Downtown Eastside (DTES) Kitchen Tables
A Community Led Food Action Plan
PHASE 1

Final Report & Action Plan
March 15th, 2010

Acknowledgements

The DTES Kitchen Tables Project acknowledges and honours the fact that our community lies within the Traditional Territory of the Coast Salish people.

In the crafting of this Community Report and in the phases to follow, numerous individuals and organizations have supported this Project. We would especially like to recognize the following individuals and participants.

- The DTES residents employed by this project who tirelessly and compassionately administered 376 individual DTES resident surveys in a very short timeframe - Fred Popowich, Paul Campbell, Caroline Westenburg, Lucie Landry, Ursula Callfas, Mike McIntyre, Ken Vallee and Leo Buswa.

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- The Volunteers and Staff of Potluck Café & Catering and the Downtown Eastside Neighbourhood House (DTES NH) who exemplify a commitment to dignity in the food they prepare for our neighbours and for their continuous support to make this project an agent of reform within the overall context of the Right to Food.

- The Public Health Agency of Canada, Potluck Café Society and DTES Neighbourhood House for their financial support of this endeavour.

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Project Summary

Project Summary

The Downtown Eastside (DTES) Kitchen Tables Project co-led by Potluck Café Society and DTES Neighbourhood House, is a 3 phase project which began in October 2009. Food Insecurity in the Downtown Eastside of Vancouver is a stark reality acknowledged and recognized by both DTES residents and stakeholders in the community and beyond. Vancouver's Downtown Eastside is bereft of a normally functioning local food economy. A vast number of residents live on inadequate incomes which prevent them from exercising their own food choices and the means to purchase those choices. Compounding this are the hundreds of homeless with 1000s more who are underhoused, creating a majority of the population whose only choice is to depend on the charitable food system.

The ultimate solution to DTES food insecurity is a living wage and adequate housing for residents, attainable by creating job opportunities for people living with barriers, reforming welfare and Employment Insurance in tandem with government reinvesting in its responsibility to build adequate social and affordable housing. In the face of the existing, overarching social inequities, the goal of the DTES Kitchen Tables Project is to reform the current and necessarily interim charity food system by designing a plan of action for food security which is grassroots, innovative, reformist and paradigm shaping with the greatest opportunity for positive community impact – both in terms of health and Community Economic Development and to ensure that these actions are in fact undertaken.

The outcome the DTES Kitchen Tables Project envisions is the creation of food security solutions which can be realistically implemented, thereby increasing the availability, accessibility, affordability and choice of quality, nutritious food security solutions for residents of the DTES and specifically to ensure affordable access to multiple nutritious meals each day for the most vulnerable of DTES residents - those living with HIV, AIDS, Hepatitis C, Diabetes and/or sheer malnourishment.

Over its life the DTES Kitchen Tables Project will:

- Consider the DTES food solution continuum from seed to compost.
- Develop Food Solutions which are sustainable in terms of health benefits, employment and their impact on economic development and the environment.
- Develop solutions which maximize efficiencies in terms of time and resources, both for organizations which provide food and DTES residents who access food.
- Develop solutions which reduce duplication and redundancy.
- Develop innovative and efficient food distribution methods.
- Develop Food Solutions which also build community capacity – education, skills, knowledge, jobs and income security.
- Create quality food standards and guidelines for the DTES neighbourhood.
- Develop solutions which support the local economy – DTES and rural BC, urban and rural growers.
- Implement food solution best practices in the DTES which are *transferable*, *scalable* and can be *shared* with other neighbourhoods and communities.
- Continue to do its part in securing the replacement of the charitable food model by a sustainable local DTES food economy, wherein residents have the living wage and

affordable housing which enable them to exercise the choices implied by their inherent Right to Food.

In Phase 1, the DTES Kitchen Tables Project has accomplished the creation of a Community Led Food Action Plan which is outlined in this Final Report.

Below is an overview of the 3 phases of the DTES Kitchen Tables Project.

Phase 1: October 1st, 2009 to March 31st, 2010

In Phase 1 multiple stakeholders including DTES residents, Policy Makers, Health Care Providers, Researchers, Food Growers & Suppliers, DTES Food Provider Organizations, Food Industry Professionals and DTES Community organizations were engaged to develop a DTES Community Led Food Action Plan including the following deliverables:

Community Report: February 1st, 2010
Action Plan: March 15th, 2010

Financial and in kind support for Phase 1 has been provided by multiple funders including the Public Health Agency of Canada, Potluck Café Society and the DTES Neighbourhood House.

This enclosed Final Report represents the completion of Phase 1.

Phase 2: April 1st, 2010 to March 31st, 2011

In Phase 2, building on the priority actions and solutions recommended in Phase 1, the DTES Kitchen Tables Project will accomplish the following through collaborative Working Groups:

A. Develop the Business Plans and a Funding Strategy to implement 7 DTES Food Solutions including:

1. Creating Nutritional Standards
2. Menu Development & Recipes
3. Food Procurement
4. Food Preparation & Processing
5. Food Distribution
6. Engaging Professional & Food Industry Expertise
7. Food Waste, Compost & Recycling

B. Initial implementation of selected Solutions including Nutritional Standards, Menu Development and Food Procurement.

Phase 3: April 1st, 2011 to _____

In Phase 3, rollout and implementation of all 7 Food Solutions and a food secure DTES which will ensure the availability, accessibility, affordability and choice of quality, nutritious food security solutions for residents of the DTES and specifically to ensure affordable access to nutritious meals each day for the most vulnerable of DTES residents - those living with HIV, AIDS, Hepatitis C, Diabetes and/or sheer malnourishment.

DTES History and Context with Demographic Data

Downtown Eastside History and Context

Vancouver's Downtown Eastside (DTES) is the poorest off Reserve community in Canada. Situated just east of the downtown business core, it is a relatively small geographic area on unceded Traditional Coast Salish Territory and home to approximately 18,000 people of many ancestries, a large number of whom are Indigenous people from various ancestral Nations. Making up the greater DTES is Gastown, Chinatown, Strathcona and what is known as the core DTES which runs from the Narrows of Burrard Inlet to the north to Hastings Street to the south, and from Cambie Street to the west and Clark Drive to the east.

The following is a cursory overview of the history and demographics of the Downtown Eastside.

Living alongside the original Indigenous population and 19th century waves of European immigrants, in the early 20th century the DTES was the home of a thriving Japanese community as well as a vibrant Chinatown during the years when the Indigenous population was being forcibly relocated from their ancestral lands to federally created Reserves. On 7th September 1907, following a march organized by the Asiatic Exclusion League, a white mob attacked local DTES residents of Asian ancestry, smashing windows in Chinatown and Japantown. "Stand for a White Canada" adorned their banners as rioters - including some politicians and labour leaders - called for an end to Asian immigration to British Columbia.

One cringing example of the success of the 1907 rioters was the Hayashi-Lemieux Agreement of 1908 between Canada and Japan which limited Japanese immigration. Another was the Canadian Parliament's 1908 Continuous Journey regulation that amended the newly minted country's Immigration Act.

This last facilitated the barring of Asian immigrants from British Columbia by requiring an immigrant's Continuous Journey between a prospective immigrant's homeland and Canada - and in its most literally enforced sense, meaning a journey by ship without stops at intermediate ports. As the Canadian government had already terminated the only direct shipping line between India and Vancouver, the Continuous Journey regulation cemented the desired exclusion of Indian immigrants to Canada.

The Chinese Exclusion Act replaced the Canadian Head Tax Policy in 1923, banning Chinese immigration to Canada. It was repealed only in 1947 at which time Chinese and South Asian immigrants were finally allowed to vote. The Indigenous population - whose ancestors had for centuries waved a welcome to all from their ancestral shores as boatloads of immigrants arrived - was only deemed worthy of the right to a Canadian vote in 1960.

The Downtown Eastside Japanese community was obliterated at the time of World War II when all property belonging to Japanese Canadians (from automobiles to homes), was seized by the Canadian government and the entire population was interned at various sites across western Canada. The sole Vancouver property returned to the Japanese Canadian community at the end of Internment was the original building belonging to the Japanese Language School on Alexander Street. Internment resulted in a Canada wide Diaspora with nary a Japanese Canadian returning to live in the DTES.

While Strathcona was home to many European immigrants, African Canadians created a community in a sub-area centred around Hogan's Alley, only to see it demolished in the 1970s by the City of Vancouver in order to build a viaduct. Hogan's Alley ran between Union & Prior Streets from the alley east of Main Street to Jackson Street. The destruction of Hogan's Alley resulted in yet another Diaspora, this time of African Canadians.

In the last decades of the 20th century, many Chinatown businesses and residents relocated to Vancouver's suburbs, notably Richmond. As of this writing there are plans afoot to revitalize Chinatown, supported by the municipal government.

Between approximately 1950 and 1980, the core DTES was the home to fishers and loggers, with restaurants and shops which supported the population. A combination of factors including the demise of the logging and fishing industries and the arrival of the modern black market drug trade in the inner city, prompted a dramatic change in the population of the core DTES in the latter years of the 20th century. Gone was the significant contribution of loggers and fishers to the local DTES economy. Businesses left the DTES, leaving us a legacy of hoarded blocks and incrementally turning the neighbourhood into Vancouver's environmental orphan. Over the course of the past decades it has become the community in which the most destitute congregate as a result of abject material poverty, substance dependency and/or mental health crises, to name but a few.

As was the case with many other North American cities, the government-orchestrated closure of residential mental health institutions such as Vancouver's Riverview Hospital in the 1990s, set adrift another population of the vulnerable, many gravitating to the DTES where their survival challenges were further compromised by an introduction to substance dependency. Today, approximately 5,000 people who are substance dependent, 700 homeless and some 5,000 underhoused (that is, those who live in a variety of Single Room Occupancy hotels or SROs), live in Vancouver's Downtown Eastside.

The basic health, housing and income infrastructures of yesteryear are no longer in place in the DTES. Cuts to government supported social programs which began in the 1980s have greatly impacted residents financially, exacerbated by the 1993 cessation of federally supported Social Housing initiatives and distinguishing Canada as the only G8 country without a National Housing Strategy.

In 2010, British Columbia's Social Assistance payments in the form of welfare have $250 less purchasing power per month than in 1980. Our minimum wage of $8/hour is the lowest in Canada and changes to Employment Insurance (EI) eligibility – once an important source of income in the DTES – have made EI virtually irrelevant to DTES residents. Prior to the 1980s, almost all DTES residents were housed, albeit modestly. At least half of all privately owned DTES Single Room Occupancy (SRO) hotels now rent for more than $375/month, that amount being the rent allowance allocated by the province for those living on welfare payments of $610/month. It is impossible for an individual to both pay rent and purchase adequate food on $610/month. People living with chronic illnesses such as Diabetes and/or HIV/AIDS and

receiving provincial Disability Assistance can apply for Monthly Nutritional Supplement and Diet Allowance subsidies. While Disability Assistance payments are higher than basic welfare rates, these nutritional subsidies are still inadequate to guarantee proper nutrition and peoples' dominion over their food choices. The meal supplements Ensure and Boost are frequently prescribed within these subsidy programs. Many DTES Residents and Stakeholders who participated in the creation of this DTES Kitchen Tables report question both the nutritional benefits of Ensure when compared with local food alternatives and the economic wisdom of public money being exported to foreign corporations who manufacture those supplements, as opposed to BC farmers, growers and businesses.

