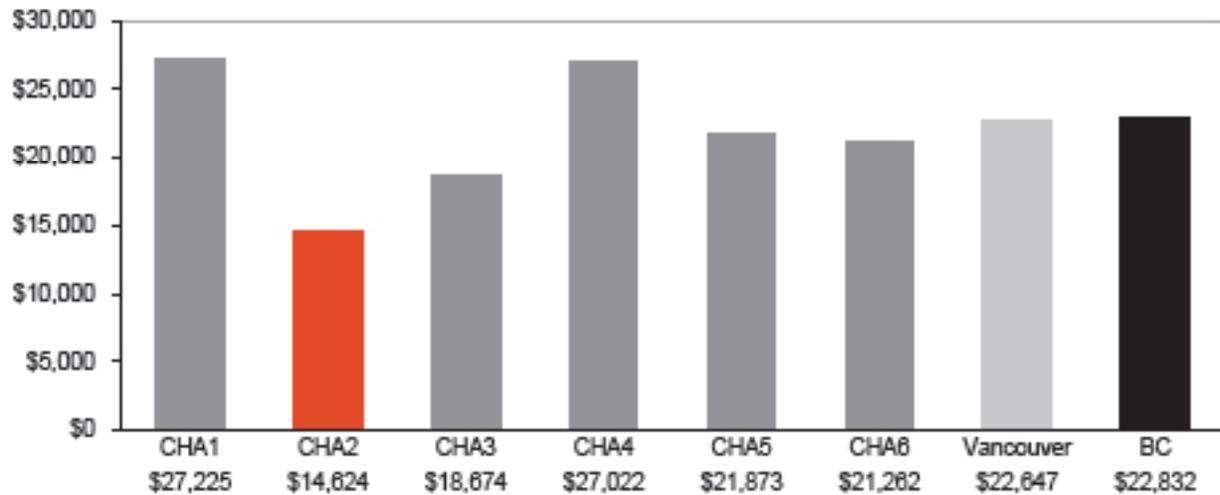


Source: Statistics Canada, 2006 Census of Population

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, July 6).

**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 2 make 5.2% more than females. This is the lowest differential in the CHAs.

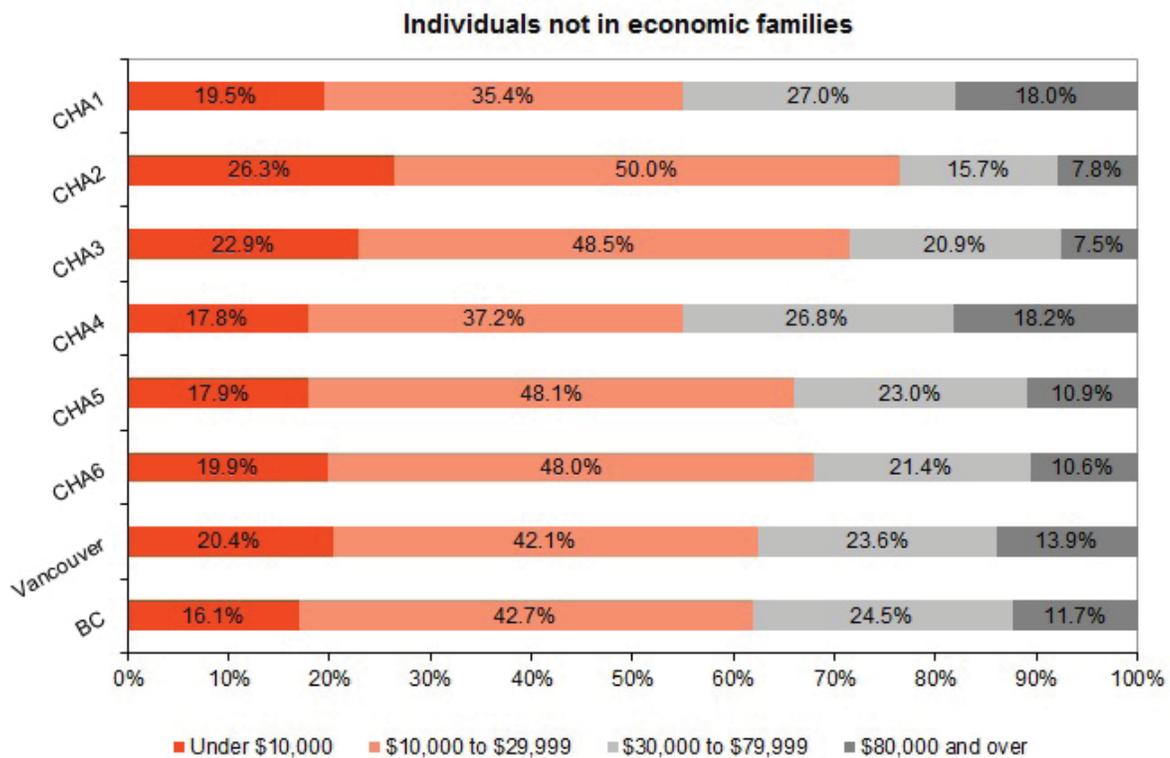
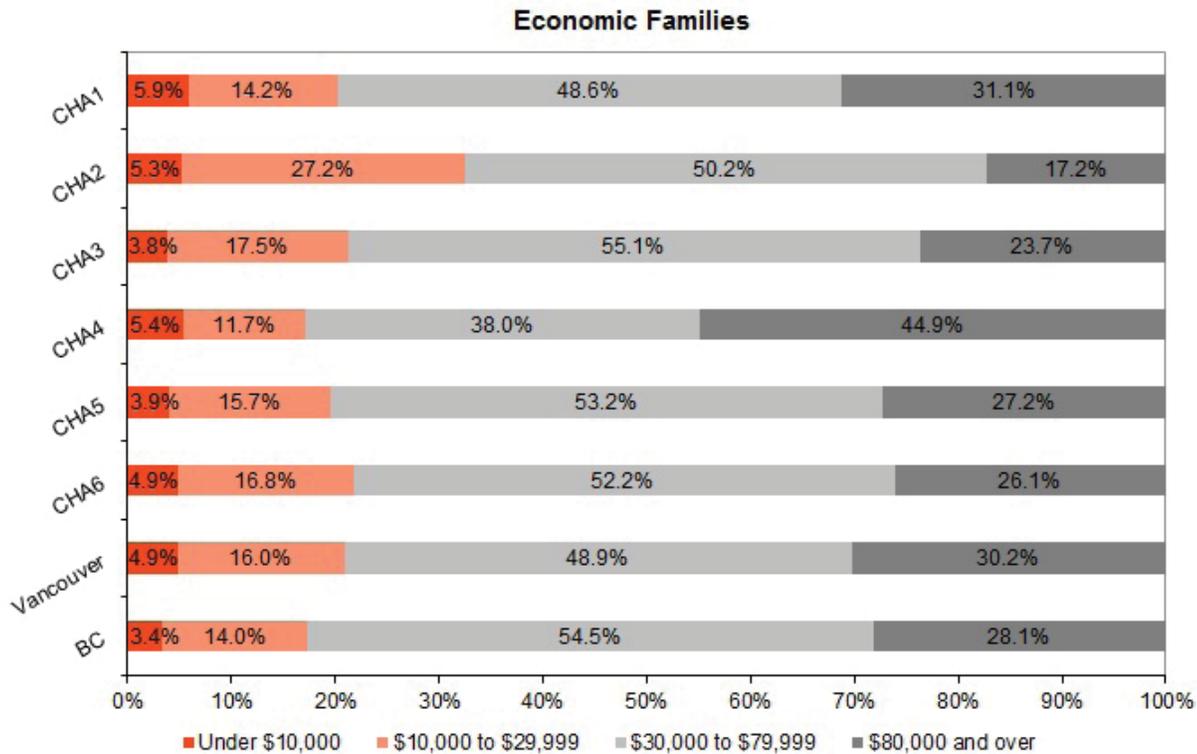
**TABLE 8.** Employment income and unemployment rates for Canadian-born, all immigrants, and recent immigrants. Community Health Areas, and British Columbia, 2006

	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)

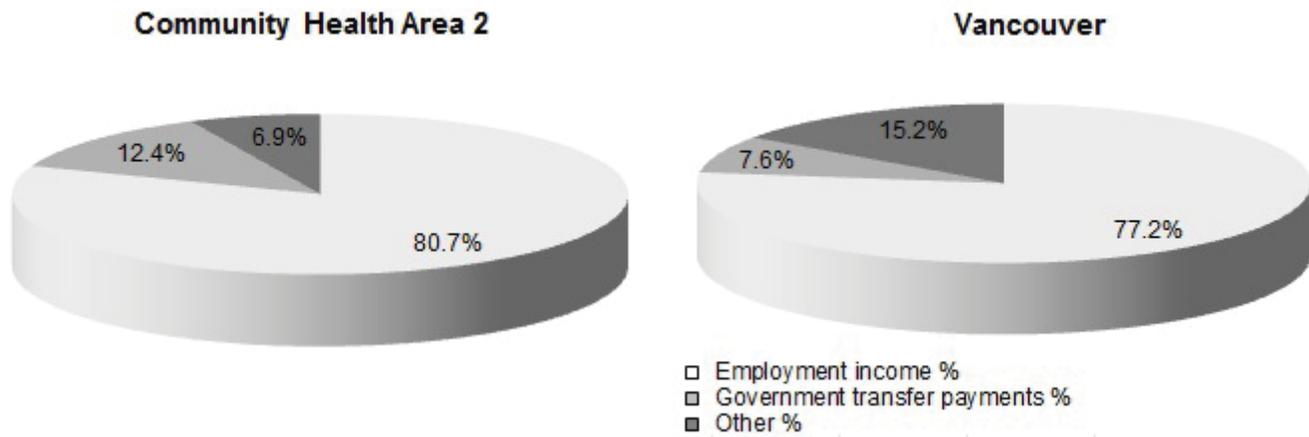
Immigrants and, in particular, recent immigrants often experience a disadvantage in the labour force. Within CHA 2, recent immigrants earn \$9,318 less than the average Canadian-born worker while facing higher rates of unemployment (9.9% vs. 8.1%). The income discrepancy is the smallest found amongst the CHAs.

**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 2 and Vancouver, 2006



Source: Statistics Canada, 2006 Census of Population

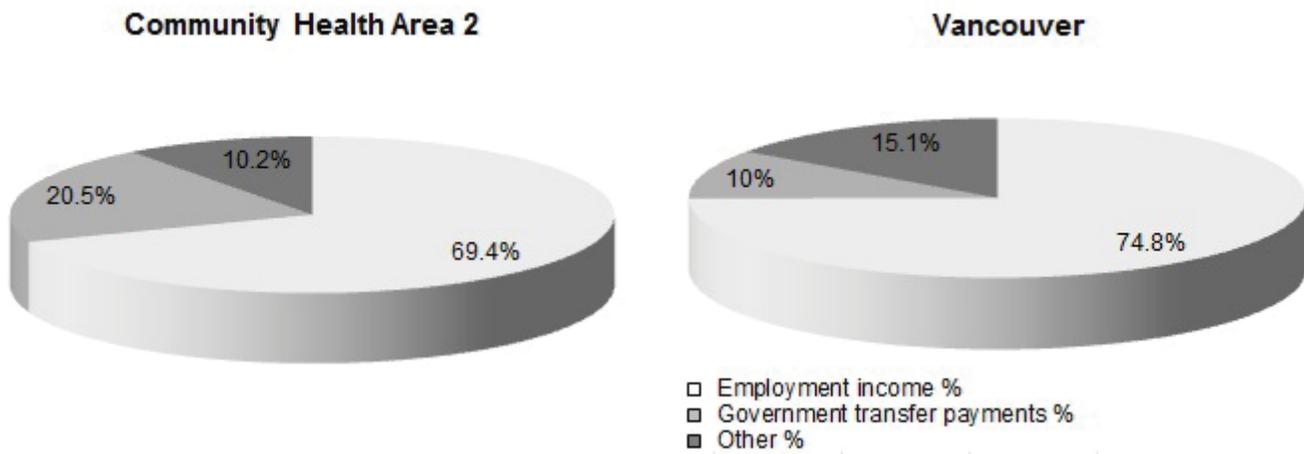
These figures break down income source (employment, government transfer payments and other sources) as a percentage of the total income of economic families in CHA 2 compared to that of Vancouver.

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.