The average current DTES resident grapples with multiple barriers often including: mental health challenges, material poverty, substandard/inadequate housing, HIV/AIDS, Hepatitis C, diabetes, lack of employment opportunities suited to those living with multiple barriers and extreme food insecurity ranging from a basic lack of food to inadequate nutrition and culturally appropriate food. Although there are a substantial number of valiant organizations offering support to DTES residents, food insecurity remains the norm. The only definitive solution is for government, the private sector, and individual citizens to assume responsibility and support for the creation of policies and programs which allow individuals to secure their livelihoods, while also ensuring that the most vulnerable who still require assistance are able to access nutritious food in a dignified manner.

Both food and housing are not only the most basic determinants of health but also irrefutable Human Rights. Neither food nor shelter are optional in terms of fundamental human survival. Until such time as people have adequate incomes (including livable rates for minimum wage, social assistance and basic income) and affordable housing, DTES residents and other vulnerable populations remain dependent on the uncertainties of a charitable food system – an unsustainable model.

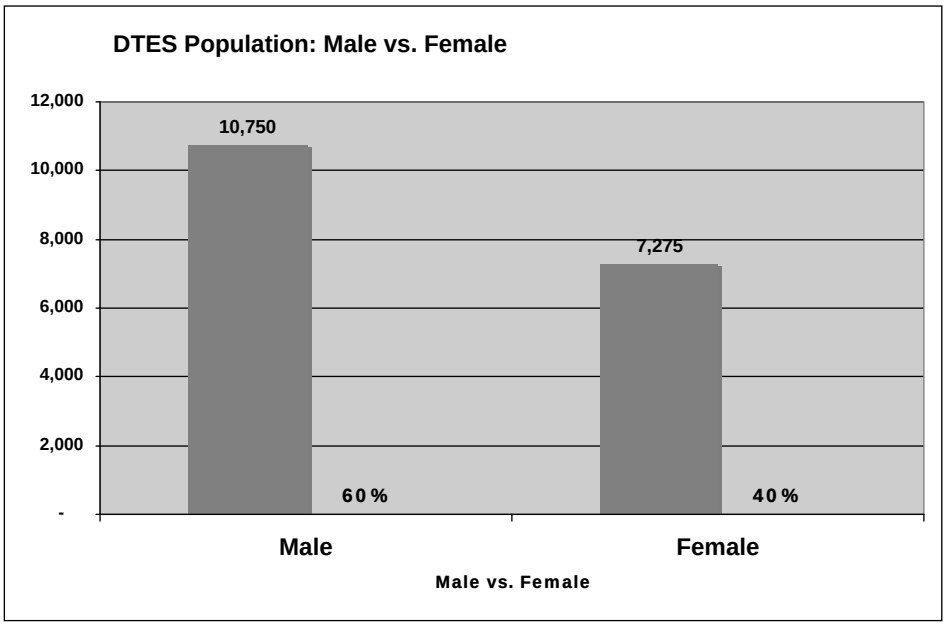
DTES Statistical Demographic Data

The following statistics underscore the fact that an extreme level of material poverty exists in the DTES. The link between income insecurity and food insecurity in this neighbourhood is both direct and flagrant.

Population

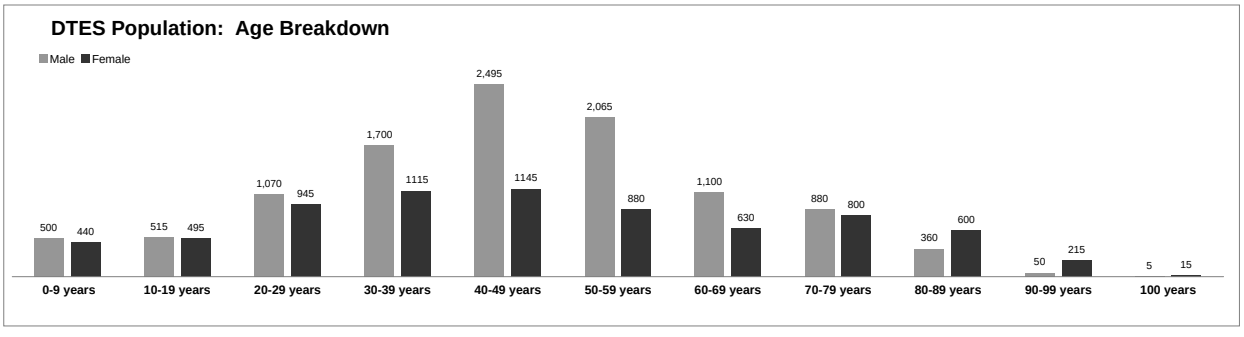
DTES Geographic Boundary: Cambie Street to the west and Clark Street to the east. The Burrard Inlet waterfront to the north and Prior Street to the south.

Total population of the DTES: **18,025**



** City of Vancouver 2006 Census Count*

Age Breakdown



** City of Vancouver 2006 Census Count*

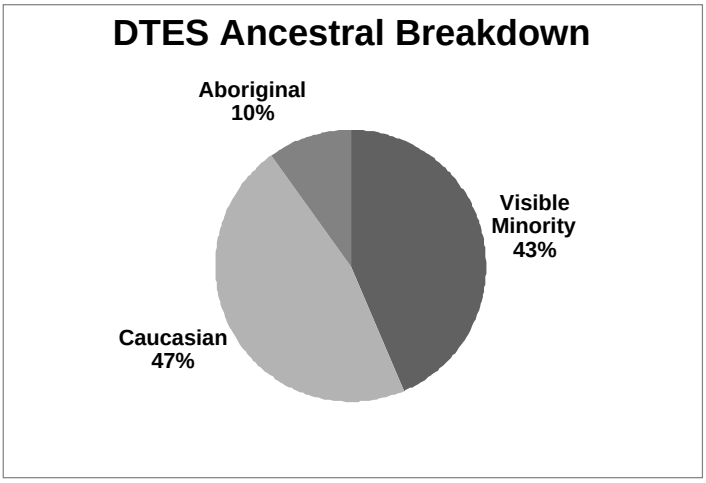
Average Life Expectancy

The life expectancy of residents of Vancouver's DTES is lower than that of residents living in other areas of the Vancouver Coastal Health Authority Region

- Between 2002 and 2006, men living in the DTES Local Health Area lived 8 years less on average than men in Vancouver overall, the difference for females living in the DTES was not as pronounced
- Despite this large discrepancy, life expectancy in the DTES improved 2.5 times more between the periods of 1997-2001 and 2002-2006 than life expectancy in VCHA region overall

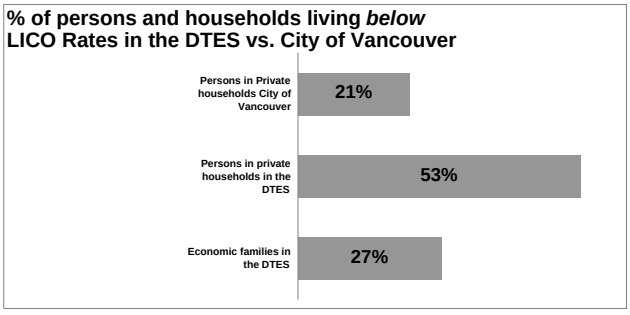
** See Appendix A - Vancouver Coastal Health Community Characteristics, Health Outcomes and Health Care Use- Vancouver's Downtown Eastside in the Context of Vancouver Coastal Health Authority and the Province of BC*

Ancestral Background



** City of Vancouver 2006 Census Count*

Low-income Cut Off Rates (LICO)



** See Appendix A - Vancouver Coastal Health Community Characteristics, Health Outcomes and Health Care Use- Vancouver's Downtown Eastside in the Context of Vancouver Coastal Health Authority and the Province of BC*

Low-income Cut Off (LICO) is the most common indicator used by the Federal Government to measure economic security. The LICO rate is based on calculations related to income versus basic household expenditures - food, shelter and clothing. Government studies indicated that Canadian families spend 50% of their total income on these expenses. Individuals or families spending 20% more than this average are considered to be below the LICO rate.

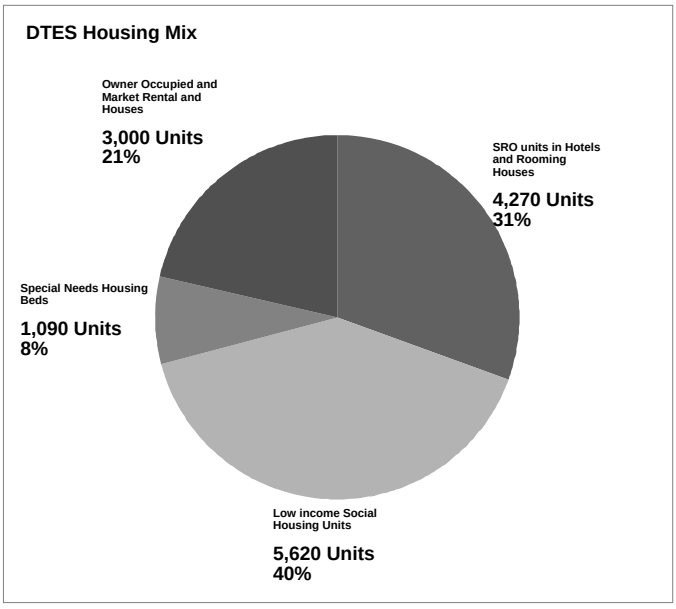
The definition of family used by Statistics Canada in assessing poverty is the so-called economic family. It includes all occupants of a dwelling unit who are related by blood, marriage or adoption. It also includes couples living together in common-law relationships. An unattached individual is a person who either lives alone or shares a dwelling unit, but is unrelated to the other occupants by blood, marriage, adoption or common-law relationship. According to Statistics Canada, both families and unattached individuals are referred to as households, even though this usage does not strictly coincide with the definition of a household which Statistics Canada uses in other surveys.

* *An excerpt from The Canadian Fact Book on Poverty 1994, by David Ross, E. Richard Shillington and Clarence Lochhead, of the Canadian Council on Social Development*

Government Transfer Payments

Socio-demographic profile, 2006 Census	Vancouver DTES Core	British Columbia
Composition of individual income in 2005 for person (aged 15+ years) not in economic families		
Government Transfer Payments (%)	**42.7%**	**15.9%**

Housing Mix



* *Internal City of Vancouver Research 2008*

There are 3,600 privately owned residential rooms (SRO's) in the DTES, half of which rent for more than $375/month. A single bathroom may be shared by as many as 20 other people, with the rooms in disrepair and the untenable infestation of pests/rodents. None of these rooms meet Canadian housing standards. According to the research of the Carnegie Community Action Project (CCAP), SROs are not being replaced quickly enough with Social Housing to address hotel rooms lost to neighbourhood redevelopment, and the construction of condos are outpacing Social Housing by a rate of 3:1. Inadequate housing directly impacts food security - without adequate housing, residents do not have access to basic cooking facilities, equipment and safe food storage.

Number of Homeless

Considering the transient nature of the homeless population, it is extremely difficult to accurately count the current number of homeless people in the DTES. A recent count was undertaken by SPARC BC in 2008 (data below), but is considered by most to be an undercount. It is believed that the count should be closer to 700 individuals.

SPARC BC DTES Homelessness Count 2008: **659 individuals**

(This number includes those living on the streets and in shelters)

At the time of the writing of this Report in March 2010, the City of Vancouver is in the process of conducting an updated Homelessness Count.

Health Data: HIV/AIDS, Hepatitis C and Diabetes

HIV/AIDS: Information obtained from AIDS Vancouver compiled from tracking intakes over the past 10 years has shown that of the 1,013 HIV positive individuals in their system, 541 of them are from the DTES which is equal to 53%.
** AIDS Vancouver*

Hepatitis C: Rates of blood-borne pathogens such as Hepatitis C and HIV were 10 to 15 times higher in 2007 in residents of the DTES core as compared to residents of the Vancouver Coastal Health Region overall.
** See Appendix A - Vancouver Coastal Health Community Characteristics, Health Outcomes and Health Care Use- Vancouver's Downtown Eastside in the Context of Vancouver Coastal Health Authority and the Province of BC*

Diabetes: Rates of Diabetes in the DTES Local Health Area were comparable to rates for British Columbia overall.
** See Appendix A - Vancouver Coastal Health Community Characteristics, Health Outcomes and Health Care Use- Vancouver's Downtown Eastside in the Context of Vancouver Coastal Health Authority and the Province of BC*

Number of Grocery and Convenience Stores

Convenience Stores	22
Grocery Stores	1

** Food retail licensees in the DTES according to City of Vancouver*

Definition of a Retail Grocery Store: *Any person not otherwise herein defined who carries on the business of selling commodities including foodstuffs directly to the public and whose business customarily includes two or more of a bakery, delicatessen, food service (snack bar) but does not include a retail dealer – market outlet. (per License By-Law No 4450)*

Definition of a Convenience Store*: An establishment for the retail sale of goods or services ie; the corner grocery store.*

Cost of Monthly Nutritious Food Basket in BC

The *National Nutritious Food Basket* is a tool developed by Health Canada which describes 67 food items and the quantities that represent a nutritious diet for a variety of individuals. Each spring, dietitians working in public health collect prices for all the food items and the prices are then pooled to obtain an average cost for the basket. In 2009 food costing was conducted in 134 randomly selected grocery stores throughout the province of BC.

Monthly Costs	Family of 4 with Income Assistance	Single Parent of 2 Children with Income Assistance	Family of 4 with Earned Income	Family of 4 Average Income
Disposable Income	$1,773	$1,724	$2,458	$4,491
Cost of Shelter	$1,028	$1,028	$740	$1,293
% Income Needed for Shelter/Housing	58%	60%	30%	29%
Cost of Nutritious Food	**$872**	**$659**	**$872**	**$872**
% of Income Needed for Food	**49%**	**38%**	**35%**	**19%**
% of Income ($) Left for all other Living Costs	**-7% or (-$127)**	**2% or ($37)**	**34% or ($846)**	**52% or ($2326)**

** See Appendix B - Cost of Eating in BC 2009 published by the Dietitians of Canada*

Environmental Scan

Environmental Scan

This section of the report highlights the food available in the DTES, much of which is generated by a charitable food system model. It is important to note that in many cases, both the free and low cost meals available in the community are ad hoc. A food distribution network based on a charitable model, as opposed to a community economic development model, has severe limitations, beginning with accessibility and the availability of food, and the inconsistent nutritional benefit of this food. As illustrated in the Environmental Scan below and in the enclosed Appendices, many attempts are made to provide food to those who live with food insecurity, but the charitable model is limited in terms of nutritional value, quality, consistency and community capacity building.

Free Meals in the DTES

** See Appendix C for a full listing of free and low cost meals in the DTES*

Ready to Eat Food, Picked Up by the Individual

These are meals offered by non-profit organizations for residents of the DTES at no cost to the individual. The meals are considered a key aspect of the organization's mandate which is why they cover all costs for the meals. Considering the large number of food insecure DTES residents, it is not surprising that there are 24 organizations that offer free meal programs. Some of those which serve food to the largest number of people are faith-based organizations such as the United Gospel Mission, Salvation Army and the Franciscan Sisters of Atonement. On average they feed up to 500 people a day on very tight budgets, relying on Volunteers to prepare and serve the food.

Many other non-profits with a specific membership such as sex trade workers or women also incorporate a free meal program. For example, the WISH Drop-In Centre Society.

There are also a number of free meal programs operated by organizations such as Potluck Café Society which offers supported employment opportunities for DTES residents in the preparation and delivery of its meals programs to supported housing facilities, emergency shelters and addictions facilities. Potluck Café and Catering is a social enterprise which trains and employs DTES residents living with barriers to employment, with a Social Worker paid for by Potluck on staff to support employees. Portland Hotel Society (PHS) Community Services also provides meals to residents of some of the Single Room Occupancy (SRO) hotels and supported housing facilities in the DTES. Most of the hotels benefitting from these programs are supported SRO's with property management provided by non-profit organizations in concert with BC Housing which in recent years purchased 12 SROs from private owners.

The majority of the available free meals are only served Monday through Friday, 9am to 5pm. It is very difficult to access free meals in the evening and/or on weekends.

Delivered to the Individual

These delivered meals are provided free of cost to the individuals and are delivered directly to where the person lives. The only existing free meal program delivered to specific individuals is run by A Loving Spoonful, an organization that feeds people living with HIV/AIDS. Potential recipients must meet the organization's criteria as well as obtain a referral from their physician. Once a week, nutritious entrees, milk, yogurt, juice, bread and fresh fruit are delivered to their homes by a team of Volunteers.

Low Cost Meals

** See Appendix C for a full listing of free and low cost meals in the DTES*

Ready to Eat Food Picked-Up by the Individual

These low cost meals are sold by DTES organizations for purchase by DTES residents at a significantly lower price than market value. There are currently 4 organizations that offer such low-cost meals, with prices ranging from $1.75 to $7.95. As the revenue from these meals augments the non-profits' food budgets, they are able to offer meals which offer choice and are more balanced and robust than the average free meal program. As with the free meal programs, the hours of operation of these low cost meal organizations are often 8am to 4:30 pm from Monday to Friday which severely limits accessibility outside of those time periods. The exceptions are Carnegie Community Centre and the Evelyne Saller Centre which have meals for sale 7 days a week.

Delivered to the Individual

These meals are delivered to individual homes, again at a significantly lower selling price. The only low-cost meal program delivered to individuals in Vancouver is available through Meals on Wheels which is administered by The Health and Homecare Society of BC. They provide low-cost meals for homebound individuals including elders, caregivers, individuals with chronic or acute illness, individuals recovering from surgery, illness or injury and new mothers.

Fee for Service Volume Meals

Food service providers in the DTES such as Potluck Café and Catering provide volume meals for a fee, delivered to program participants at venues such as Onsite (the residential Detox arm of InSite, the supervised injection site in the DTES), and clients housed under the Community Transition Care Team (CTCT) and Pennsylvania (Support Services). Program participants do not pay for these meals. Instead these meals are publicly funded by entities such as the Vancouver Coastal Health Authority which recognizes that the participants involved have an extremely compromised health status and require nutritionally balanced meals. Publicly funded

meals are also often provided to the homeless who are living in DTES shelters, generally paid for by a combination of municipal and provincial monies. Currently, some homeless shelters provide 2 meals per day, seven days a week.

** See Appendix D for full listing of homeless shelters in Metro Vancouver*

Non-Food Focused based Organizations which Provide Meals

Given the vast number of food insecure DTES residents, many organizations whose core mandate is other than food have nevertheless integrated food into their programming over time in order to respond to the sheer reality of hunger. Obviously, they have found that their members are more apt and better able to participate in programs once they have eaten. Considering the degree of their members' general malnutrition coupled with serious health issues, these organizations respond to the pressure and responsibility to offer some form of nourishment. Most of these organizations do not have a budget for meals and financially struggle to provide food. One example is the Downtown Community Court which currently has no food budget but is able to offer snacks such as fruit which they use as an enticement for people to participate in the Court's programs. In other cases, organizations without funding or capacity to provide food resort to accepting and distributing donations of pastries from corporate donors such as Starbucks.

Special Community Event Meals

Throughout the year there are special event meals provided by longstanding DTES food providers such as Union Gospel Mission and First United Church, the DTES Women's Centre and smaller event-based food providers such as Truck Stop Dining and others such as the BC Chefs Association and the film industry. Special event meals are usually concentrated in the summer months and/or over the holiday seasons (Christmas and Thanksgiving). These meals can sometimes be of high quality and large quantity eg; the film industry's Christmas meal in Oppenheimer Park, provided free of charge to residents. Some other special event meals are an accompaniment to the launch of new community initiatives. Pancakes, hot dogs with pop, and chili with bannock are the typical menus of the non-Christmas season, while turkey dinners are the staple of Thanksgiving and Christmas. Although such meals add to the food provided in the DTES, their overall impact on food security is both varied and limited as they do not occur on a regular basis and the nutritional content is also varied.

Food Reclamation Organizations

The two food reclamation organizations available to the DTES are the Greater Vancouver Food Bank Society and Quest Food Exchange, each with warehouses situated elsewhere in Vancouver. Quest has a DTES retail store open to residents. Both organizations offer reclaimed and/or donated food to both DTES residents and food providing organizations. These organizations are successful in garnering a large number of donations and are able to pass on much needed food to the community. While well intended, many of the donors who donate to

these organizations lack an understanding of the nutritional value or suitability of their donations on those who are malnourished or with compromised health. As a result the Food Bank and Quest still receive donations of past-dated, moldy or otherwise unusable food in addition to quality foods. Due to issues of shelf life and cold storage constraints or both, these organizations predominantly solicit and receive non-perishable food items. Typically, non-perishable foods often have a much lower nutritional value than would be the case with perishable items such as fresh fruits, vegetables and protein including dairy. Furthermore, as will be illustrated in the Gap Analysis enclosed in this Report, meat, fruits and vegetables are a clear gap in the food supply of the neighbourhood.

Both the Food Bank and Quest provide a vast amount of food to those in need in the area and many DTES food providers rely heavily on their donations. According to the Quest website, nonprofit organizations can purchase their food at 30% of market value. The Food Bank operates a program entitled Downtown Eastside Community Kitchens (DECK) and its Coordinators offer non profits the opportunity to establish a Community Kitchen with food supplied by the Food Bank and kitchen items available via another Food Bank initiative called Fresh Choice Kitchens. Fresh Choice Kitchens also offers important services such as Food Safe Certification and Canning courses and manages a very informative website which shares food resources.

Another food reclamation organization operating in Vancouver and benefitting DTES residents is the Fruit Tree Project. Administered predominately by Volunteers, this project connects individuals who have excess fruit from their backyard fruit trees with people who are able to harvest the fruit. Most of the harvested fruit is donated to non profit organizations.

Community Gardens and an Urban Farm

There are 3 community gardens in the DTES, mostly devoted to flowering plants but with some growing food which is available to a small number of DTES residents. One of the gardens is operated by the Portland Hotel Society which houses people living with mental health challenges and/or those dealing with substance dependency. The other two gardens are stewarded by the Jacob's Well Ministry, whose food is available to individuals living with the same issues. These three gardens have limited food production.

A more impactful community farm in terms of larger food specific production currently in the development stage is the SOLEfood (Save Our Living Environment) Urban Farm, an initiative of United We Can, a DTES social enterprise whose employees are 'binners' – our recycling champions. SOLEfood Farm will be in full food production by October 2010. As a fully functioning Urban Farm in raised beds on a half acre of land on a former parking lot, their goal is to not only sell local, organic food to organizations, caterers and restaurants but to also provide training and employment for DTES residents living with multiple barriers. This model is meant to be completely sustainable environmentally, economically and socially. Ideally, this larger plot of land coupled with innovative farming techniques will allow SOLEfood Farm to produce substantial yields compared to the three existing community gardens and therefore increase the

impact on available fresh produce in the neighbourhood. A second aspect of SOLEfood Farm will be a composting program available to both DTES organizations and residents, again employing low-income DTES residents.