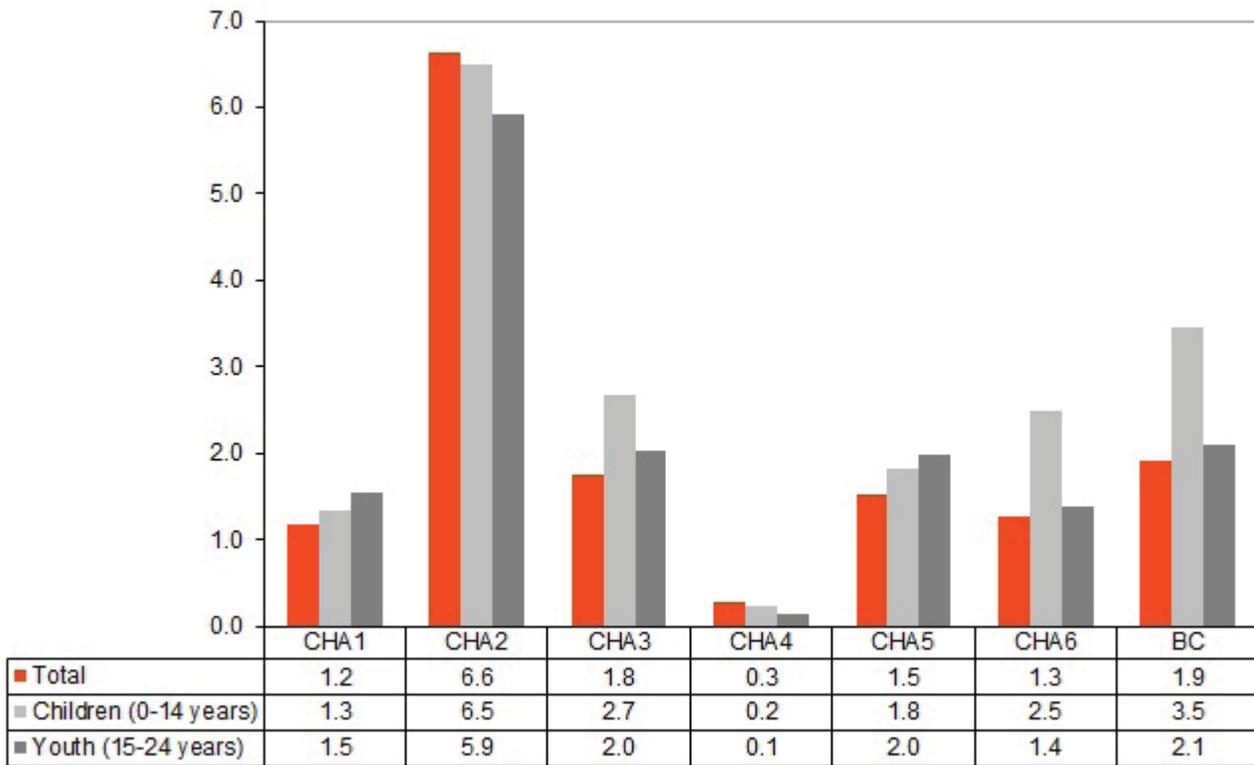
**FIGURE 15.** Composition of individual income of persons (aged 15+ years) not in economic families. Community Health Area 2 and Vancouver, 2006



Source: Statistics Canada, 2006 Census of Population

When it comes to composition of individual income in CHA 2, the relative share of employment income is 69.4%, while the relative share of government transfer payments is 20.5%.

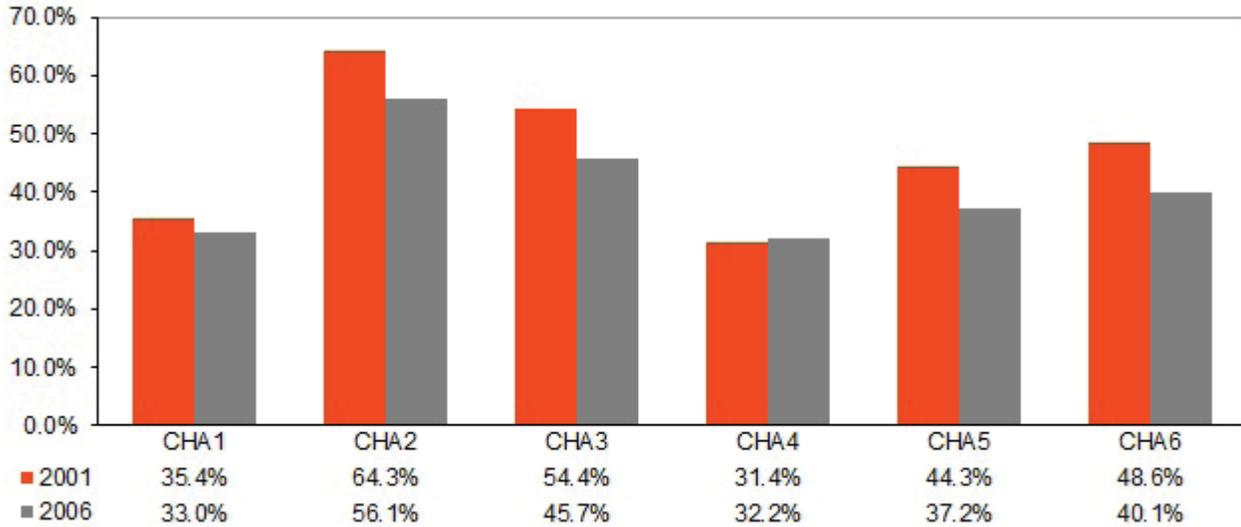
**FIGURE 16.** Percentage of population (%) receiving income assistance. Community Health Areas and British Columbia, 2010



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 (BC Stats, n.d.).

**FIGURE 17.** Incidence of low-income among individuals over age 15 after-tax. Community Health Areas, 2001 and 2006.

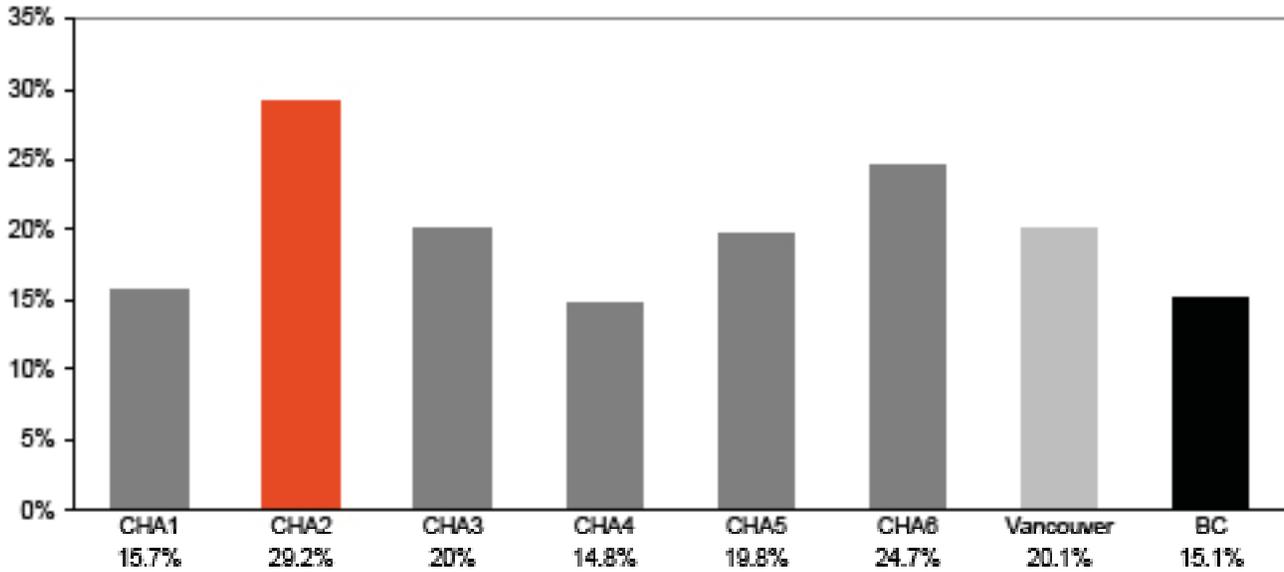


Source: Statistics Canada, 2001 Census of Population and 2006 Census of Population

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).

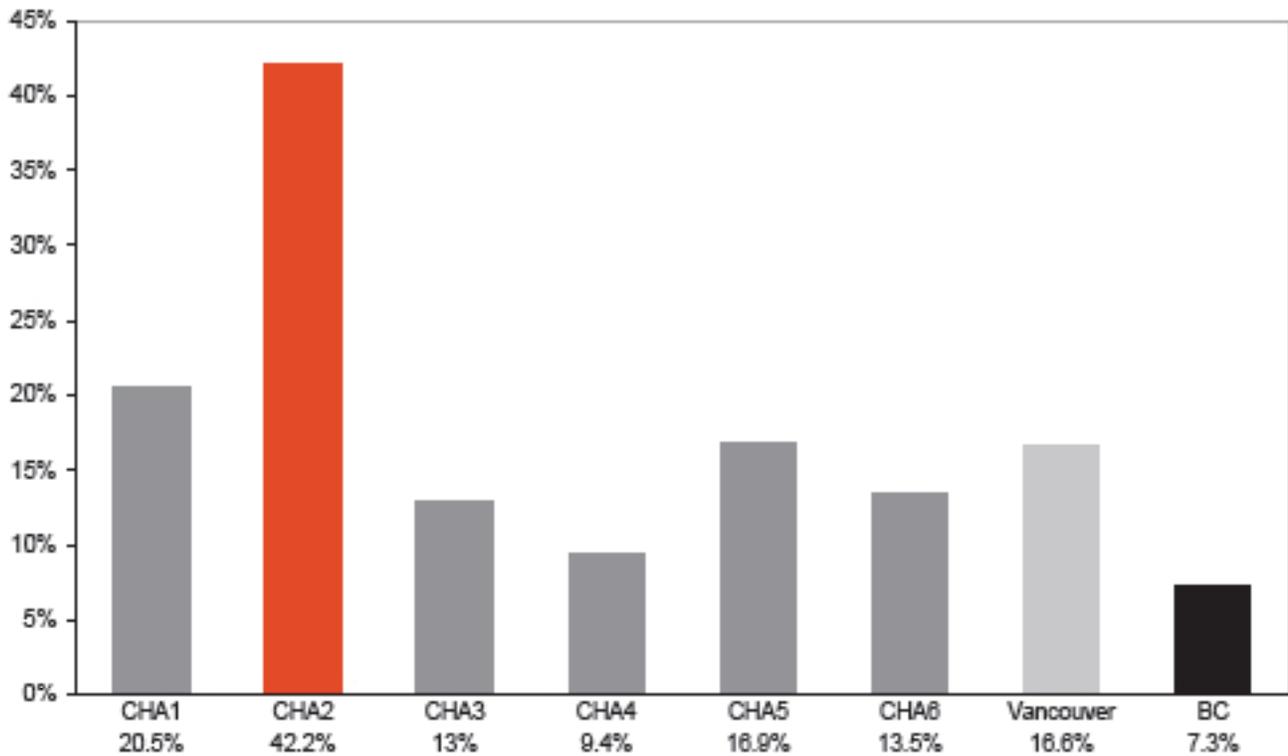
From 2001 to 2006, the incidence of low-income among individuals over the age of 15 decreased in all CHAs with the exception of CHA 4 (Westside), which showed a very small increase.

**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

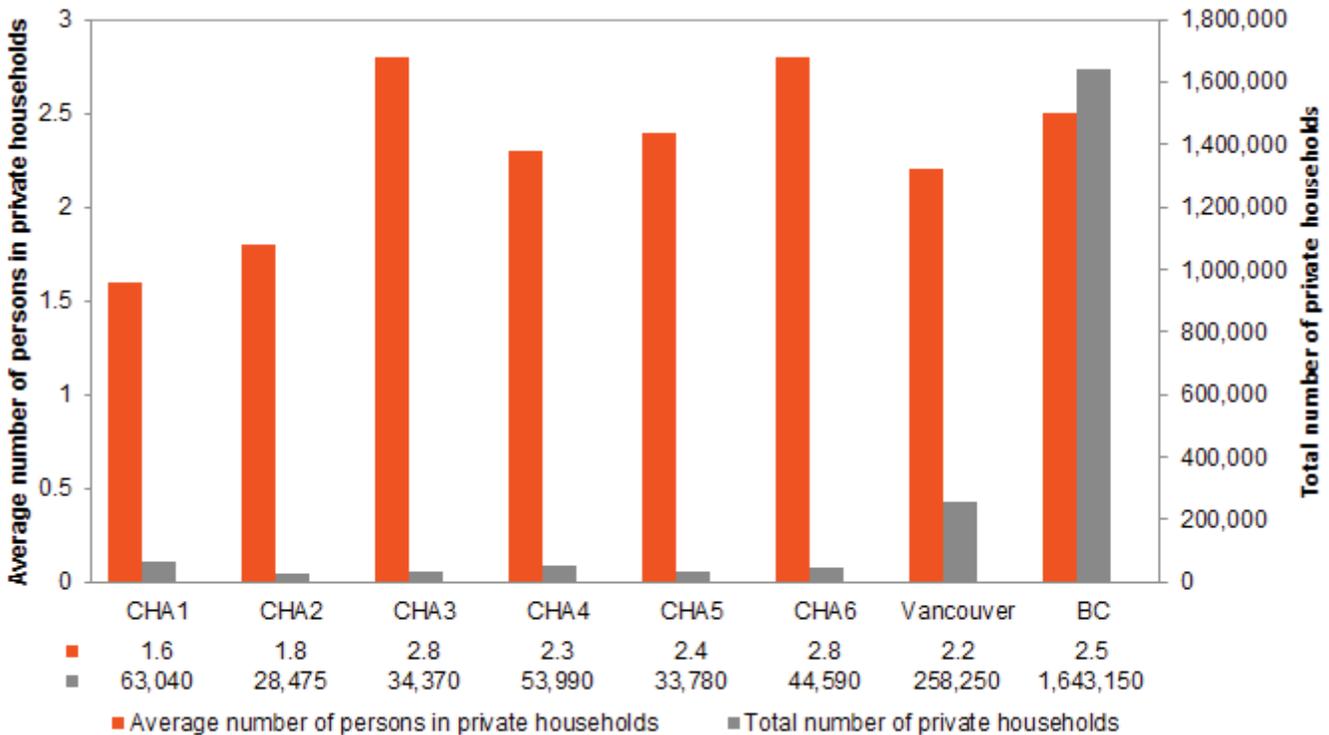
**FIGURE 19.** Seniors, aged 65 years and over, (%) living in low income conditions, after-tax. Community Health Areas, Vancouver, and British Columbia, 2006



Source: Statistics Canada, 2006 Census of Population

## 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 2 has a low average number of people in a household. This reflects the large number of people living alone and couples without children living in CHA 2.

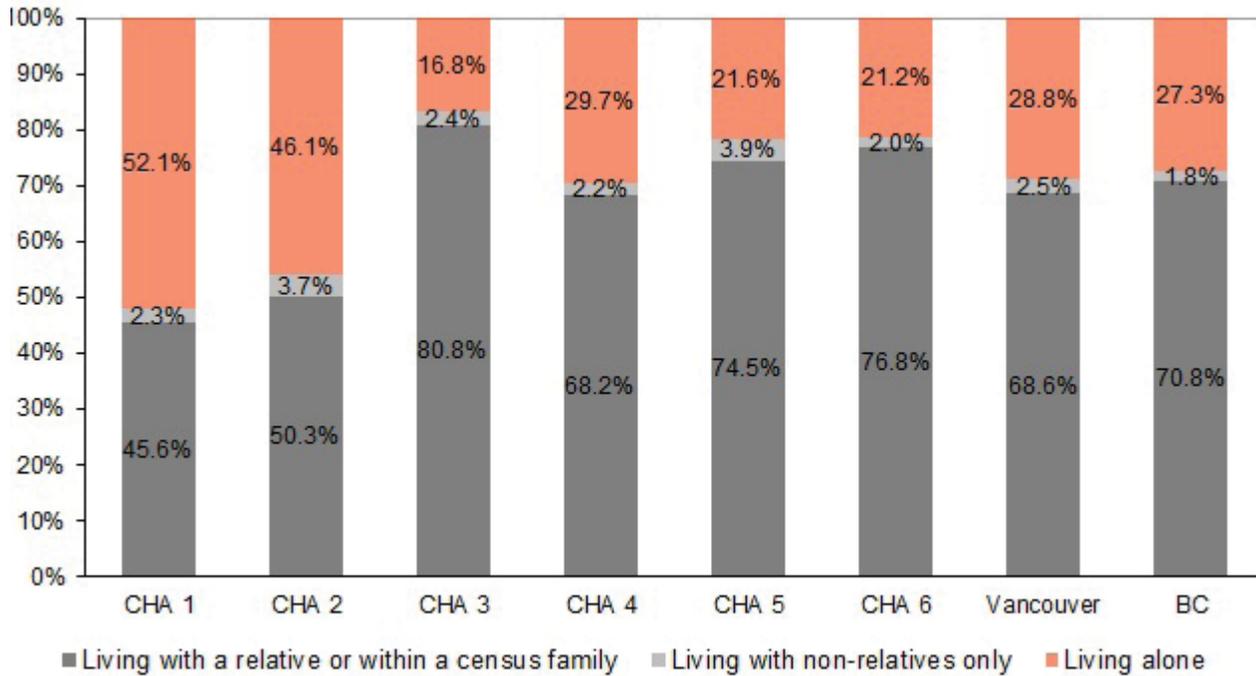
**TABLE 9.** Total lone parent families as a percentage of all census families by sex of parent. Community Health Areas, Vancouver, and British Columbia, 2006

	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.

**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

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%

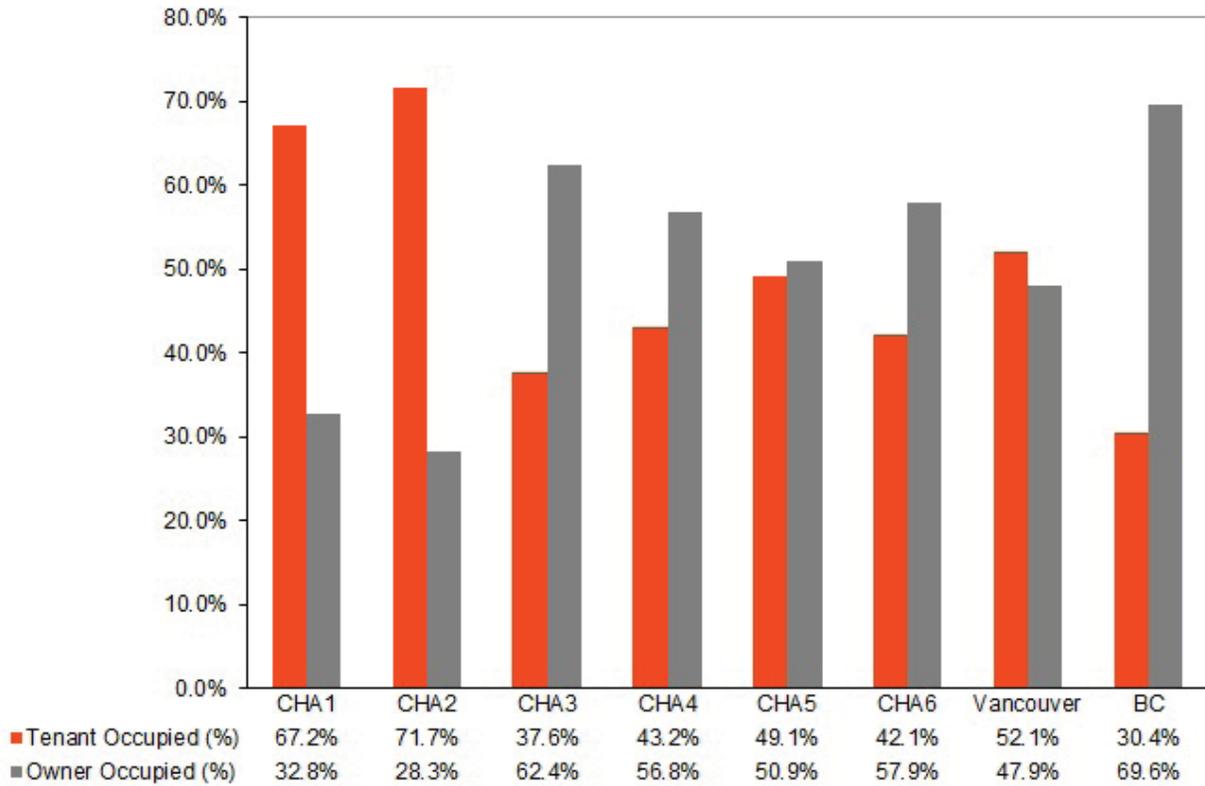
Source: Statistics Canada, 2006 Census of Population

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).

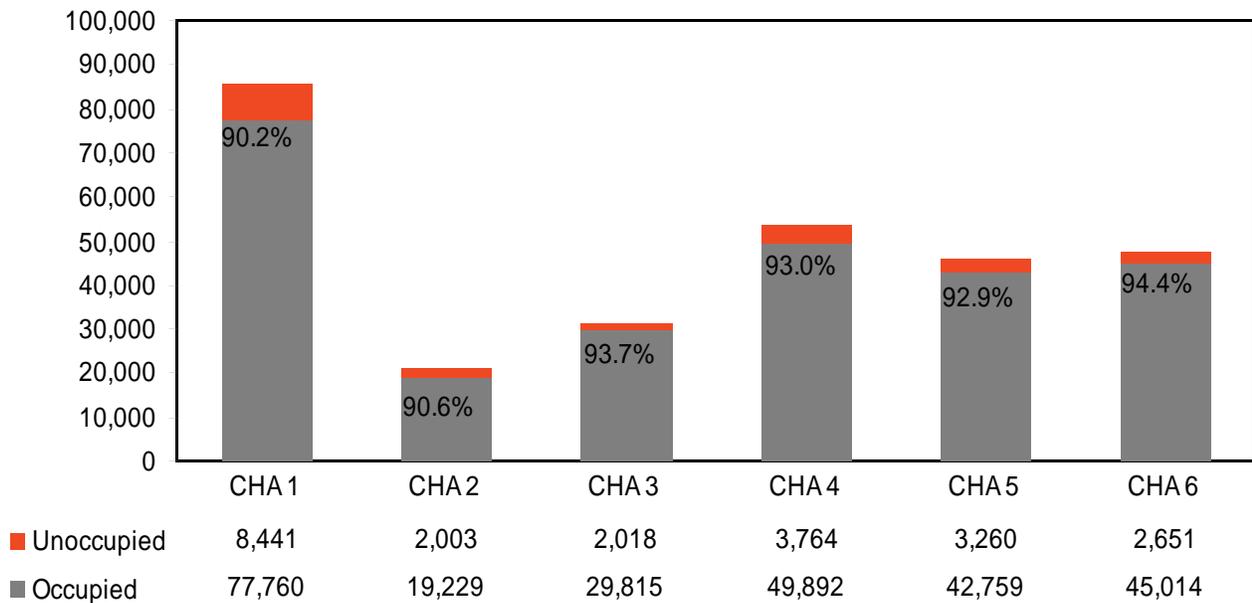
**FIGURE 22.** Tenant and owner occupied dwellings. Community Health Areas, Vancouver, and British Columbia, 2006



Source: Statistics Canada, 2006 Census of Population

Amongst the CHAs, CHA 2 has the highest percentage of tenant-occupied dwellings.

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



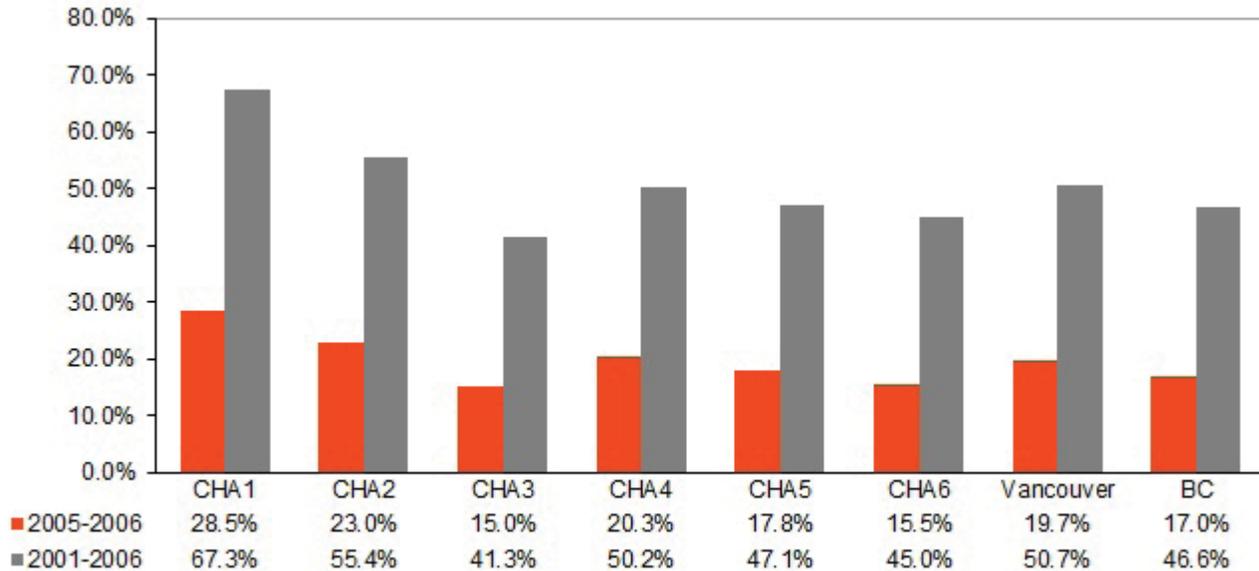
Source: City of Vancouver, Personal Communication, July 5, 2012

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, July 5, 2012).