Community Kitchens

There are approximately 15 Community Kitchens currently operating in the DTES. This vehicle for nourishing, sharing and educating has gained popularity in the DTES over the past few years. These programs allow residents to learn cooking, nutrition and budgeting skills in a friendly community based environment. They also allow individuals to share in a communal meal and nurture relationships which can be a welcome departure from their usual routines. As previously mentioned, the Vancouver Food Bank operates a program entitled Downtown Eastside Community Kitchens (DECK) and its Coordinators offer mentoring to non profits with the opportunity to establish a Community Kitchen with food supplied by the Food Bank and kitchen items available via the Food Bank's Fresh Choice Kitchens program. Another twist on the Community Kitchen model is the Roving Community Kitchen of the DTES Neighbourhood House. This Roving program is a blender based Community Kitchen which visits multiple DTES sister organizations on the Tuesday eve of each month's Welfare Wednesday, sharing nutritionally rich smoothies with 100's of DTES residents and most typically, those for whom a traditional Community Kitchen is not a good fit.

* *See Appendix E for a list of Community Kitchens in the DTES*

Housing Facilities

Social Housing – particularly as it pertains to SROs under the domain of BC Housing and its role in food security, is currently a focus of discussion in the DTES and city wide. It has recently been acknowledged that operators of Social Housing must take into account the impact which the housing structure has on an individual's access to food.

Currently many residents living in SRO's do not have access to any facilities which would allow them to either cook meals or refrigerate/heat any meals. Often these housing units are infested with vermin and rodents, which makes safe food storage an impossibility. Without the basic amenities to refrigerate and cook/heat foods, residents are not able to take advantage of the less expensive option of cooking for themselves, nor are they able to store any of the food they may access through other meal programs including Community Kitchens. There are also a number of residents who are physically unable or lack the skills to cook meals for themselves and would benefit greatly from having a communal food space/cafeteria situated within the Social Housing in which they reside. The few housing providers who offer this option find it to be very successful.

A lengthier study on housing and Food Security has been prepared by Christiana Miewald of the Centre for Sustainable Community Development at Simon Fraser University (SFU), entitled Food Security and Housing in Vancouver's Downtown Eastside. It is widely agreed upon that all

people must have some access to food in their housing units, given the obvious impact on their overall Food Security. It is also universally recognized that there is not necessarily one model which works for all types of Social Housing and individuals' needs.

** See Appendix F for a report on Food Security and Housing in Vancouver's DTES*

Meal Substitution Programs

The BC Provincial Government offers a number of supplement programs for those with both chronic and short-term health issues. The Monthly Nutritional Supplement and the Diet Allowance programs provide for monthly financial subsidies which are allocated to individuals living with chronic illnesses such as Diabetes and/or HIV/AIDS, thereby enabling individuals to possess the monetary resources needed to pay for their increased nutritional needs. Under these programs Short-Term Nutritional Supplement Products known by consumer names such as Ensure or Boost are meant only for short-term acute situations prescribed by a physician. Physicians and Vancouver Health Authority Nutritionists are able to write prescriptions for Ensure for individuals who need an immediate nutritional supplement. The supplement is not intended to be a substitute for a long-term solution.

Although products such as Ensure have been administered as a necessary stopgap measure for individuals who are at severe risk of extreme malnutrition, such products have a high street resale value in the DTES and are often sold for quick cash as opposed to being ingested by the individuals for whom they were prescribed. Furthermore, these supplements are not a substitute to the benefits of a proper, complete meal prepared from real food. Actual food includes phytonutrients, fibre and other qualities absent in supplements. It is also important to recognize that meal supplements such as Ensure are mass produced, not produced locally through growers or suppliers. Consequently, there is no additional Community Economic Development advantage for the local or provincial BC economy. In fact, public monies spent to purchase Ensure only serve to increase revenues of the Abbott Laboratories Corporation based in New Jersey, USA.

Farmers Markets

In the past year, Vancouver Farmers Market relocated one of its 4 Markets to a site closer to the DTES. A Sunday Gastown Farmers Market located adjacent to the DTES was piloted in the summer of 2009. The current model of Farmers Markets offer produce priced out of the range of most DTES residents with insufficient income, so affordability and accessibility remain fundamental barriers to taking advantage of these markets.

The BC Association of Farmer's Markets initiated the province wide BC Farmer's Market Nutrition Coupon Program in 2007, designed for low-income pregnant women and low-income families with young children. This program provided weekly coupons for purchases at Farmer's Markets as well as cooking and nutritional education for participating parents. The three organizations which administered the Vancouver portion with a annual combined total of 50

participants were the DTES Neighbourhood House, Collingwood Neighbourhood House and the Hastings Sunrise Community Centre. Despite the enormous success of the Farmer's Markets Coupon program from 2007 through 2009 and its undeniable nutritional impact on low-income families with young children, provincial funding is not available for its continuation in 2010.

Grocery Stores

The core DTES is known to be a 'food desert', meaning that there is a severe lack of grocery stores in the area supplying nutritious, affordable and culturally appropriate foods. Grocery chains and big box stores are not attractive options to many of the low-income DTES community who have a stated preference for independent 'mom and pop' grocery stores. Currently there are a few affordable, independent grocery stores that sell fresh produce. A solution needs to be found to address the limitations of smaller grocery stores in the neighbourhood such as Sunrise Market which is very popular and offers a large selection of produce and products, but due to space constraints has cramped aisles which limit its selection of bulk items and its accessibility for parents shopping with children in tow and/or people dependent on walkers and wheelchairs for their mobility.

Many other small grocers operating in Chinatown offer a variety of fruits, vegetables and meat products but a real or imagined language divide creates a barrier for many DTES residents in accessing these grocers.

The lack of accessibility to affordable, healthy food ingredients such as fresh fruits, vegetables and protein including dairy is a large contributing factor to food insecurity in the DTES. One larger chain grocery store just southwest of the neighbourhood is T & T Market, its location limiting its accessibility. The recently opened Woodward's Redevelopment on the western edge of the DTES houses 500+ condos and 200 units of Social Housing (125 for individuals and 75 for families) along with retail outlets including Nesters grocery store. Nesters is a more expensive grocery store chain, beyond the reach of low-income DTES residents and raises concern and apprehension in the community for what it signal as the future of potential price points for a local DTES food economy.

Convenience Stores

In comparison to grocery stores, there is an overabundance of convenience stores in the DTES. These corner stores tend to be expensive and generally carry no fresh produce other than a few whole fruits and no meat other than that of the processed and packaged variety. The majority of food products stocked by convenience stores are pre-packaged, processed foods that are proven to be low in nutrient value. While convenient, abundantly situated across the DTES neighbourhood and open for 20 hours/day, the nature of the corner store food supply only exacerbates the nutritional vulnerability of DTES residents.

Gap Analysis

Gap Analysis

As the Environmental Scan reveals, there is a fair amount of food available in the DTES and many residents and food providers would attest to this. So what explains the gaps and why is there such Food Insecurity in the DTES?

A DTES food Gap Analysis from the perspective of both DTES Residents and Stakeholder Organizations was undertaken to inform next steps in the DTES Kitchen Tables Action Plan. As illustrated in the Gap Analysis below, common themes have emerged from both residents and organizations.

Food Gap Analysis – The View from DTES Residents

The DTES Kitchen Tables Project employed 8 community residents to conduct one-on-one surveys across the DTES over a three week period in November 2009. In total, 376 individual surveys were administered. The results were coded and used as the foundation for this section of the Gap Analysis and can be found in the enclosed Appendices.

** See Appendix G for the DTES Resident Survey*

Food Quality and Nutrition

- Mythology that there is adequate amounts and suitable, nutritious food available in the DTES
- 25% of residents surveyed:
    - Eat fruit, vegetables and meat once a day
    - Have access to proper cooking and storing facilities
    - Cite the choice and quality of grocery stores in the DTES is inadequate
    - Cite that meat and other proteins are expensive in the DTES
- 50% of residents surveyed:
    - Are not satisfied with the nutritional quality or the quantity of the free food they access
    - Are not satisfied with the days of the week and times of day that food is available to them
    - Cite that receiving moldy food and/or contracting food poisoning are common experiences
    - Are on medication that needs to be ingested with food but are unable to access food at the necessary times
- Majority of residents define the word ‘meal’ as having 4 food groups made of quality ingredients and resulting in a full stomach, eaten in a warm environment where they can be seated
- Unacceptable and alarming number of residents become sick because of the available food in the DTES

- If given a Magic Wand to improve DTES food, majority of DTES residents would improve quality and have food accessible 24/7
- Lack of culturally appropriate foods
- Inadequate nutrition for residents, the majority of whom:
    - Live with compromised health status
    - Are homeless or under-housed
    - Live well below the poverty line
    - Live on Disability income, which is basic $610/month of Welfare, plus an additional financial supplement on average of $400/month

Efficiencies and Collective Action

- Lack of coordination among food providing organizations regarding the times that food is available in the neighbourhood

Food Accessibility and Distribution

- Better quality food should be available 24/7
- Overwhelming majority see the necessity of food distribution at non-food venues where they wait for other services or programs
- Majority of residents access food through line-ups and find it time consuming, unhealthy in bad weather of all seasons, intimidating and humiliating
- Majority of DTES residents surveyed cite:
    - Food is not available when they are actually hungry
    - They visit at least 4 places a day to search +/- 3 hours per day for food
    - They eat a maximum of twice per day
    - They would prefer to eat 3 times per day
    - Their health status would improve if they could more easily and frequently access quality food
    - Much of the food available is white rice, white bread, potatoes and pastries
    - They would like to cook for themselves but currently do not
    - They eat soup daily
    - They are unable to access the foods they would like to eat
    - Meat, dairy, vegetable and fruit as their top 3 food priorities

Dignity

- Majority of residents access food through line-ups and find them time-consuming, physically uncomfortable and unhealthy in inclement weather, intimidating and humiliating
- The common distribution of moldy and outdated food is insulting
- Due to the current food distribution system and lack of quality many residents have resigned themselves to the attitude of “beggars can’t be choosers”

- Majority of respondents over 45 years of age are deemed ‘seniors’ by virtue of a shortened life span of DTES

Sustainability

- The current process of preparing and delivering free food is unsustainable

Food Related Resources

- The number of Community Kitchens and Community Food Gardens currently available have little impact on the majority of residents because of their limited reach and size
- Majority lack adequate income to eat well and often
- Majority lack proper cooking tools (hot plates, ovens, microwaves) and food storage means (fridges, freezers) to cook their own food which most would prefer to do if adequately housed and accessing adequate income
- Majority of residents with compromised health status do not have access to quality and abundant food, nor to free, prepared meal programs

Food Gap Analysis – The View from Organizational Stakeholders

In addition to DTES residents, the DTES Kitchen Tables Project engaged a number of stakeholder organizations through surveys and a total of 4 - 3 hour Lunch and Share Sessions held on November 25th & 30th and December 1st & 7th, 2009. Stakeholder invitees and participants represented:

DTES Food Providers
DTES Community Non Profit & Social Enterprise Organizations
Food Service Professionals (Chefs, Cafes and Restaurants)
Food Growers & Suppliers
Municipal, Federal and Provincial Social Policy Makers
DTES Health Care Providers
Researchers whose work has included Food Security in the DTES

** See Appendix H for a complete list of Stakeholder Invitees and Attendees*

The results of stakeholder surveys and Lunch and Share Sessions are summarized below and serve as a foundation for this section of the Gap Analysis.