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

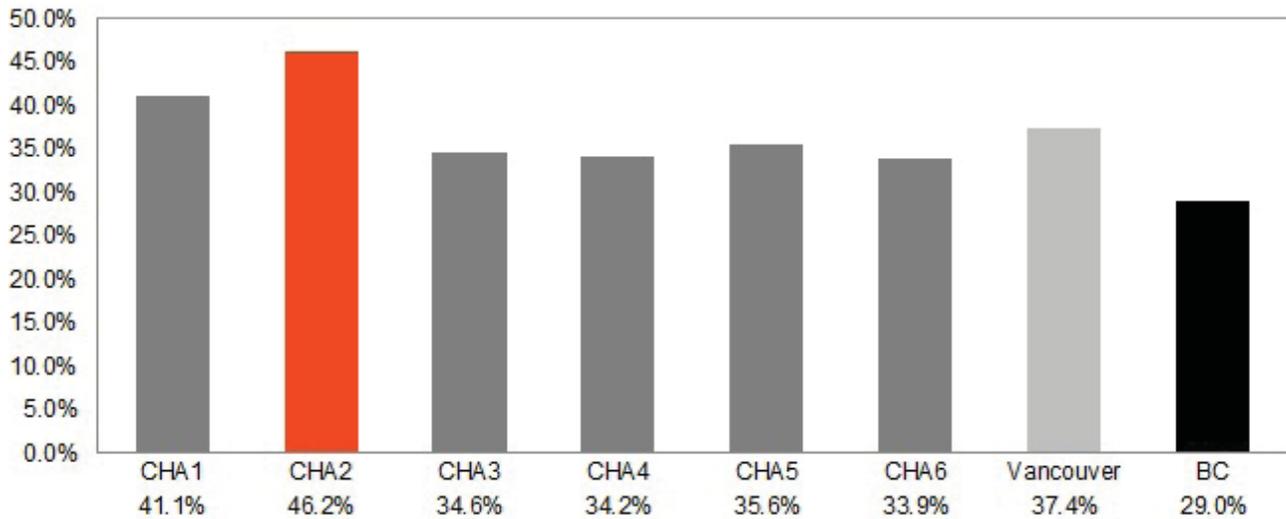


Source: Statistics Canada, 2006 Census of Population

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, July 6).

A more stable community with lower mobility may imply a closer social support network with higher social capital and consequent positive health effects.

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

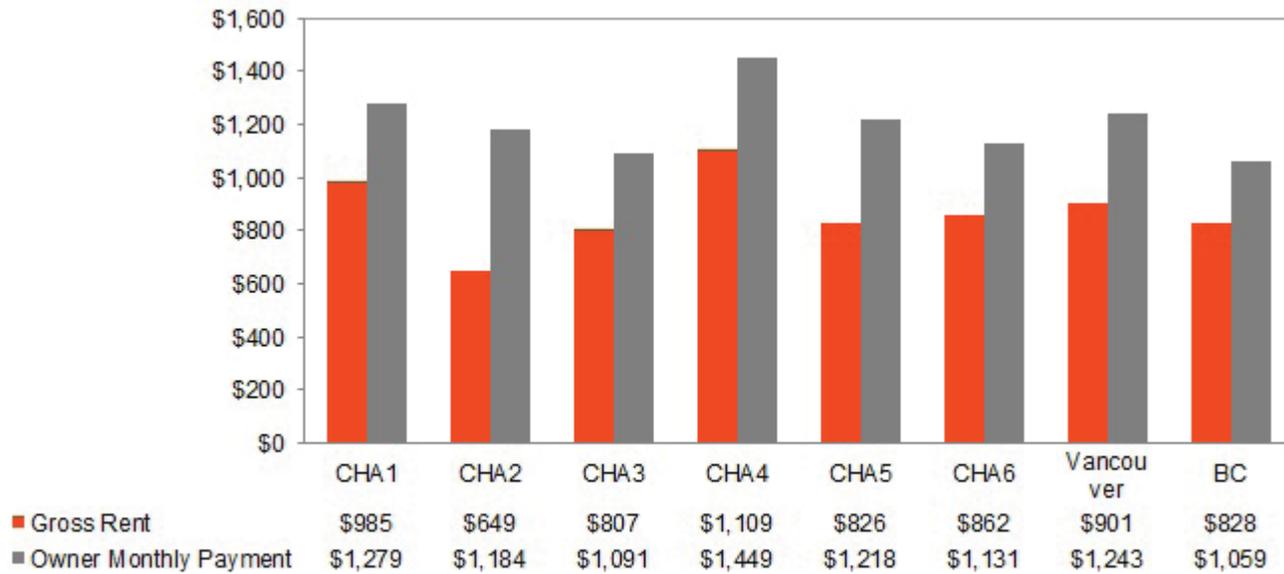


Source: Statistics Canada, 2006 Census of Population

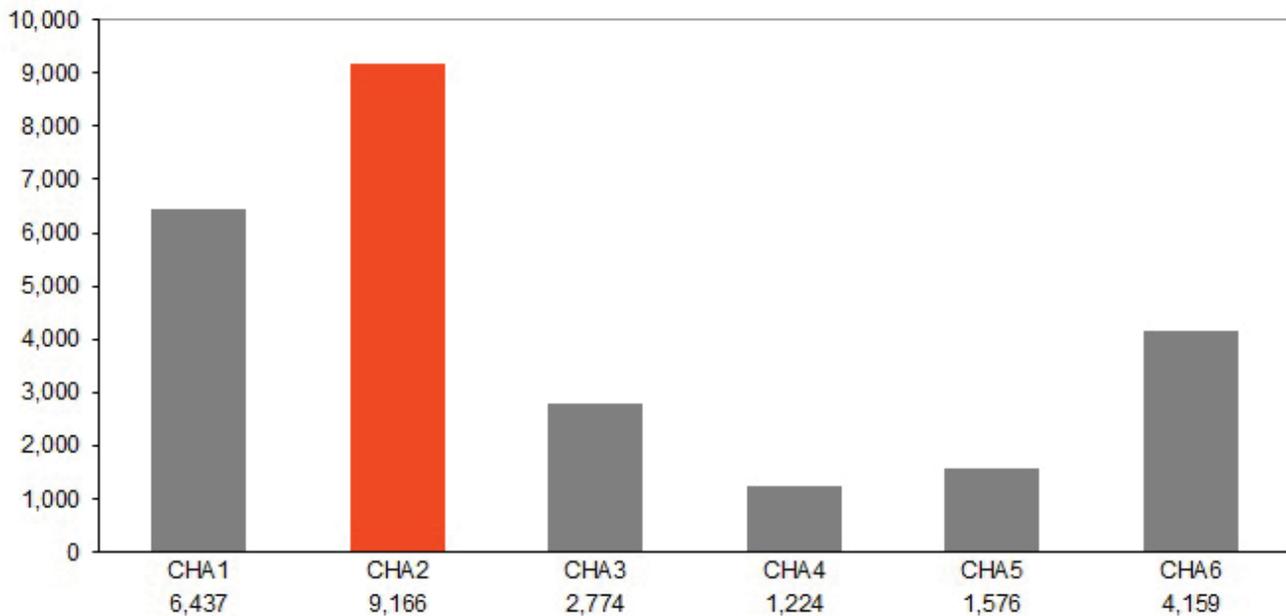
A household paying more than 30% of their annual income on housing is considered to be living in unaffordable conditions. This cost burden makes it difficult to pay for other necessities such as food, clothing, education, transportation, and health care.

Forty-six percent of the CHA 2 population is paying 30% or more of their income on housing costs, the highest amongst the CHAs. This may be attributable to the area's low-income population and the increasing cost of housing in the area.

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



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 (City of Vancouver, 2010).

CHA 2 has 182 non-market complexes with 9,166 units, the most amongst the CHAs. 47% are concentrated within the DTES, while another 36% are concentrated within Grandview-Woodlands. Of these, 39 are housing co-operatives, 21 are for seniors, 20 are for Aboriginal people, 12 are for persons living with a mental illness, 9 are for women, and 8 are for persons at risk of homelessness. Despite having the most non-market facilities and units, area service providers still note a lack of social and affordable housing to meet the needs of its residents.

**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, Personal Communication, (2012, June 26)

According to the City of Vancouver 2012 Homeless Count, CHA 2 has a sheltered homeless population of 461 people, mostly found within the DTES, and a street homeless population of 134 people who were found throughout all three CHA 2 neighbourhoods. (Note: all homeless counts underestimate the number of homeless people at one time and do not take into account the mobility of this population).

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

For temporary shelter spaces, these include all HEAT or Winter Response shelters that were open at any point during 2011/2012 (some closed or are scheduled to close). This does not include Extreme Weather Alert shelter spaces.

# Health status

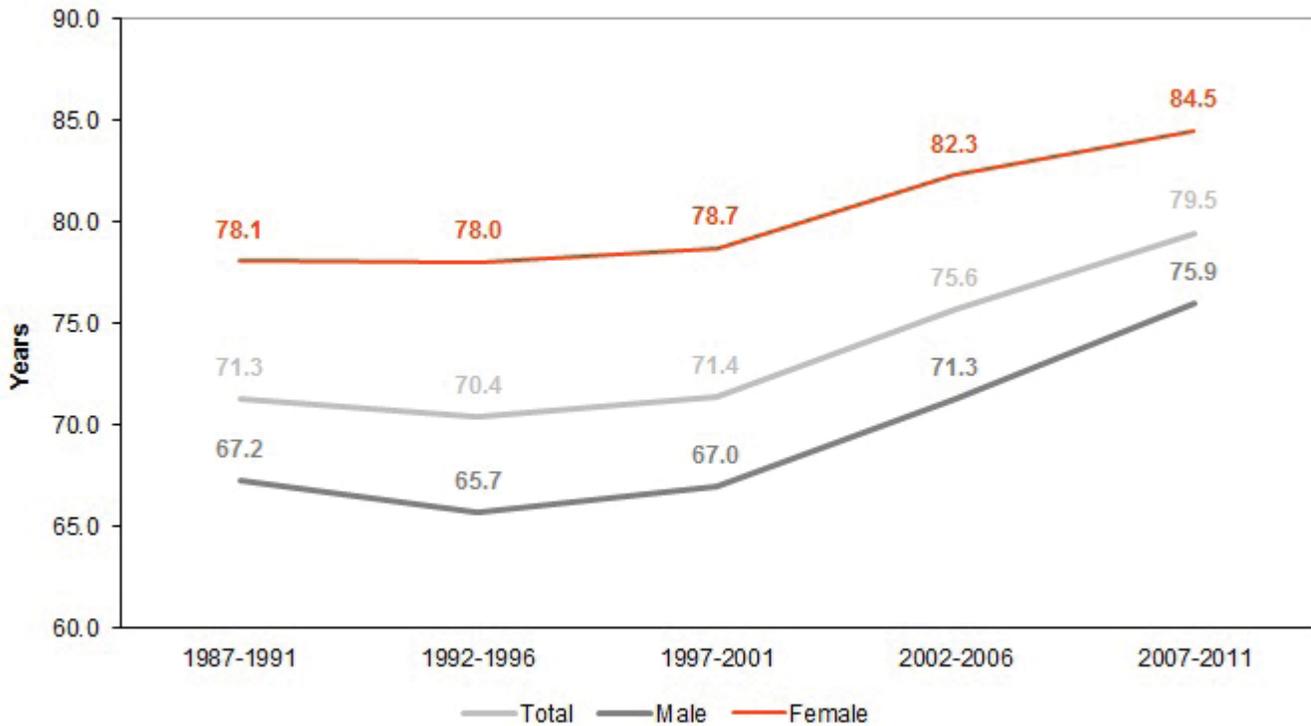
This section details the type of data used to profile the health of communities and illustrates the interaction between the determinants of health, illness and injury.

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.

Community Health Area 2 experiences many health inequities, which is unsurprising given the social determinants of health that contribute to individual and population health, including: education, income, and living and working conditions. However, CHA 2 is not a homogenous area and there are residents within CHA 2 that do not share these same disadvantages.

## Life expectancy

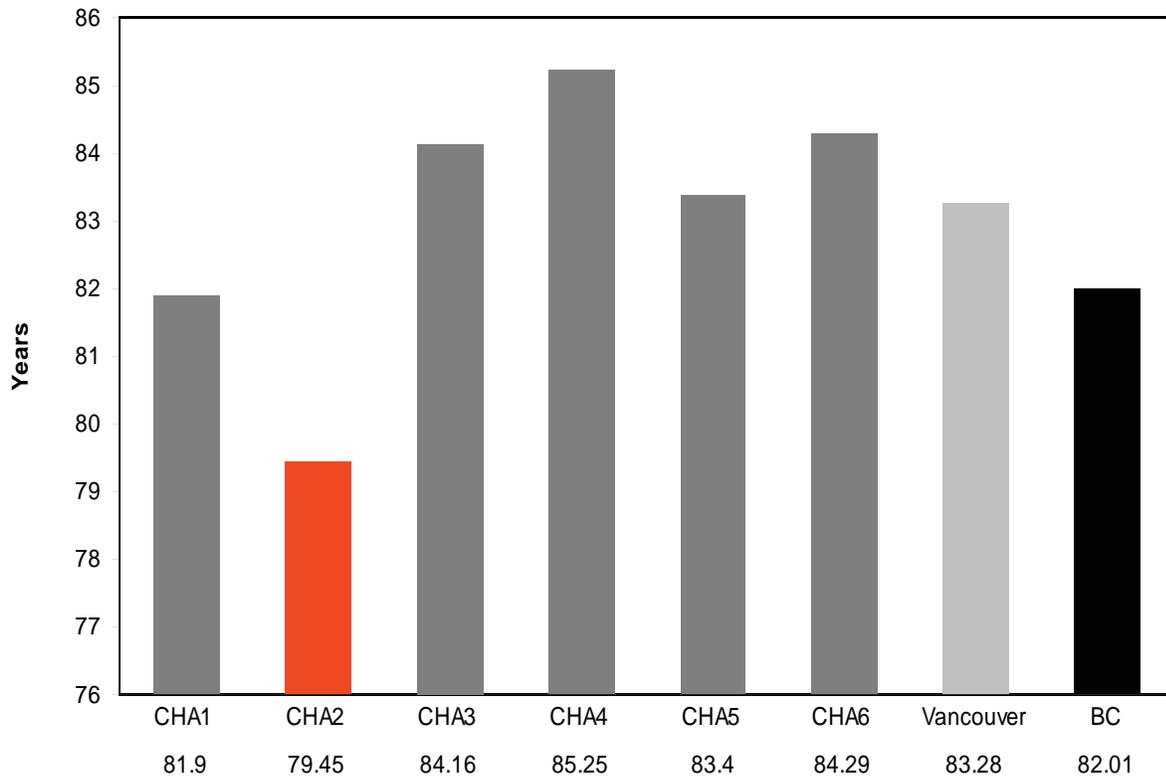
**FIGURE 28.** Life expectancy at birth. Community Health Area 2, 1987-2011



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, "Selected Vital Statistics and Health Status Indicators, Annual Report 2008" [www.vs.gov.bc.ca/stats/annual/index.html](http://www.vs.gov.bc.ca/stats/annual/index.html)).