** See Appendix I for Stakeholder Surveys*

Food Quality and Nutrition

- Lack of funds to provide proper nutrition: organizations generally provide meals on very tight budgets and are therefore reliant on donations or are not able to purchase adequate nutritious ingredients and with the frequency needed
- Poor quality of donations: often food which is donated is expired, moldy or otherwise not acceptable or of very low nutritional value ie; starchy foods, desserts, pastries
- Lack of nutritional food standards amongst food providers especially as they are so often providing food to individuals with compromised immune systems eg; individuals living with HIV/AIDS, Hepatitis C and/or Diabetes
- Lack of food safety education
- Meal replacement products such as Ensure distributed in lieu of an actual meal: sends a questionable message that meal replacements are as socially and nutritionally valuable as a meal or 'real food'
- Lack of choice for:
    - the free food distributed
    - special dietary restrictions (celiac, lactose intolerance, renal)
    - food allergies
    - poor dental health
- Lack of culturally appropriate foods
- Lack of access to clean drinking water; dehydration is a prominent reality in the DTES
- Common experience among stakeholders that the DTES is a 'dumping ground' for unsafe, poor quality food that lacks nutritional quality
- Lack of understanding of food as a fundamental Human Right

Efficiencies and Collective Action

- No collective body to aid in efficiencies for food providers: organizations continue to work fractured from one another as opposed to using collective resources to avoid redundancy and duplication thus saving time and money
- Food providers compete with one another for the same pool of food donations or the little food funding which is available
- Lack of collective quality standards as a guideline for food donors
- No centralized resource hub for menus, recipes and general information: many food providing organizations could benefit from the knowledge of others if there was an easy way to access the information
- DTES food security issues could be better integrated into other DTES policy work including economic development, public health, Social Housing policy and environmental justice initiatives
- DTES food research needs to more thoroughly integrate community capacity building opportunities including food safety and training, jobs, menu creation, food procurement, food preparation and processing, food distribution, health education, purchasing local food

- DTES food providers need to work together more in the following areas:
    - Purchasing Food
    - Growing Food
    - Transporting Food
    - Transporting Meals
    - Cold Food Storage
    - Dry Food Storage
    - Food Program Training & Staffing
    - Food Safety Education
    - Funding and Fundraising
    - Food Program Delivery
    - Menu Planning & Development
    - Bulk Buying Including Forward Food Purchasing
    - Creating a sustainable community economic development alternative to the charitable food system model
- Need to call on food industry experts to help develop improve food processes and systems in DTES organizations (ie. Chefs, Restaurant Managers, Restaurant Owners)
- Lack of collaboration among organizations to champion food standards and collectively educate donors
- Lack of empowerment within organizations to ask for the healthy food donations they '*need and want*', and a greater ability to say *no* to poor, unsuitable food donations they receive

Food Accessibility and Distribution

- DTES residents need access to better quality food, on a regular and consistent basis
- More quality meal delivery in Single Room Occupancy Hotels (SROs) is needed
- Too much purchased and donated food being wasted due to lack of a comprehensive distribution strategy
- Need to reconsider food lineups, replacing them with innovative solutions including:
    - Integrating food distribution into venues of other programs or services
    - More creative 'pockets' and 'pods' for food distribution in the DTES
    - Take a number systems
    - Plan 'quick to serve' meals
- Food needs to be available 24/7, not just Monday through Friday from 9 to 5 to meet the needs of DTES residents
- Lack of pooling of food resources
- Poor interconnectedness of timetables for food distribution amongst community organizations
- Some residents and clients lack mobility to access food
- Lack of food available in a time sensitive manner for individuals who are obliged to take medications with food
- Lack of efficient food distribution eg; the ability to access food at the same time as accessing programs and services within all variety of organizations to save time and energy

Dignity

- Lack of understanding and some misconceptions as to the prevalence of poverty related malnutrition and transient hunger as they exist in Vancouver and Canada.
- Food lineups are undignified and undermine individuals' sense of worth
- Lack of awareness that offering food to residents in DTES organizations should be positioned as a Human Right and a social benefit not an act of charity, which would in turn humanize food distribution and prioritize the shift to eradicate the charitable food model
- Lack of choice and variety in food
- Lack of meaningful employment opportunities suited to DTES residents living with barriers, enabling individuals to purchase meals: even if provided at a significantly reduced cost, residents have a greater sense of dignity if they are able to purchase their meals

Sustainability

- The vast majority of food providing organizations are based on the charity model: reliance on donations and Volunteers is not sustainable and inevitably results in organizational insecurity and a lack of Community Economic Development
- Lack of meaningful employment: residents should be paid a decent wage for their food related work thereby contributing to DTES Community Economic Development
- Lack of 'flexible' employment opportunities suitable to those living with barriers (mental health, substance recovery, childcare)
- Meaningful Food Solutions would create a bed of empowerment for residents, replacing emotional desperation and the psychological beggar mentality
- Effectiveness of social, recreational and economic programs in the DTES are directly affected by lack of food eg; morning programs for children have been proven to be ineffective unless children have eaten
- Lack of food processing, facilities and knowledge
    - canning fruits, vegetables, fish, protein
    - dehydrated food

Resources

- Volume and frequency of food donations available are inadequate to meet community needs
- Lack of funding for food programs and food staffing
- More food producing community gardens needed
- More individual/communal kitchens needed
- Lack of adequate food storage and cooking tools and facilities for DTES residents
- Lack of nutrition based education for DTES residents

- Need more partnerships with food stakeholders from the private sector (Sysco, Yen Brothers, Gordon Food Services, farmers, restaurants, grocers)
- Lack of resources and infrastructure to support ‘perishable’, healthier foods, including donations, such as protein, dairy, fresh fruits and vegetables
- Food providers do not have access to resources from the food and beverage industry: currently there are a lack of partnerships between experts in the food and beverage industry and food providing non profits. Food industry professionals could offer a wealth of resources for systems and information to food providing DTES organizations.

Community Priority Setting

DTES Community Priority Setting - A Roadmap of Solutions

The goal of the Community Priorities set out in this Report, and influenced by the research and feedback assembled during the DTES Kitchen Tables consultation process, is to contribute to the day when a local, robust, sustainable and equitable DTES Food Economy is available by choice to DTES low-income residents, replacing the current charitable food system model.

The conclusions of the information gathered during this Phase 1 of the DTES Kitchen Tables Project including DTES History, Demographics, Environmental Scan and Gap Analyses of DTES Residents and Stakeholder Organizations support the recommendation of **7 Food Solution Priorities** listed below. These priorities have directly informed the creation of the plan of action which completes Phase 1 of the DTES Kitchen Tables Project.

The information gathered in Phase 1 also clearly points to a need to create *community capacity building opportunities* within and around each of the 7 Food Solution priorities. Community capacity building is a priority as the action plan is intended to be an engine in creating a fully functioning DTES Food Economy which will replace the charitable food model, a critical ingredient of which is providing multiple opportunities for low-income DTES residents to earn a living wage.

Solution No. 1 Create Nutritional & Food Quality Standards

To create Nutritional and Food Quality Standards for the DTES which can be used to assess the suitability and quality of both purchased and donated food. The Standards can then collectively support and strengthen food provider organizations, food banks & food recovery programs. Nutritionally vulnerable people can only begin to exercise their right to food once there is community wide adoption of Nutritional and Food Quality Standards.

Benefits:

- Empowers both the community and food providers, including food banks & food recovery programs, to purchase food and/or solicit donated food according to nutritional criteria rather than being pressured to accept what is offered. It would guarantee the elimination of nutritionally poor or spoiled/ unsafe food ‘dumping’.
- Enables us to collectively educate well intentioned donors who support food providers, food banks and food recovery programs and increase food donations which actually benefit DTES residents, especially those living with HIV/AIDS, Hepatitis C and Diabetes.
- These standards can be shared and easily transferred to other neighbourhoods and communities.

Solution No. 2 Recipes & Menu Development

To develop quality, nutritious Menus which can be shared among DTES food providers, housing providers and individual residents.

Benefits:

- Increases efficiencies and shared knowledge among organizations so that no one is operating in nutritional isolation or 'reinventing the wheel' eg; establishing a new Community Kitchen within a Social Housing facility.
- Ensures universal adoption of Nutritional Standards and Guidelines.
- Enables more efficient food Planning and Procurement, both purchased and donated and more efficient Distribution.

Solution No. 3 Food Procurement

To create a centrally organized food ordering system for both purchased and donated food.

Benefits:

- Saves money through volume food purchasing.
- Saves staff administration time & offers financial savings for each organization.
- Streamlines food procurement by efficiencies for both purchased and donated food.
- Facilitates a sharp increase of fresh, locally grown foods in DTES, including food provider menus, which also directly support local farmers and growers.

Solution No. 4 Food Preparation & Processing

To create skill building and employment opportunities for DTES residents in the preparation, processing and delivery of food in the community.

Benefits:

- Community capacity building.
- DTES Community Economic Development.
- Enhances skills and job opportunities for residents and food service providers in terms of food safety and sanitation standards as well as all facets of the food system from growing to compost.

Solution No. 5 Food Distribution

To create more efficient and dignified methods of food distribution in the DTES by expanding the number of food distribution points in the neighbourhood.

Benefits:

- Food is available at more organizations across the DTES.
- Food providers create the same amount of food without the pressure of being the sole DTES distributors or distribution points, resulting in fewer food lineups and wait times for residents.
- Other efficiencies include making food available at the same time as other services are provided eg; while residents wait for Doctor's appointments.
- Non food providing organizations benefit by having adequate amounts of prepared food items eg; smoothies, delivered daily for consumption by their members/clients.

- The physical, emotional, spiritual and psychological health of DTES residents improves as they access nutritious food, as their hunger dictates.

Solution No. 6 Professional Support

To create Food Activist Teams made up of food service industry professionals who can support established DTES organizations and emerging food programs by increasing efficiency, food safety and variety.

Benefits:

- Benefiting from professional food service knowledge to enhance the food production, processes and systems of DTES organizations.
- Creative and quality recipe and menu development.

Solution No. 7 Food Composting & Waste Solution

To create an ecologically sound food waste system for the DTES community, including capitalizing on the existing waste solutions provided by United We Can, Recycling Alternative and others who support Community Economic Development in the neighbourhood.

Benefits:

- Considers the seed-to-compost continuum in the creation of DTES Food Solutions.
- Creates employment and Community Economic Development opportunities through local composting.

Community Action Plan and Timeline

Action Plan and Timeline

Phase 1: October 1st, 2009 to March 31st, 2010

Phase 1, the results of which are enclosed in this DTES Kitchen Tables Action Plan Final Report, has been completed.

Phase 1 Budget: Funding Complete

Budget	Activities	Funders
$31,600	Professional Services	Public Health Agency of Canada
$2,686	Required Travel to Ottawa	Public Health Agency of Canada
$1,312	Administration & Overhead	Public Health Agency of Canada
$8,000	Surveying Staff Wages & Professional Services	Potluck Café Society
$5,000	Professional Services	DTES Neighbourhood House
$48,600	**Total Budget**	

Phase 2: April 1st, 2010 to March 31st, 2011

In order to successfully address the **DTES Kitchen Tables: 7 Food Solutions** priorities set out in Phase 1 of this project report, a number of sustainable Programs and/or Social Enterprises will be created as a fundamental part of the Action Plan. With this in mind, it is imperative that proper business planning around the creation of these Programs and/or Social Enterprises be undertaken. Below is the intended timeline for Phase 2 of the DTES Kitchen Tables project beginning April 1st, 2010 and ending March 31st, 2011 which includes both business planning and some initial implementation. This business planning and implementation will be completed under the co-leadership of the DTES Neighbourhood House and Potluck Café Society.

Business Planning

The goal of business planning is to create 7 business plans, including funding strategies, to properly guide the creation of or support for existing Programs and/or Social Enterprises that accomplish the **DTES Kitchen Tables: 7 Food Solutions.**

	SOLUTION	TIME FRAME	LED BY
1	**Creating Nutritional & Food Quality Standards**	April 1 to 21, 2010 *Approx. 3 weeks*	Project Manager Working Groups
2	**Menu Development & Recipes**	April 22 to May 5, 2010 *Approx. 2 weeks*	Project Manager Working Groups
3	**Food Procurement**	May 6 to June 9, 2010 *Approx. 4 weeks*	Project Manager Working Groups
4	**Food Preparation & Processing**	June 10 to July 9, 2010 *Approx. 4 weeks*	Project Manager Working Groups
5	**Food Distribution**	July 26 to August 27, 2010 *Approx. 5 weeks*	Project Manager Working Groups
6	**Engaging Professional & Food Industry Expertise**	August 30 to September 10, 2010 *Approx. 2 weeks*	Project Manager Working Groups
7	**Food Waste, Compost and Recycling**	September 13 to 24, 2010 *Approx. 2 weeks*	Project Manager Working Groups

Initial Implementation

The implementation of Programs and/or Social Enterprises accompanying the creation of Solution No. 1 Nutritional & Food Quality Standards and Solution No. 2 Menu Development & Recipes will be done in tandem as many of their issues and tools will overlap.

The last two months of Phase 2 will be used to begin implementation of the Programs and/or Social Enterprises accompanying the creation of Solution No. 3

	SOLUTION	TIME FRAME	LED BY
1	**Creating Nutritional & Food Quality Standards**	October 1, 2010 to January 31, 2011	Project Manager TBD
2	**Menu Development & Recipes**		
3	**Food Procurement**	February 1 to March 31, 2010	Project Manager TBD

Phase 2: Funding TBD

Budget	Activities	Funders
$3,000	Business Planning - Nutritional & Food Quality Standards	
$3,000	Business Planning - Menu Development & Recipes	
$15,000	Business Planning - Food Procurement	
$10,000	Business Planning - Food Preparation & Processing	
$15,000	Business Planning - Food Distribution	
$1,500	Business Planning - Engaging Food Industry Expertise	
$2,500	Business Planning – Food Waste, Compost & Recycling	
$4,000	Nutritional & Food Quality Standards, Menu Development Implementation (develop marketing & communication tools eg; website & collateral materials to share info)	
$4,000	Food Procurement Tool Development & Implementation	

$4,000	Administration & Overhead	
$15,600	Professional Services	Potluck Café Society & TBD
$15,600	Professional Services	DTES Neighbourhood House & TBD
$93,200	**Total Budget**	

Phase 3: April 1st, 2011 to _____

Phase 3 will mark the rollout and implementation of all 7 Food Solutions and a food secure DTES which will ensure the availability, accessibility, affordability and choice of quality, nutritious food security solutions for residents of the DTES and specifically to ensure affordable access to nutritious meals each day for the most vulnerable of DTES residents - those living with HIV, AIDS, Hepatitis C, Diabetes and/or sheer malnourishment.

Phase 3 Budget: Funding TBD

Budget	Activities	Funders
TBD	Rollout and implementation of solutions TBD by Business Planning recommendations	

The DTES Kitchen Tables project is seeking financial and in kind support from multiple funders and collaborators.

DTES Kitchen Tables Evaluation Framework

Glossary

Community Collaborators	Includes any DTES Community Stakeholder and/or DTES Community Resident who participates in the development or adoption of DTES Kitchen Tables solutions
DTES	Acronym for Downtown Eastside. It is implied that this Food Action Plan and OMF categories refer to the DTES specifically
Food	All food available in the DTES, purchased, donated or distributed publically, including free food
Food Procurement	All food that is acquired, purchased or donated
Social Enterprise	Refers to business ventures operated by non-profits, whether they are societies, charities, or co-operatives. These businesses sell goods or provide services in the market for the purpose of creating a blended return on investment, both financial and social. Their profits are returned to the business or to a social purpose, rather than maximizing profits to shareholders.
Working Group	Interested individuals from among DTES Residents and/or Stakeholders. What others refer to as a committee.

DTES Kitchen Tables Evaluation Framework

Solution No. 1 Creation of Nutritional and Food Quality Standards

INPUTS	ACTIVITES	OUTPUTS	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Project Manager Working Group Community Collaborators Food and Beverage Industry Professionals Funding for Project Manager Funding for office and overhead	Standards completed Social Enterprises and/or Programs created for Nutritional and Quality Standards Standards distributed to participating Community Collaborators	Number of Standards (form to be determined) produced Number of Standards (form to be determined) distributed Number of Social Enterprises and/or Programs created to support Creation of Nutritional and Food Quality Standards **these Outputs will be counted and tracked by the Program Manager*	Community Collaborators have standards they share with staff and volunteers Community Collaborators have standards they share with donors Donors receive education from these standards and no longer see the DTES as a dumping ground for unsuitable or unsafe food	All DTES food providers adopt Standards All charitable food distributed in the DTES is of high quality and nutritional standards Community Social Enterprises created to support Creation of Nutritional and Food Quality Standards

OUTCOME			
SHORT-TERM OUTCOMES	**INDICATOR**	**SOURCE/METHOD**	**RESPONSIBILITY**
Community Collaborators have standards they can share with staff and volunteers	Number of Community Collaborators who ensure staff and volunteers use Standards Number of community partners that find the Standards to be useful and effective	Count Community Collaborators Survey Community Collaborators	Project Manager Project Manager Working Groups
Community Collaborators have standards they share with donors	Number of charitable food donors receiving and using Standards	Survey Community Collaborators Survey charitable food donors	Project Manager Working Groups
Donors receive education from these standards and no longer see the DTES as a dumping ground for unsuitable or unsafe food	Number of community partners that mark increased nutritional changes in their donations Number of donors who understand and adopt the new Standards	Survey Community Collaborators Survey charitable food donors	Project Manager Working Groups Project Manager
LONG-TERM OUTCOMES	**INDICATOR**	**SOURCE/METHOD**	**RESPONSIBILITY**
All DTES food providers adopt the book of standards	Number of menus changed in charitable distributed based on the Standards	Survey Community food providers	Project Manager Working Groups

All food distributed in the DTES is of high quality and nutritional standards	Increase in quality and nutrition of charitable food distributed Increase in fresh, perishable foods distributed	Focus groups and interviews involving community residents Survey Community food providers/observation	Project Manager Project Manager Working Groups
Community Social Enterprises created to support Creation of Nutritional and Food Quality Standards	Number and types of Social Enterprises at least breaking even financially	Survey Social Enterprises	Project Manager

DTES Kitchen Tables Evaluation Framework

Solution No. 2 Recipes and Menu Development

INPUTS	ACTIVITES	OUTPUTS	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Project Manager Working Group Community Collaborators Food and Beverage Industry Professional Funding for Project Manager Funding for office and overhead Tools to circulate recipes and menus	Recipe and Menu Resources completed System created to employ residents Social Enterprises and/or Programs created for recipe and menu development Distribution tools created Nutritional standards are maintained	Numbers of Community Collaborators accessing resources Numbers of Community Residents accessing resources Number of employment opportunities created for Residents Number of Social Enterprise and/or Programs created for recipe and menu development Number of menus changes reflecting use of resources **these Outputs will be counted and tracked by the Program Manager*	Residents earn wages from employment in Social Enterprises/Programs Community Collaborators are able to administer food distribution programs more efficiently Community Collaborators save dollars due to increased efficiency Residents empowered by use of Resources	Increase in members of the Community accessing Resources Savings due to increased efficiencies allow the Community to contribute more resources to other programs Community Social Enterprises created to support Recipe and Menu Resources operate as sustainable businesses

OUTCOME			
SHORT-TERM OUTCOMES	**INDICATOR**	**SOURCE/METHOD**	**RESPONSIBILITY**
Residents earn wages from employment in Social Enterprises	Number of Residents earning wages that were not previously employed	Count and track number of Residents earning wages Survey employed Residents	Project Manager Project Manager
Community Collaborators are able to administer food distribution programs more efficiently	Number of hours saved by participating Community Collaborators	Survey Community Collaborators	Project Manager Working Groups
Community Collaborators save dollars due to increased efficiency	Number of dollars saved by participating Community Collaborators	Survey Community Collaborators	Project Manager Working Groups
Residents empowered by use of Resources	Number of Residents cooking for themselves using Recipe and Menu Resources	Survey Residents accessing Resources	
LONG-TERM OUTCOMES	**INDICATOR**	**SOURCE/METHOD**	**RESPONSIBILITY**
Increase in members of the Community accessing Resources	Number of Community food providers actively using Recipe and Menu Resources to guide their food programs Number of Residents cooking for themselves using Recipe and Menu Resources	Count and survey Community food providers Count and survey Residents accessing Resources	Project Manager Working Groups
Savings due to increased efficiencies allow the Community	Number of existing programs enhanced and/or new programs	Survey Community programs	

to contribute more resources to other programs	implemented within Community food distributing organizations using Recipe and Menu Resources		
Community Social Enterprises created to support Recipe and Menu Resources operate as sustainable businesses	Number and types of Social Enterprises at least breaking even financially	Survey Social Enterprises	

DTES Kitchen Tables Evaluation Framework

Solution No. 3 Food Procurement

INPUTS	ACTIVITES	OUTPUTS	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Project Manager Working Group Community Collaborators Food and Beverage Industry Professionals Food Growers and Suppliers Funding for Project Manager Funding for office and overhead	System created to employ residents Social Enterprises and/or Programs created for collective Community Food Procurement Best practices for Food Procurement developed in consultation with food and beverage industry professionals and food growers and suppliers	Number of employment opportunities created for residents Number of Social Enterprises and/or Programs created for Community Food Procurement **these Outputs will be counted and tracked by Project Manager*	Residents earn wages from employment in Social Enterprises/Programs Those Community Collaborators interested, participate in collective Food Procurement system Collective Food Procurement allows for savings through volume purchasing Collective Food Procurement allows for more local food purchasing Community Collaborators are able to procure food more efficiently There is an increase in access to fresh foods that were previously, not widely available	Increase in number of food providing organizations participating in collective Food Procurement Savings from volume purchasing allows the Community to contribute more resources to other programs Community Social Enterprises created to support collective Food Procurement operate as sustainable businesses Increase in economic benefit (dollars) to BC and Canadian Farmers

OUTCOME			
SHORT-TERM OUTCOMES	**INDICATOR**	**SOURCE/METHOD**	**RESPONSIBILITY**
Residents earn wages from employment in Social Enterprises/Programs	Number of Residents earning wages that were not previously employed	Count and track number of Residents earning wages Survey employed Residents	Project Manager
Those Community Collaborators interested, participate in collective Food Procurement	Number of Community Collaborators that are actively using the collective Food Procurement	Count and track number of Community Collaborators	Project Manager
Collective food procurement system allows for savings through volume purchasing	Dollars saved by Community Collaborators as a direct result of actively using the collective Food Procurement	Survey Community Collaborators	Project Manager Working Groups
Collective Food Procurement system allows for more local food purchasing	Increase in the number of dollars spent on local product by Community Collaborators as a direct result of actively using the collective Food Procurement	Survey Community Collaborators	Project Manager Working Groups
Community Collaborators are able to procure food more efficiently	Number of dollars saved through collective Food Procurement by participating Community Collaborators	Survey Community Collaborators	Project Manager Working Groups