Within CHA 2, life expectancy has been steadily increasing, reaching a high of 79.5 years in 2007-2011. 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 8.6 years longer than their male counterparts; the largest discrepancy in gendered life expectancy amongst the CHAs.

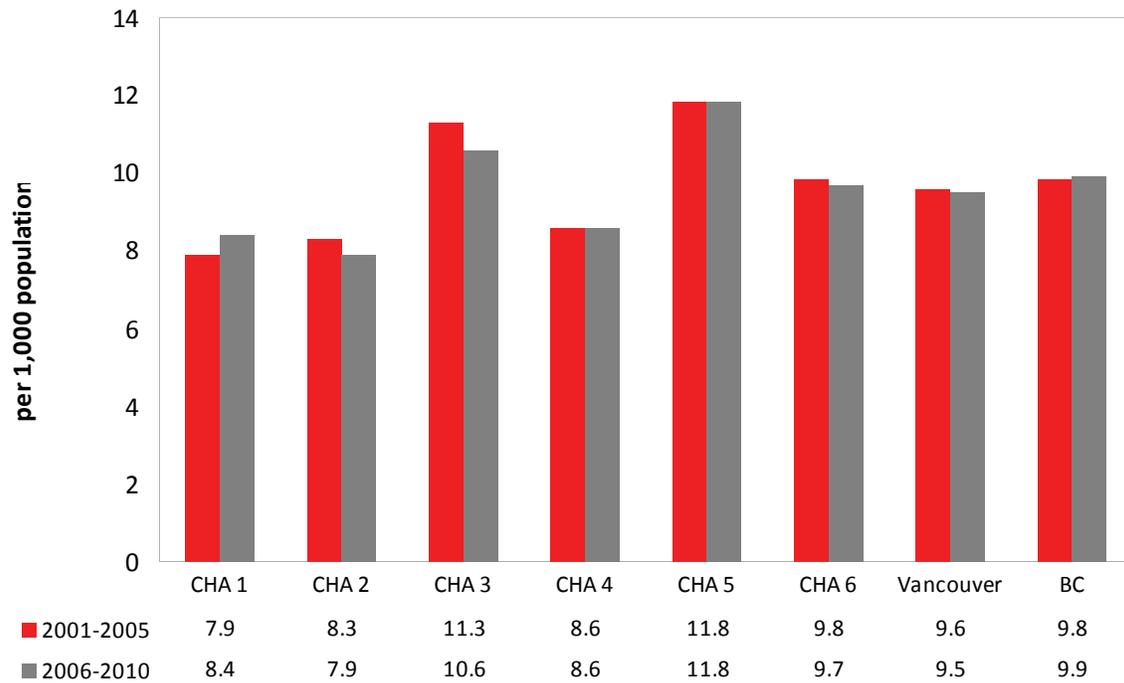
**FIGURE 29.** Life expectancy at birth. Community Health Areas, Vancouver, and British Columbia, 2007-2011

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.

## Births

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

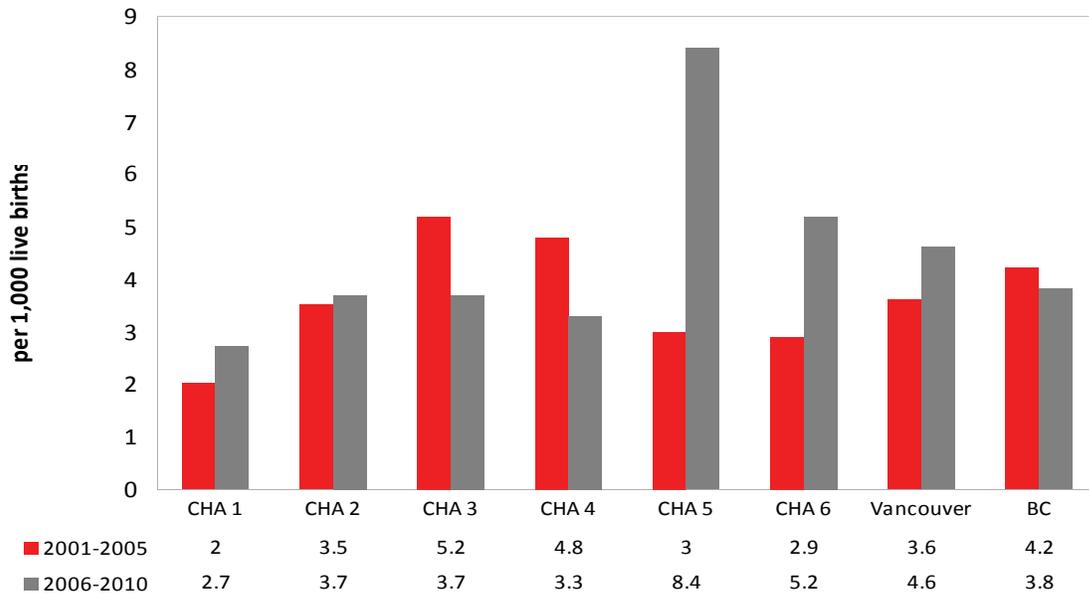


Source: BC Vital Statistics Agency (VISTA), June 16, 2011

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 2 has decreased by 4.8% from 8.3 to 7.9 per 1,000 population, respectively. From the 2006-2010 period, this was the lowest birth rate amongst the CHAs.

**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), April 14, 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).

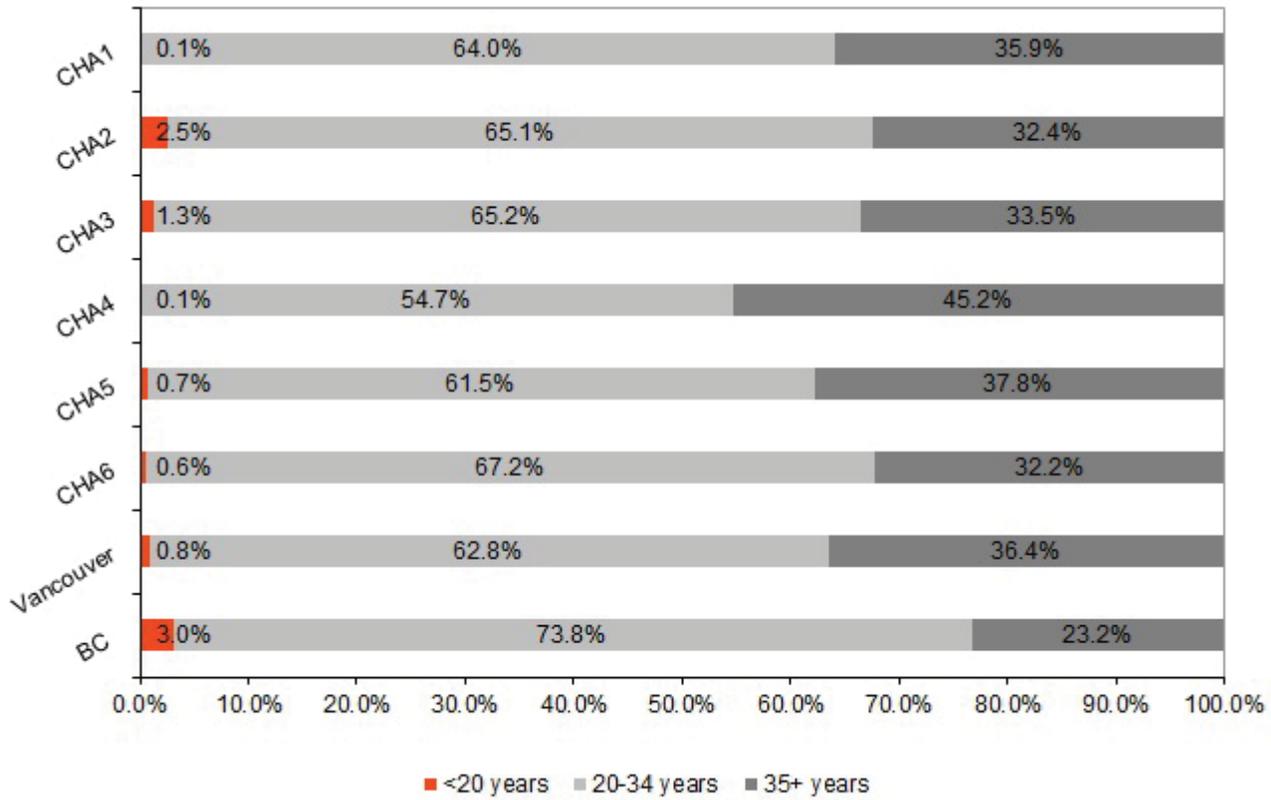
The infant mortality rate in Vancouver increased slightly between 2001-2005 and 2006-2010. The rate in Vancouver is slightly higher than the provincial average. Figure 31 shows that infant mortality rates increased in some CHAs between 2001-2005 and 2006-2010, notably CHAs 1, 2, 5 and 6. However, these 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 which sought to determine whether increases in the number and rate of deaths 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). (British Columbia Provincial Health Officer, 2003).

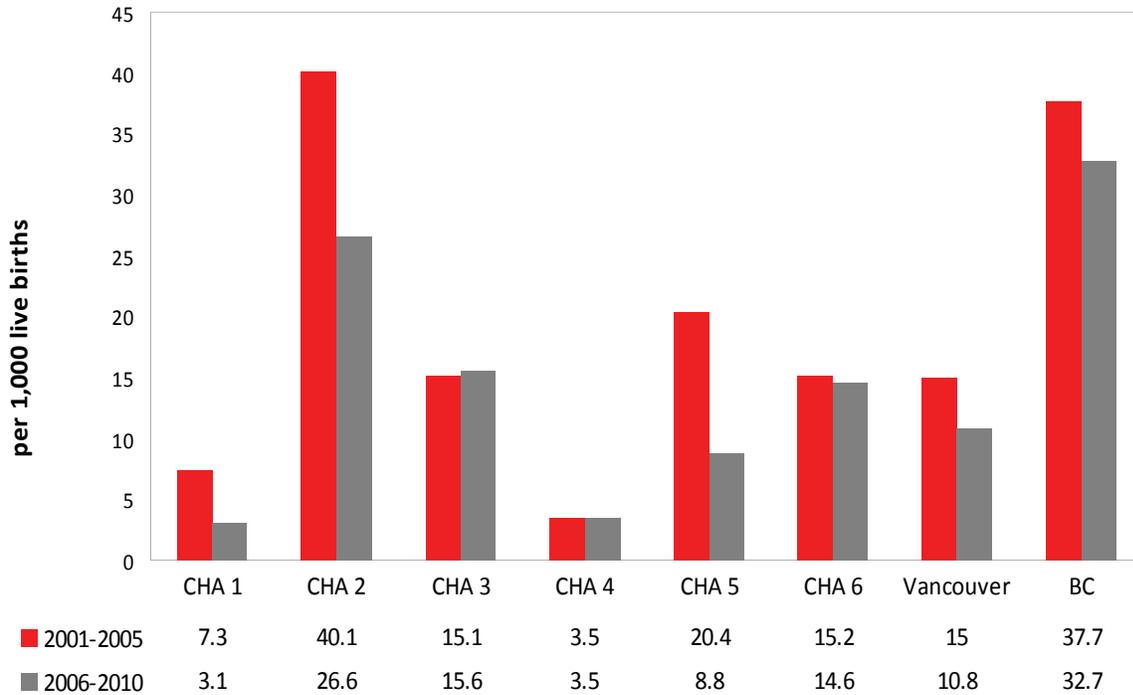
**FIGURE 32.** Live births by age of mother (%). Community Health Areas, Vancouver, and British Columbia, 2010



Source: BC Statistical Agency (VISTA), June 16, 2011

CHA 2 has the highest percentage of mothers who were less than 20 years of age when they gave birth, which is still slightly lower than the rate in BC as a whole (3.0%).

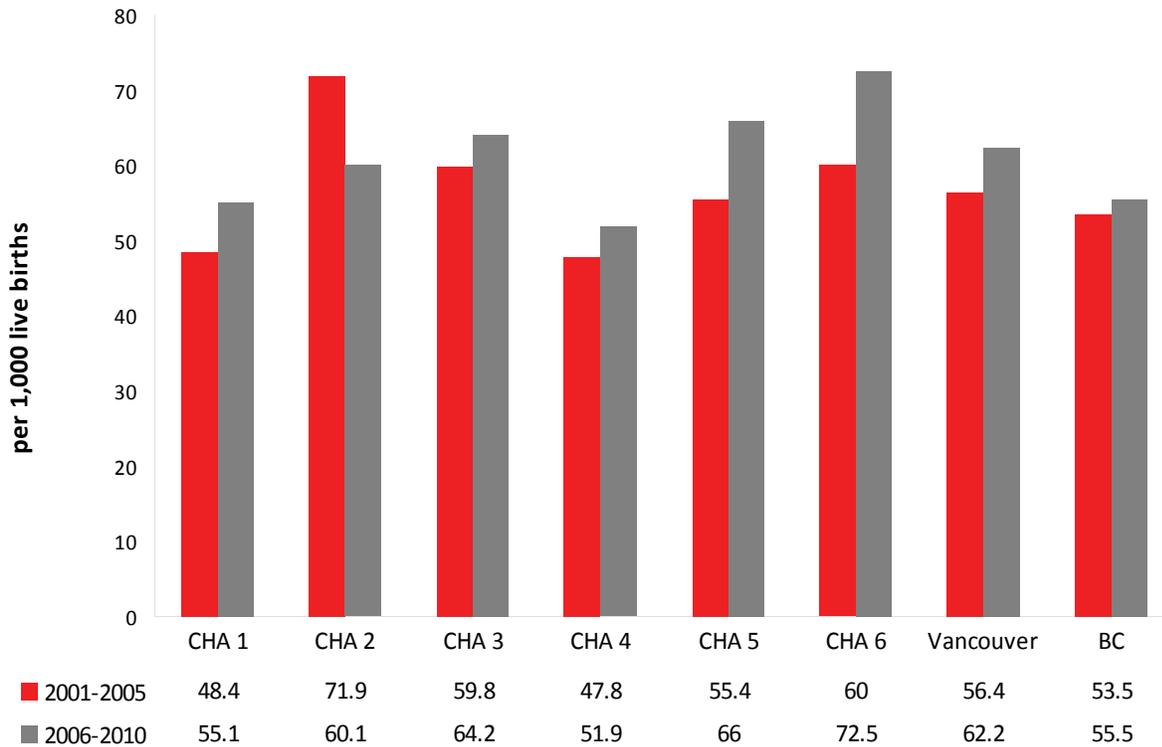
**FIGURE 33.** Teenage mother (females aged less than 20 years) birth rates per 1,000 live births. Community Health Areas, Vancouver, and British Columbia, 2001-2005 vs. 2006-2010



Source: BC Statistical Agency (VISTA), June 16, 2011

From 2001-2005 to 2006-2010, teenage mother birth rates within CHA 2 have dropped 34% from 40.3 to 26.6 per 1,000 live births. Despite this reduction, CHA 2 still has the highest rate amongst the CHAs, which was roughly 2.5 times higher relative to Vancouver overall from 2006-2010.

**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 Statistical Agency (VISTA), June 16, 2011

Figure 34 shows the number of low birth weight births for every 1,000 births in each CHA. For example, in CHA2 there were 59.3 babies born with low birth rate for every 1,000 babies born between 2006 and 2010. The figure also shows that 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.

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).

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.

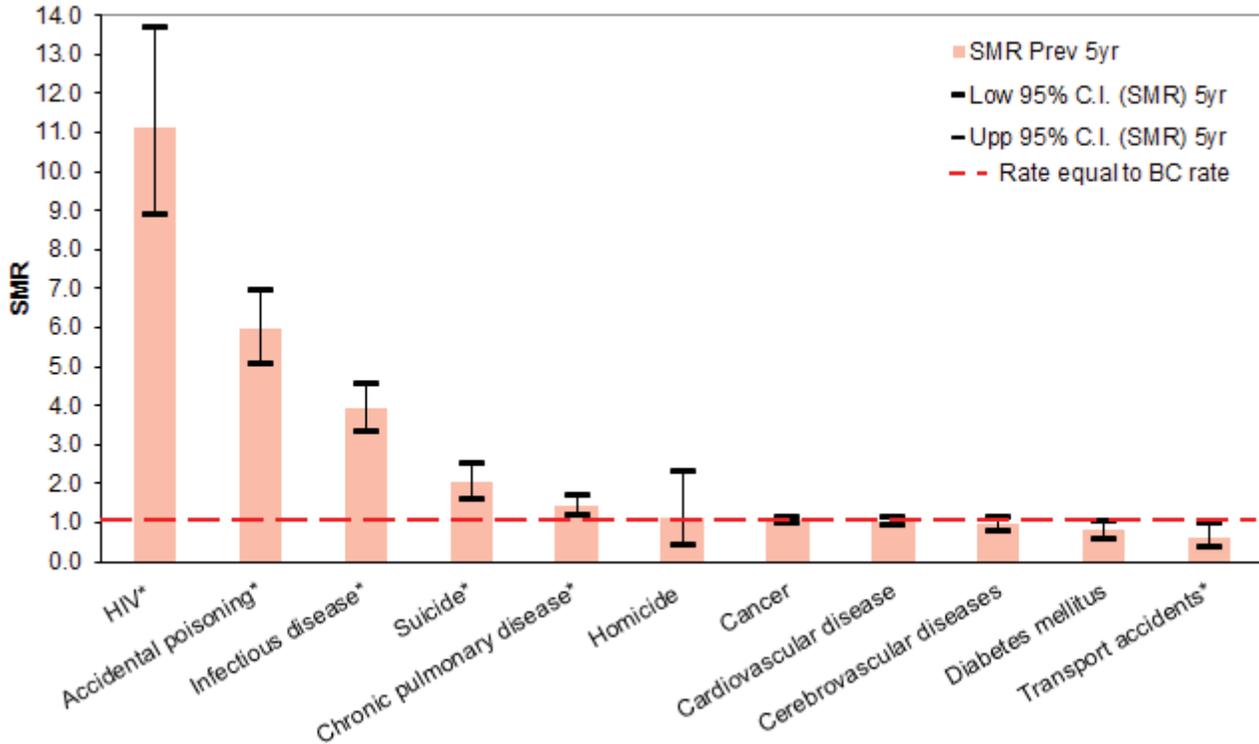
**Table 12.** Leading causes of death per 10,000 population. Community Health Areas, Vancouver, and British Columbia, 2006-2010

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

Source: 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 causes of death are malignant neoplasms, cardiovascular disease, unintentional injuries.

**FIGURE 35.** Standardized mortality ratio (SMR) by specific cause of death. Community Health Area 2, 2007-2011



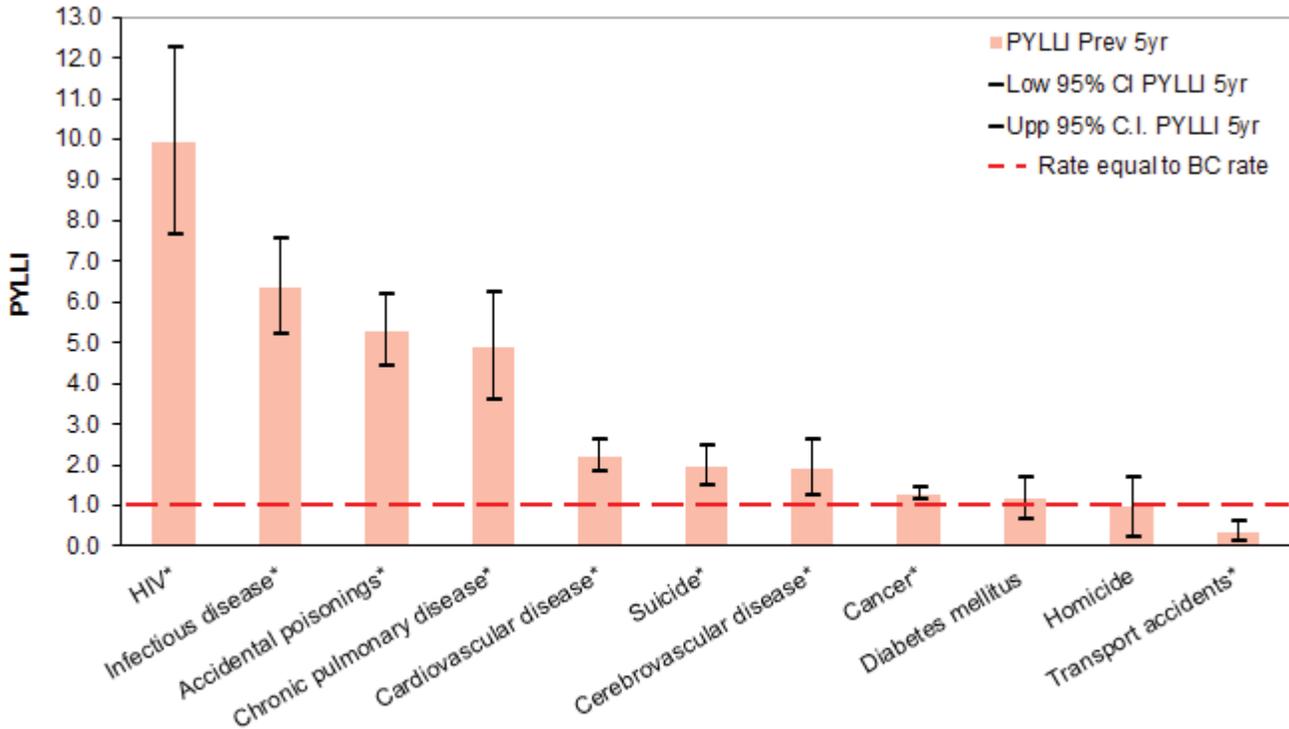
Source: BC Vital Statistics Agency (VISTA), July 28, 2011

Within CHA 2, significantly more people are experiencing mortality from infectious disease (3.91) (specifically being driven by HIV, 11.11), accidental poisonings (5.96), suicides (2.02), and chronic pulmonary disease (1.44) than what is expected based on provincial rates. Significantly less people are dying from transport accidents (0.62). Among the CHAs, CHA 2 has the highest SMR for infectious disease, HIV, cardiovascular disease, chronic pulmonary disease, transport accidents, accidental poisonings, and suicide.

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).<sup>1</sup>

<sup>1</sup> 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

**FIGURE 36.** Potential years of life lost index (PYLLI) by specific cause of death. Community Health Area 2, 2007-2011



\*, where the observed CHA2 PYLL is statistically significantly different from the expected PYLL

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

Within CHA 2, there are significantly greater numbers of premature deaths related to HIV (9.95), infectious disease (6.37), accidental poisonings (5.3), chronic pulmonary disease (4.9), cardiovascular disease (2.22), and suicide (1.96) than what is expected based on provincial rates. CHA 2 has the highest PYLLI for all specific causes of death except for diabetes and transport accidents.

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.<sup>2</sup>

<sup>2</sup> 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), July 28, 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 peoples 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 CHA 2 the highest suicide rate in 2006-2010 is within the 45-64 age group.

**TABLE 14.** Lifestyle related deaths, Community Health Area 2, 2006-2010

	Standardized Mortality Ratio (SMR)	Potential Years of Life Lost (PYLL)	PYLL Index (PYLLI)
Alcohol-related	2.08*	5105	2.07*
Medically treatable	3.66*	1168	3.47*
Drug induced	5.28*	5242	4.92*
Smoking attributable	1.29*	4521	2.27*

\*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).

CHA 2 has significantly more deaths and premature deaths related to all four lifestyle related deaths than what is expected based on provincial rates. CHA 2 has the highest SMR and PYLLI for all lifestyle related deaths amongst the CHAs.

## 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 2, Vancouver, and British Columbia

	CHA 2	Vancouver	BC
Chronic disease new diagnosis rate per 100,000 population, 2010/11 (compared to 2008/09)			
Arthritis (osteoarthritis and rheumatoid arthritis)	574.6 (468.8)	487.2 (447.6)	690.5 (642.8)
Cardiovascular disease	357.4 (401.3)	358.5 (364.8)	421.7 (469.6)
Chronic obstructive pulmonary disease (COPD) (aged 45+ years)	417.6 (739.9)	298.0 (476.1)	424.7(643.5)
Diabetes	538.1 (549.8)	641.0 (561.3)	644.6 (650.4)
Communicable disease new diagnosis rate per 100,000 population, 2009/11 (compared to 2006/08)			
HIV (males)	46.7 (98.5)	42.0 (51.0)	11.1 (13.7)
HIV (females)	10.6 (48.6)	5.2 (7.9)	2.6 (3.3)
Hepatitis C	277.4 (390.0)	58.4 (75.7)	N/A (64.3)

Sources: 1. BC Primary Health Care Disease Registries, November 2011. 2. BC Centre for Disease Control, Annual Report 2011. 3. VCH, Public Health Surveillance Unit (PARIS), July 16 2012.