	Number of staff hours saved through collective Food Procurement by participating Community Collaborators		
There is an increase in access to fresh foods that were previously, not widely available	Increase in the amount of fresh fruits, vegetables, protein and dairy distributed by participating Community Collaborators	Survey Community Collaborators	Project Manager Working Groups
LONG-TERM OUTCOMES	**INDICATOR**	**SOURCE/METHOD**	**RESPONSIBILITY**
Increase in number of food providing organizations participating in collective Food Procurement	Number of Community food distributors that are actively using the collective procurement system	Count and track participants	Project Manager
Savings from volume purchasing allows the Community to contribute more resources to other programs	Number of existing programs enhanced and/or new programs implemented within Community food providing organizations participating in the collective Food Procurement	Survey food providing organizations	Project Manager
Community Social Enterprises created to support collective Food Procurement operate as sustainable businesses	Number and types of Social Enterprises at least breaking even financially	Survey Social Enterprises	Project Manager

Increase in economic benefit (dollars) to BC and Canadian Farmers	Increase in the number of dollars spent on local product	Survey local farmers/suppliers currently used by collective Food Procurement system	Project Manager

DTES Kitchen Tables Evaluation Framework

Solution No. 4 Food Preparation and Processing

INPUTS	ACTIVITES	OUTPUTS	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Project Manager Working Group Community Collaborators Food and Beverage Industry Professionals Funding for Project Manager Funding for office and overhead	System created to employ Residents Social Enterprises and/or Programs created or strengthened for Community Food Preparation and Processing Best practices for Food Preparation and Processing developed in consultation with food and beverage industry professionals	Number of employment opportunities created for Residents Number of Social Enterprises and/or programs create for Food Preparation and Processing **these Outputs will be counted and tracked by the Program Manager*	Residents earn wages from employment in Social Enterprises/Program Those Community Collaborators interested participate in Food Preparation and Processing Social Enterprise/Program Increase in access of prepared and processed food of high nutritional value throughout the Community Increase in choice of prepared and processed food of high nutritional value throughout the Community Food Preparation and Processing Social Enterprise/Program allows for more local purchasing Food Preparation and Processing Social Enterprise/Program allows for more local donations to be received	Increase in number of Community food providing organizations participating in Food Preparation and Processing Social Enterprise/Program Community Social Enterprises created to support Food Preparation and Processing operate as sustainable businesses Increase in economic benefit (dollars) to BC and Canadian Farmers

OUTCOME			
SHORT-TERM OUTCOMES	**INDICATOR**	**SOURCE/METHOD**	**RESPONSIBILITY**
Residents earn wages from employment in Social Enterprises/Program	Number of Residents earning wages that were not previously employed	Count and track number of Residents earning wages Survey employed Residents	Project Manager Project Manager
Those Community Collaborators interested participate in Food Preparation and Processing Social Enterprise/Program	Number of Community Collaborators that are actively using the Food Preparation and Processing Social Enterprise/Program	Count and track number of Community Collaborators	Project Manager
Increase in access of prepared and processed food of high nutritional value throughout the Community	Number and types of food items prepared available to Residents	Count and track food available	Program Manager
Increase in choice of prepared and processed food of high nutritional value throughout the Community	Number and types of food items prepared available to Residents	Count and track food available	Program Manager
Food Preparation and Processing Social Enterprise/Program allows for more local purchasing	Number of dollars spent on local product	Survey Social Enterprise/Program	Project Manager
Food Preparation and Processing Social Enterprise/Program allows for more local donations to be received	Amount of food donated and processed	Survey Social Enterprise/Program	Project Manager

LONG-TERM OUTCOMES	INDICATOR	SOURCE/METHOD	RESPONSIBILITY
Increase in number of community food providing organizations participating in Food Preparation and Processing Social Enterprise/Program	Number of Community food distributors that are actively using Food Preparation and Processing Social Enterprise/Program	Count and track participants	Program Manager
Community Social Enterprises created to support Food Preparation and Processing operate as sustainable businesses	Number and types of Social Enterprises at least breaking even financially	Survey Social Enterprises	Project Manager
Increase in economic benefit (dollars) to BC and Canadian Farmers	Increase in the number of dollars spent on local product	Survey local farmers/suppliers currently used by Food Preparation and Processing Social Enterprise/Program	Project Manager

DTES Kitchen Tables Evaluation Framework

Solution No.5 Food Distribution

INPUTS	ACTIVITES	OUTPUTS	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Project Manager Working Group Community Collaborators Funding for Project Manager Funding for office and overhead	System created to employ Residents Social Enterprises and/or Programs created for Food Distribution	Number of employment opportunities created for Residents Number of Social Enterprises and/or Programs created for Food Distribution **these Outputs will be counted and tracked by the Program Manager*	Residents earn wages from employment in Social Enterprises/Programs Those Community Collaborators interested participate in Food Distribution Social Enterprises/Programs Residents spend far less time accessing food Residents are able to access food in the evenings and the weekends There is an increase in access to fresh foods that were previously, not widely available	Increase in number of Community organizations participating in Food Distribution Social Enterprises/Programs Line-ups for charitable food in the DTES are considerably reduced Food in the Community is distributed in a dignified manner Community Social Enterprises created to support Food Distribution operate as sustainable businesses

OUTCOME			
SHORT-TERM OUTCOMES	**INDICATOR**	**SOURCE/METHOD**	**RESPONSIBILITY**
Residents employed through this system	Number of Residents earning wages that we not previously employed	Count and track number of Residents earning wages Survey employed Residents	Project Manager
Those Community Collaborators interested participate in Food Distribution Social Enterprises/Programs	Number of Community Collaborators that are actively implementing systems from Food Distribution Social Enterprises/Programs	Count and track number of Community Collaborators	Project Manager Working Groups
Residents spend far less time accessing food	Number of hours reduced in searching for food for Residents accessing food	Survey Residents accessing food	Project Manager
Residents are able to access food in the evenings and the weekends	Increase in number of places Residents are able to access food on evenings and weekends	Track hours and locations food is available in the Community- compare to previous records	Project Manager
There is an increase in access to fresh foods that were previously, not widely available	Increase in amount of fresh fruits, vegetables, protein and dairy distributed by Community Collaborators	Document and track nature and type of food accessible Survey Residents accessing food	Project Manager Project Manager
LONG-TERM OUTCOMES	**INDICATOR**	**SOURCE/METHOD**	**RESPONSIBILITY**
Increase in number of Community organizations participating in Food Distribution Social	Number of Community organizations that are actively implementing systems from Food	Count and track number of Community	Project Manager Working Groups

Enterprises/Programs	Distribution Social Enterprises/Programs	organizations	
Line-ups for charitable food in the DTES are considerably reduced	Number of food providing organizations that distribute food through line-ups	Count and track number of organizations that still use the line-up method to deliver food-compare to previous records	Project Manager Working Groups
Food in the Community is distributed in a dignified manner	Number of residents who no longer line-up for food	Survey Residents	Project Manager
Community Social Enterprises created to support Food Distribution operate as sustainable businesses	Number and types of Social Enterprises at least breaking even financially	Survey Social Enterprises	Project Manager

DTES Kitchen Tables Evaluation Framework

Solution No. 6 Professional Support

INPUTS	ACTIVITES	OUTPUTS	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Project Manager Working Group Community Collaborators Food and Beverage Industry Professionals Funding for Project Manager Funding for office and overhead	Social Enterprise and/or Program created to sustain Professional Support from food and beverage industry consultants	Number of Social Enterprises and/or Programs created for Professional Support **these Outputs will be counted and tracked by the Project Manager*	Those Community Collaborators interested participate in Professional Support Strong partnership between Community Collaborators and food and beverage industry professionals is forged Increased efficiencies from Professional Support result in savings	Increase in members of the Community accessing Professional Support Savings from increased efficiencies allows the Community to contribute more resources to other programs Community Social Enterprise created for Professional Support operates as sustainable businesses

OUTPUT/OUTCOME			
SHORT-TERM OUTCOMES	**INDICATOR**	**SOURCE/METHOD**	**RESPONSIBILITY**
Those Community Collaborators interested participate in Professional Support	Number of Community Collaborators that are actively using Professional Support Social Enterprises/Programs	Count and track number of Community Collaborators	Project Manager
Strong partnership between Community Collaborators and food and beverage industry professionals is forged	Number of contacts created through the Social Enterprise/Program	Survey Community Collaborators	Project Manager Working Groups
Increased efficiencies from Professional Support result in savings	Dollars and hours saved by Community Collaborators accessing Professional Support	Survey Community Collaborators	Project Manager Working Groups
LONG-TERM OUTCOMES	**INDICATOR**	**SOURCE/METHOD**	**RESPONSIBILITY**
Increase in members of the Community accessing Professional Support	Number of food providing organizations accessing Professional Support	Count and track number of participants	Project Manager
Savings from increased efficiencies allows the Community to contribute more resources to other programs	Number of existing programs enhanced and/or new programs implemented within Community food providing organizations participating in Professional Support	Survey Community food providing organizations	Project Manager
Community Social Enterprise created for Professional Support operates as sustainable businesses	Number and types of Social Enterprises at least breaking even financially	Survey Social Enterprises	Project Manager

DTES Kitchen Tables Evaluation Framework

Solution No. 7 Food Composting and Waste Solution

INPUTS	ACTIVITES	OUTPUTS	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Project Manager Working Group Community Partners Waste and Composting Industry Professionals Funding for Project Manager Funding for office and overhead	System created to employ Residents Social Enterprises and/or Programs created or strengthened that are already involved in Food Composting and Waste eg; United We Can, Recycling Alternative Waste and Composting Industry Professionals are consulted for best practices	Number of employment opportunities created for residents Number of Social Enterprises and/or Programs created for Food Composting and Waste Solution **these Outputs will be counted and tracked by the Project Manager*	Residents earn wages from employment in Social Enterprises/Programs Those Community Collaborators interested, participate in Food Composting and Waste Social Enterprises/Programs Decrease in conventional food waste practices	Increase in Community members participating in Food Composting and Waste Social Enterprises/Programs Positive environmental impact in the Community Community Social Enterprises created to support Food Composting and Waste operate as sustainable businesses

OUTCOME			
SHORT-TERM OUTCOMES	**INDICATOR**	**SOURCE/METHOD**	**RESPONSIBILITY**
Residents earn wages from employment in Social Enterprises/Programs	Number of Residents earning wages that were not previously employed	Count and track number of Residents earning wages Survey employed Residents	Project Manager
Those Community Collaborators interested, participate in Food Composting and Waste Social Enterprises/Programs	Number of Community Collaborators that are actively using Food Composting and Waste Social Enterprises/Programs	Count and track number of Community Collaborators	Project Manager
Decrease in conventional food waste practices	% of conventional waste removal still used	Survey waste removal companies	Project Manager
LONG-TERM OUTCOMES	**INDICATOR**	**SOURCE/METHOD**	**RESPONSIBILITY**
Increase in Community members participating in Food Composting and Waste Social Enterprises/Programs	Number of Community members that are actively using Food Composting and Waste Social Enterprises/Programs	Count and track participants	Project Manager Working Groups
Positive environmental impact in the Community	Number of newly created composting sites available the Community	Count and track number of composting sites	Project Manager
Community Social Enterprises created to support Food Composting and Waste operate as sustainable businesses	Number and types of Social Enterprises at least breaking even financially	Survey Social Enterprises	Project Manager

DTES Kitchen Tables Project Contacts

DTES Kitchen Tables Contacts

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Appendices

Appendix A

Community Characteristics, Health Outcomes and Health Care Use - Vancouver's Downtown Eastside in the Context of Vancouver Coastal Health Authority and the Province of British Columbia

- Vancouver Coastal Health Authority

Community characteristics, health outcomes and health care use

Vancouver's Downtown Eastside in the context of Vancouver Coastal Health Authority and the province of British Columbia