In 2010/11, CHA 2 had the highest chronic disease new diagnosis rates for arthritis and COPD among the CHAs, however these are still lower compared to BC rates. The highest new diagnosis rates for Hepatitis C are found within CHA 2, however these rates have decreased by 28.9% from 2006/08-2009/11. New diagnosis rates for HIV in CHA 2 have decreased by 52.5%.

Note: Chronic disease cases are notified to various registries by primary care physicians and therefore 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 below report on two indicators for school immunization coverage. Meningococcal C immunization protects against meningococcal 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 (Tdap) (British Columbia Centre for Disease Control, 2011).

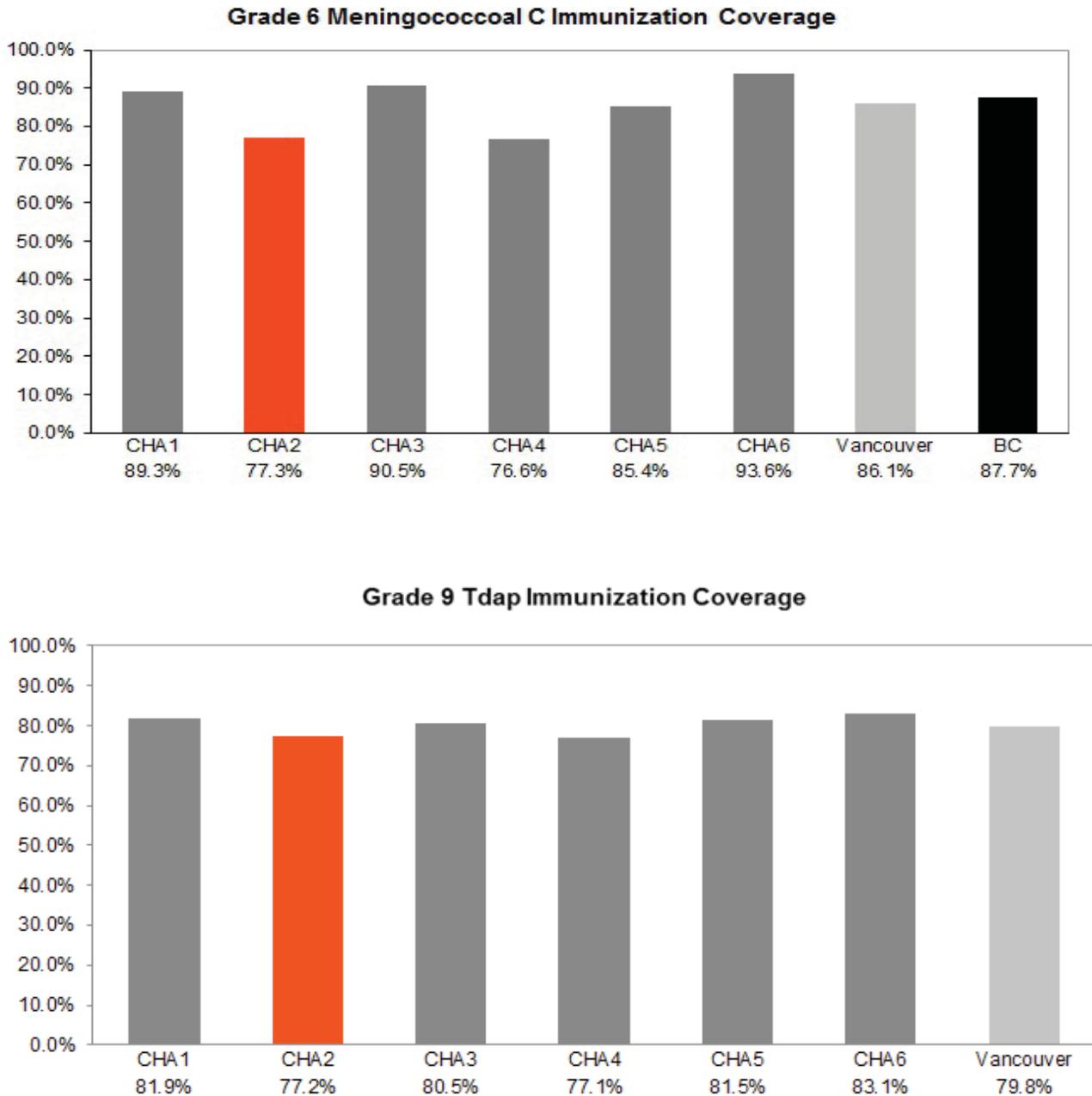
BC's publicly funded immunization program offers many vaccinations free of charge. VCH is the public health authority in Vancouver responsible for providing these vaccinations in the school setting, however, private practice general practitioners may also provide the vaccine (British Columbia Centre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

CHA 2 has one of the lowest rates of school-age immunization coverage amongst the CHAs, with 77% of grade 6 students having been vaccinated against Meningococcal C and around 77% 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 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 vaccinations for minors.

**FIGURE 37.** Grade 6 Meningococcal C and Grade 9 Tdap (tetanus, diphtheria 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

Acute care includes hospital admissions related to the:

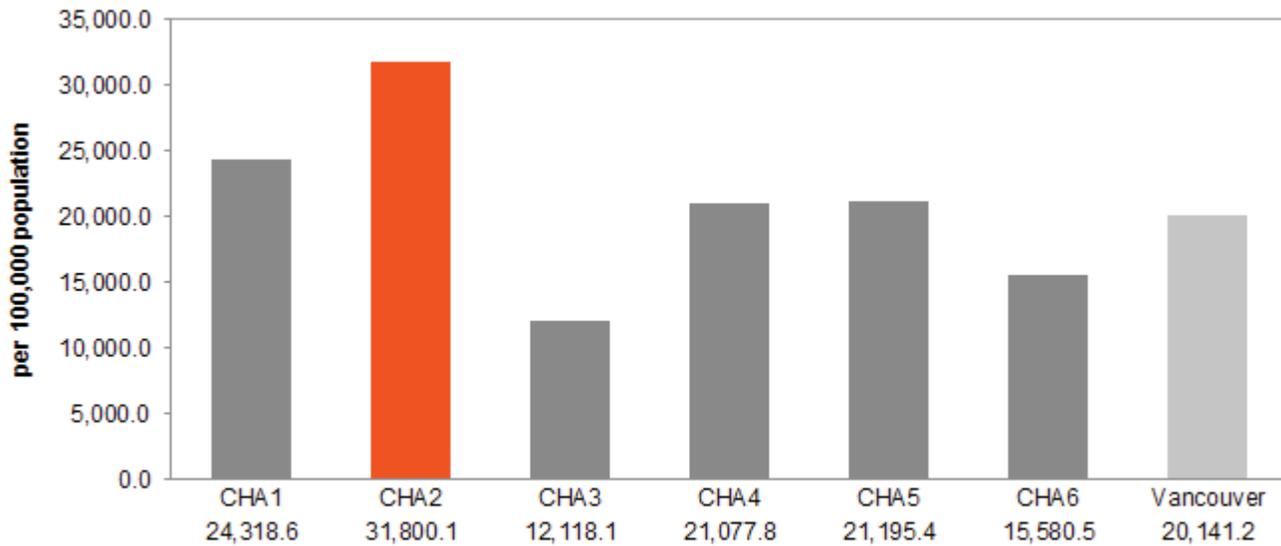
- Circulatory system include heart disease, hypertensive disease, and diseases of the arteries or veins
- Digestive system include diseases of the oral cavity, esophagus, stomach, small intestine, liver, gallbladder, appendicitis, hernia, enteritis and colitis
- Respiratory system include pneumonia, 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, 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

CHA 2 has the highest acute hospital admission rates related to the circulatory system, respiratory system, mental disease and disorders, and significant trauma, injury, poisoning, and toxic effect of drugs. The Downtown East Side has a high concentration of residents with serious addiction and mental illness which likely contributes to these high rates of hospital admission. Reflecting CHA 2's low birth rate, it also has the lowest hospital admission rates related to pregnancy and childbirth.

**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)

In 2010, the rate for emergency room visits by CHA 2 residents was 31,800.1 visits per 100,000 population. This was the highest rate amongst the CHAs and 36.7% higher as compared to Vancouver.

## 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 2 and Vancouver, 2010/11

	CHA 2	Vancouver
Adult Day Service	1.3	1.4
Assisted Living Service	1.7	1.0
Case Management Services	13.6	8.3
Community Rehabilitation Services	13.0	10.2
Home Nursing Services	11.3	8.6
Home Support Services	15.0	7.9
Home Support Services - Short Term	3.4	2.6
Residential Care Services	2.6	8.1

Source: Vancouver Coastal Health, June 28, 2012

People aged 65 years and over represent 10.1% of the CHA 2 population and this age group is projected to increase to 20.5% of the population over the next 25 years. A key challenge 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.

CHA 2 has higher utilization rates for assisted living, case management, community rehabilitation, home nursing, and home support services than the rest of Vancouver but noticeably lower rates for residential care services.

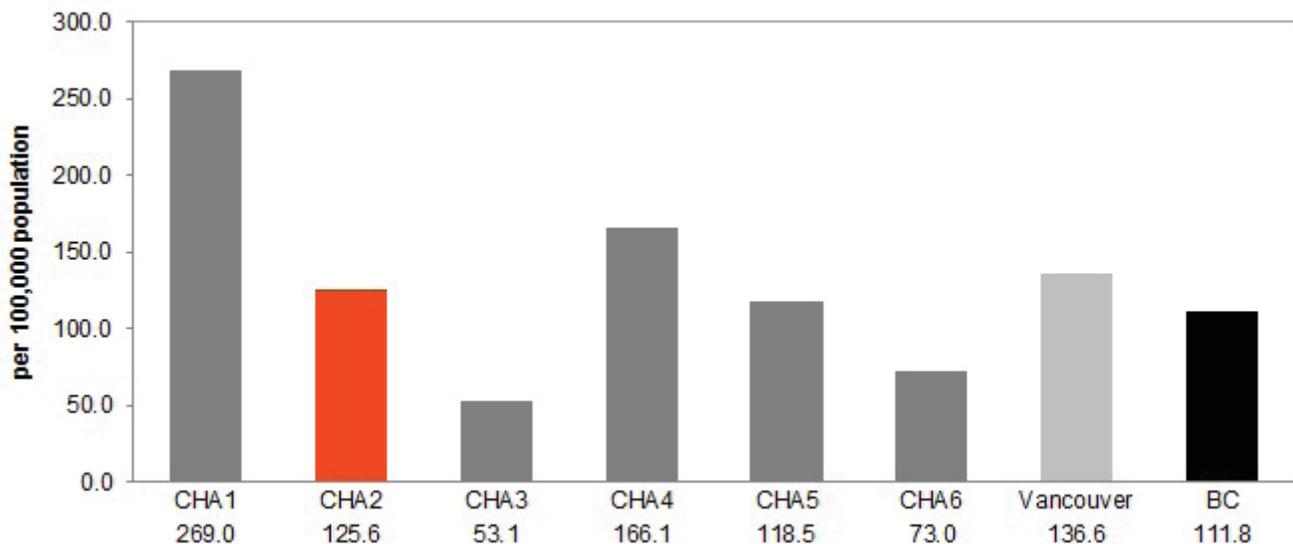
**TABLE 18.** The number of publicly funded assisted living, hospice, and residential care beds. Community Health Areas and Vancouver, 2010/2011

	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

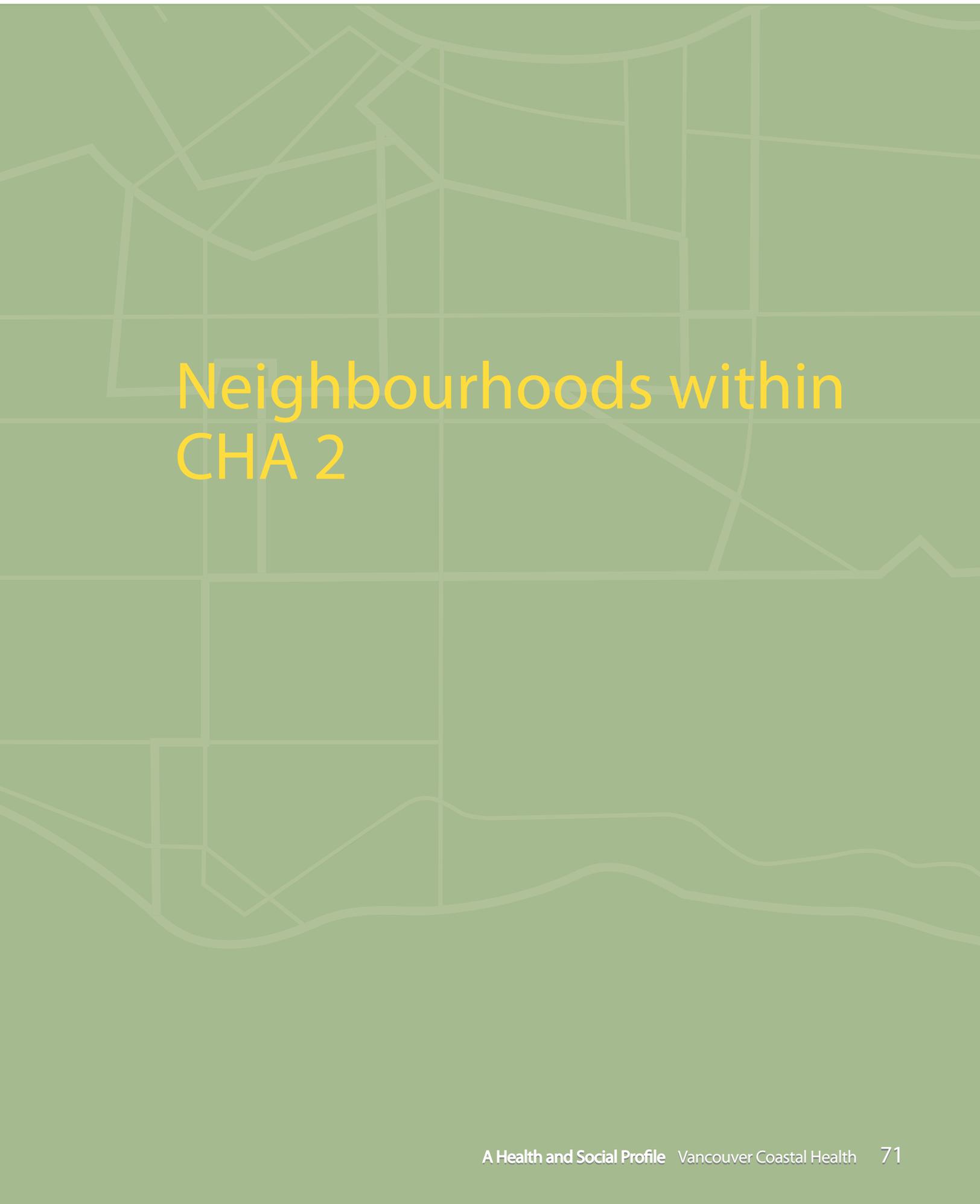
Source: BC Ministry of Health Services Health Systems Planning Division, 2009

Note: Assisted living, hospice, and residential care facilities are open to all residents and do not just serve a community. Some residents in a community health area might access home and community health services outside their area of residence but most prefer to stay in their neighbourhood whenever possible.

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



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



# Neighbourhoods within CHA 2

CHA 2 (Mid-East) is comprised of three of Vancouver's earliest neighbourhoods: Strathcona, Grandview-Woodlands, and the Downtown Eastside (DTES).

These are multicultural neighbourhoods where new immigrants traditionally first settled when arriving to Vancouver. All three neighbourhoods share many social and health issues and are the lowest-income neighbourhoods within Vancouver.

## Strathcona and the Downtown Eastside

Boundaries: stretching from Clark Drive to Quebec Street and from East Hastings to Great Northern Way

Population: 5,760

As data compiled by Statistics Canada for the Strathcona neighbourhood includes the Downtown Eastside, Strathcona and Downtown Eastside-specific neighbourhood socio-demographic statistics cannot be provided.

## Downtown Eastside

Boundaries: stretching from Clark Drive to Main Street and from the Burrard Inlet to East Hastings Street.

Population: 12,715

Strathcona is Vancouver's oldest residential neighbourhood. Built around the work provided by the Hastings Mill, Strathcona has always been home to a diverse population. Strathcona includes Vancouver's Chinatown and remains the home of a large multi-generational Chinese-Canadian population.

The smallest of the three CHA 2 neighbourhoods, the Downtown Eastside (DTES) was once the economic, commercial, and entertainment hub of the city. The DTES has achieved certain notoriety due to high levels of poverty, homelessness, and substance misuse. Important though is its rich history, diversity, and architecture, including historic Gastown and the Oppenheimer District which was home to Vancouver's Japantown prior to Japanese internment in World War II.

Strathcona and the Downtown Eastside are also home to the largest concentration of artists in Vancouver. Historically lower residential and commercial rents as well as significant amounts of warehouse space have provided opportunities for many artists to live and maintain studios in CHA 2, many of which the public has the opportunity to visit during the Eastside Culture Crawl event each November.

Strathcona and the DTES, however, are facing significant change due to market housing development in the area. The resulting increase in rental costs for housing and commercial space is rapidly changing the mix of retail and residential space in the area.

Within CHA 2, Strathcona and the DTES have the highest percentage of its population aged 40-64 years (38.9%) and 65 years and over (24.0%). 43.9% report English as their mother tongue,

while another 40.3% report Chinese and 4.7% report Vietnamese.

The median household, after-tax income is \$15,558, the lowest within Mid-East Vancouver and Vancouver overall, where the majority (59.4%) of the population live in low income households. 24.3% of families are led by a single parent, higher as compared to Vancouver (16.3%). Strathcona and the Downtown Eastside are composed primarily of low-rise (48.0%) and high-rise apartments (33.8%), with rentals making up 86.2% of the dwellings at an average gross rent of \$500 (City of Vancouver, 2009).

For a complete description of Strathcona socio-demographic statistics, please visit: <http://vancouver.ca/commsvcs/planning/census/2006/localareas/strathcona.pdf>.

## Grandview-Woodlands

Boundaries: stretching from Nanaimo Street to Clark Drive and from Burrard Inlet to East Broadway.

Area: 448

Population: 28,205

Grandview-Woodlands is known for its cosmopolitan appeal and diversity of people, housing, land use, and culture. At the heart of Grandview-Woodlands is Commercial Drive, a collection of eclectic restaurants, bars, and shops, bustling with street activity. Once commonly known as "Little Italy", the largest ethno-cultural communities include Italian, Latin-American, Portuguese, and Asian and Pacific Islander, and the largest Aboriginal population in the city.

Within CHA 2, Grandview-Woodlands has the highest percentage of persons aged 19 years and under (16.1%) and 20-39 years (38.4%). At 62.0%, the majority report English as their mother tongue, while another 14.4% report Chinese, 2.3% report Italian, 2.3% report Spanish, and 2.1% report Tagalog.

The median household income is \$35,342, with 35.2% of households living in low income conditions. Grandview-Woodlands is a family-oriented community with a high number of families (6,635) most with children living at home (5,995). 26.1% of families are led by a single parent, which is higher than Vancouver (16.2%). Grandview-Woodlands is composed primarily of low-rise apartment buildings (66.5%), detached duplexes (13.7%), and single family homes (9.8%) with an average gross rent of \$715. Among dwellings within Grandview-Woodlands, 66.2% are rentals and as renters tend to move more often than home owners, it is unsurprising that 48.4% of households in Grandview Woodlands changed addresses at least once between 2001-2006 (City of Vancouver, 2009).

In Spring 2012, the City of Vancouver embarked on the comprehensive Grandview-Woodland Community Plan that will enlist public and stakeholder consultation to provide long-term guidance on a variety of issues including housing, transportation, parks and public space, and social issues.

CHA 2

community resources

**Public elementary schools**

7 in total

2 in Strathcona (Admiral Seymour and Lord Strathcona)

5 in Grandview-Woodlands (Britannia, Grandview/  
Uuqinak'uuh, Sir William MacDonald, Lord Nelson and  
Queen Victoria Annex)

**Public secondary schools**

2 in total, located in Grandview-Woodlands (Britannia and  
Lord Templeton)

**Family resource programs**

Eastside Family Place

3 Strong Start Programs (MacDonald, Nelson and  
Seymour)

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**

182 in total

31 in Strathcona: 5 housing co-operatives, 8 are for seniors, 6 are for families

66 in Grandview-Woodlands: 19 housing co-operatives, 3 are for seniors, 2 are for families, 6 are for low income singles or families, 6 are for people living with a mental illness, 3 are for women, 17 are for Aboriginal people, and 3 are for single-parent families

85 in the DTES: 5 housing co-operatives, 10 are for seniors, 6 are for low income families or singles, 6 are for people living with a mental illness, 7 are for people at risk of homelessness, 12 are for people living with a disability, 6 are for women, 3 are for Aboriginal people, 5 are for people in recovery

**Adult homeless shelters**

Beacon Shelter- Salvation Army

Bridge's Women's Emergency Shelter

Crosswalk - Salvation Army

Haven Shelter- Salvation Army

Lookout Downtown

Triage Shelter- RainCity Housing and Support Society

Union Gospel Mission

**Publicly funded residential care facilities**

Villa Cathay Care Home

**Publicly funded hospices**

May's Place

**Adult Day Centres**

Lion's Den

SUCCESS Multi-Level Care Society

**Public Parks**

20 in total

## Libraries

- Strathcona Branch Library
- Britannia Branch Library
- Carnegie Centre Branch Library

## Community centres

- Strathcona Community Centre
- Carnegie Community Centre
- Britannia Community Centre
- Ray Cam Community Centre

## Neighbourhood houses

- Downtown Eastside Neighbourhood House
- Kiassa Neighbourhood House (located in CHA 3)

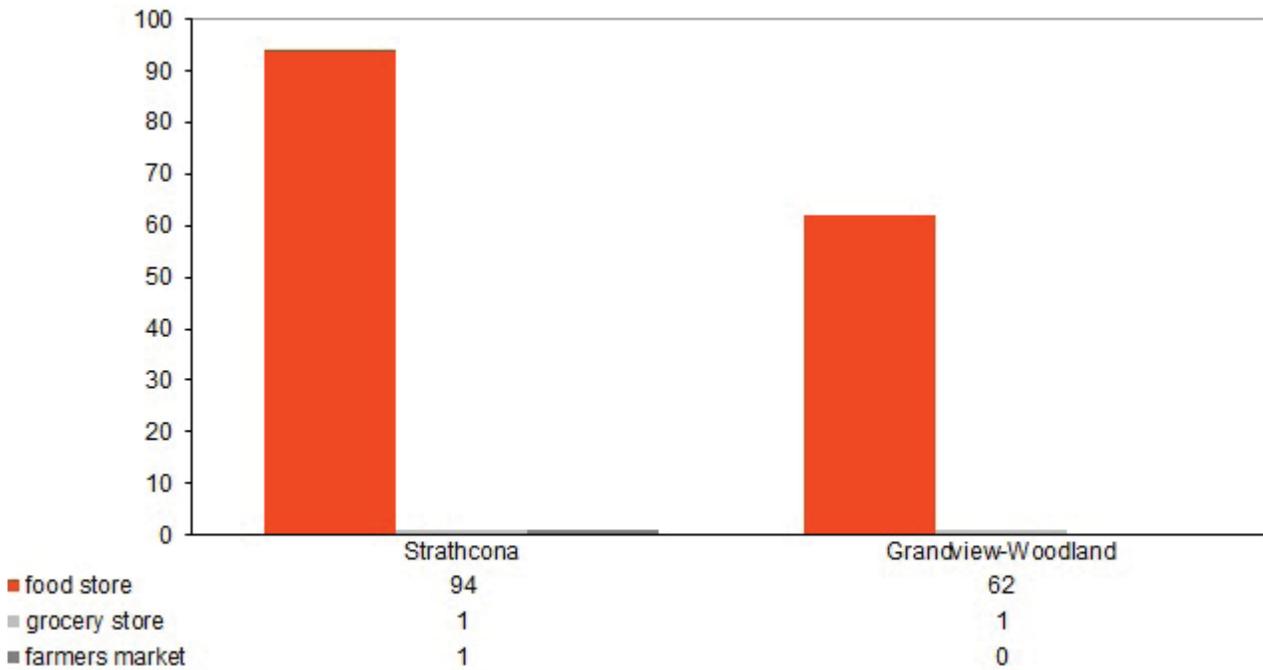
## Community policing centres

- Grandview Woodland Community Policing Centre
- Vancouver Aboriginal Community Policing Centre
- Chinese Community Policing Centre

## Business improvement areas

- 6 (Chinatown, Commercial Drive, Gastown, Hastings Crossing, Hastings-North, and Strathcona)

FIGURE A. Number of food stores by type, Community Health Area 2, 2009



Source: Food Secure Vancouver, 2009

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

## VCH Community Health Resources

Downtown Community Health Centre  
569 Powell Street  
Vancouver, BC V6A 1G8  
Tel: 604-255-315

Robert and Lily Lee Family  
Community Health Centre  
1669 E Broadway  
Vancouver, BC V5N 1V9  
Tel: 604-675-3980

Pender Community Health Centre  
59 West Pender Street  
Vancouver, BC, V6B 1R3  
Tel: 604-669-9181

Strathcona Mental Health Team  
#201- 330 Heatley Street  
Vancouver, BC, V6A 3G3  
Tel: 604-253-4401

Sheway  
533 East Hastings Street  
Vancouver, BC V6A 1P9  
Tel: 604-216-1699

InSite and Onsite  
139 East Hastings St  
Vancouver, BC V6A 1N5  
Tel: 604-687-7483

For mental health, addictions, youth clinics and other health service information, contact your local community health centre.

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