Key Messages

Please note: this summary should be read in conjunction with the summary data tables and maps provided

Community profile

- The total population of Vancouver's Downtown Eastside (DTES) core in 2006 was 18,020 residents, 3.1% of the population of Vancouver
- Males and people of Aboriginal identity are over-represented in the DTES core
    - Males make up 59.7% of the population in 2006 compared to 49% of the British Columbia population overall
    - People of Aboriginal identity made up 10% of the DTES core population in 2006, four times greater than the overall VCHA region's Aboriginal population and twice as high as the Aboriginal population in British Columbia overall
- Residents of the DTES core are less educated than those in the comparison areas
    - The proportion of residents of the DTES core aged 25-64 years with no educational qualifications (certificate, diploma or degree) is at least twice that of British Columbia overall
- The DTES core has a higher proportion of low income individuals and families than the comparison areas
    - The proportion of low income economic families (after-tax) in the DTES (2005) was approximately 2.7 times that of British Columbia families overall
    - The proportion of low income individuals (after-tax) in the DTES (2005) was approximately 2.6 times that for British Columbia overall

Health outcomes

- The life expectancy of residents of Vancouver's DTES is lower than that of residents of the comparison areas
    - Between 2002 and 2006, men living in the DTES Local Health Area lived 8 years less on average than men in Vancouver overall; the difference for females living in the DTES was not as pronounced
    - Despite this large discrepancy, life expectancy in the DTES improved 2.5 times more between the periods of 1997-2001 and 2002-2006 than life expectancy in VCHA region overall

- Premature death is more likely in residents of Vancouver's DTES than in residents of the comparison areas
    - On average, between 2002 and 2006, the number of years of life lost due to premature death was 2.8 times greater in Vancouver's DTES Local Health Area than in Vancouver overall; this was twice as high in men in the DTES Local Health Area than in women living there.
    - Relative to British Columbia overall, the reduction in premature death among those living in the DTES was three times greater between the periods of 1997-2001 and 2002-2006

- Death rates from a number of causes are higher in residents of Vancouver's DTES as compared to residents of the comparison areas
    - In 2006, residents of the DTES Local Health Area were 8 times more likely to die from accidental poisonings and 3 times more likely to die from homicide than those in British Columbia overall
    - In 2006, residents of the DTES Local Health Area had 5 times the death rate from infectious diseases compared to British Columbia overall
    - Death rates from chronic diseases in the DTES Local Health Area were comparable to rates for British Columbia overall

- The burden of certain chronic diseases in residents of Vancouver's DTES is higher than for residents of Vancouver and VCH overall
    - In 2006/7, residents of the DTES Local Health Area aged 45 years and older, were, on average, almost twice as likely to be diagnosed with chronic obstructive pulmonary disease than residents of VCH overall
    - Rates of cardiovascular disease and diabetes in the DTES Local Health Area were comparable to rates for British Columbia overall

- The burden of certain communicable disease in residents of Vancouver's DTES is higher than for residents of Vancouver and VCH overall
    - Rates of sexually transmitted infections such as Gonorrhea and Syphilis were up to 4 times higher in 2007 in residents of the DTES Core than residents of VCH overall; rates of Chlamydia were similar to the comparison areas
    - Rates of invasive Group A streptococcal disease were 27 times higher in 2007 in residents of the DTES core as compared to residents of VCH overall
    - Rates of invasive pneumococcal disease (IPD) were 14 times higher in 2007 in residents of the DTES core as compared to residents of VCH overall; 2007 saw the tail end of an outbreak of IPD in the DTES that started in the Fall of 2006
    - Rates of blood-borne pathogens such as Hepatitis C and HIV were 10-15 times higher in 2007 in residents of the DTES core as compared to residents of VCH overall
    - Residents of the DTES core are vulnerable to enteric diseases such as Shigellosis; in 2007 the rate of Shigellosis in the DTES core was almost 20 times higher as compared to VCH overall due to an extended outbreak between October 2007 and early 2008

Health care use

- Acute health care service use for various conditions differed between residents in Vancouver's DTES Local Health Area and residents of the comparison areas
    - In 2006/7, use of acute health care services for mental diseases and disorders was 3 times greater for residents of Vancouver's DTES Local Health Area than for residents of British Columbia overall
    - In 2006/7, use of acute health care services for HIV infection was 23 times higher for residents in Vancouver's DTES Local Health Area than for residents of British Columbia overall

Indicator	Vancouver Downtown Eastside Core	Vancouver Downtown Eastside Local Health Area	Vancouver Health Service Delivery Area	Vancouver Coastal Health Authority	British Columbia
Socio-demographic profile*, 2006 Census					
Total population (n)	18,020	51,960	583,690	1,016,710	4,074,380
Male (%)	59.7%	53.1%	49.0%	48.7%	49.0%
Under 5 years (%)	1.3%	1.6%	2.2%	2.2%	2.5%
5 to 19 years (%)	4.4%	5.4%	7.2%	8.2%	9.5%
20 to 44 years (%)	21.9%	24.2%	21.5%	19.1%	16.6%
45 to 64 years (%)	21.9%	15.6%	12.5%	13.4%	13.9%
65+ years (%)	10.0%	6.2%	5.6%	5.9%	6.5%
Female (%)	40.4%	47.0%	51.0%	51.3%	51.0%
Under 5 years (%)	1.1%	2.0%	2.1%	2.2%	2.4%
5 to 19 years (%)	4.1%	4.8%	6.7%	7.6%	8.9%
20 to 44 years (%)	14.9%	21.7%	22.2%	20.0%	17.4%
45 to 64 years (%)	9.4%	11.5%	13.2%	14.3%	14.6%
65+ years (%)	10.7%	7.0%	6.9%	7.2%	7.6%
Aboriginal population (%)	10.0%	8.5%	2.0%	2.4%	4.8%
Immigrant population (%)	39.0%	36.2%	45.6%	43.2%	27.5%
Visible minority population (%)	43.4%	38.2%	51.1%	45.0%	24.8%
Education - No certificate, diploma or degree (aged 25-64 years) (%)	29.6%	17.7%	10.0%	9.1%	12.4%
Unemployment rate (aged 15+ years) (%)	12.1%	8.4%	6.0%	5.8%	6.0%
Family income distribution in 2005 of economic families (%)					
Under $10,000	7.1%	5.3%	4.7%	4.5%	3.2%
$10,000 to $29,999	37.3%	25.9%	14.9%	13.9%	13.0%
$30,000 to $99,999	47.8%	54.0%	53.3%	53.1%	58.9%
$100,000 and over	7.5%	14.8%	27.1%	28.5%	24.9%
Median family income ($)	NA	$48,345	$ 63,870	$ 66,589	$ 65,787
Average family income ($)	$45,452	$59,424	$ 89,165	$ 91,477	$ 80,511
Low income economic families before-tax in 2005 (%)	45.6%	30.9%	21.2%	19.0%	13.3%
Low income economic families after-tax in 2005 (%)	27.2%	21.6%	16.0%	14.5%	9.9%
Composition of family income in 2005 of economic families (%)					
Employment income (%)	67.8%	80.7%	77.2%	77.5%	77.1%
Government transfer payments (%)	23.0%	12.4%	7.6%	7.4%	9.6%
Other (%)	9.2%	6.9%	15.2%	15.1%	13.4%
Individual income distribution in 2005 of persons (aged 15+ years) not in economic families (%)					
Under $10,000	34.0%	26.2%	20.1%	18.4%	15.8%
$10,000 to $29,999	53.4%	45.6%	36.2%	36.7%	41.5%
$30,000 to $59,999	9.5%	20.3%	29.1%	30.1%	30.2%
$60,000 and over	2.9%	7.8%	14.6%	14.9%	12.5%
Median income ($)	NA	$ 14,980	$ 24,899	$ 25,990	$ 25,121
Average income ($)	$16,466	$ 23,305	$ 34,431	$ 34,990	$ 32,637
Low income persons (aged 15+ years) not in economic families before-tax in 2005 (%)	80.3%	61.8%	44.4%	41.4%	36.7%
Low income persons (aged 15+ years) not in economic families after-tax in 2005 (%)	74.9%	56.1%	38.8%	35.6%	29.0%
Composition of individual income in 2005 for persons (aged 15+ years) not in economic families (%)					
Employment income (%)	52.3%	69.4%	74.8%	71.7%	66.0%
Government transfer payments (%)	42.7%	20.5%	10.0%	11.3%	15.9%
Other (%)	5.0%	10.2%	15.1%	17.1%	18.2%

Community characteristics, health outcomes and health care use

Vancouver Coastal Health Authority and British Columbia

Indicator	Vancouver Downtown Eastside Core	Vancouver Downtown Eastside Local Health Area	Vancouver Health Service Delivery Area	Vancouver Coastal Health Authority	British Columbia
Health outcomes					
Life expectancy, 2002-2006 combined (years)[†]	NA	75.1	81.7	82.1	80.9
Male	NA	70.8	79.1	79.9	78.6
Female	NA	81.7	84.2	84.3	83.2
Change from 1997-2001 combined (%)	NA	+ 5.7%	+ 2.6%	+ 2.2%	+ 1.4%
Potential years life lost standardized rate per 1,000 population, 2002-2006 combined (years)[†]	NA	106.6	43.1	38.7	45.1
Male	NA	137.0	56.5	49.7	57.2
Female	NA	66.9	29.6	27.9	33.0
Change from 1997-2001 combined (%)	NA	- 25.7%	- 20.8%	- 17.7%	- 8.7%
Mortality rate per 100,000 population, 2006 compared to (2003-2005 average)[†]					
Accidental poisonings	NA	56.9 (51.3)	10.5 (10.8)	7.5 (7.5)	7.0 (7.0)
Cancer	NA	192.2 (197.4)	158.6 (158.0)	166.9 (166.4)	195.7 (197.4)
Circulatory disease	NA	231.3 (275.7)	176.5 (198.6)	187.7 (203.1)	221.0 (233.3)
Homicide, 1997-2006 combined	NA	6.6	2.5	1.9	2.1
Infectious disease	NA	80.1 (80.1)	27.8 (26.2)	20.8 (20.1)	15.3 (13.3)
Chronic disease incidence rate per 100,000 population, 2006/07 compared to (2003/04-2005/06 average)[‡]					
Cardiovascular disease	NA	455.5 (531.8)	360.6 (420.9)	387.4 (442.3)	464.4 (534.1)
Chronic obstructive pulmonary disease (aged 45 years and over)	NA	730.8 (982.3)	411.8 (522.9)	406.4 (460.6)	510.0 (575.4)
Diabetes	NA	617.4 (615.0)	580.8 (539.5)	571.4 (527.3)	616.5 (562.6)
Communicable disease notifications rate per 100,000 population, 2007 compared to (2004-2006 average)[§]					
Chlamydia	266.4 (NA)	246.1 (203.1)	315.2 (292.7)	266.7 (244.0)	226.8 (210.4)
Gonorrhea	183.1 (NA)	65.9 (79.8)	74.9 (79.3)	50.2 (51.5)	28.8 (25.5)
Group A streptoccoccal disease, invasive	199.8 (116.5)	79.7 (42.3)	11.0 (7.0)	7.4 (5.1)	5.6 (4.0)
Hepatitis C	788.0 (930.4)	370.9 (422.0)	76.7 (100.0)	62.2 (74.5)	66.0 (69.8)
HIV	188.7 (NA)	104.0 (79.2)	30.4 (30.8)	19.0 (19.2)	9.0 (9.4)
Male	195.3 (NA)	133.9 (101.2)	51.3 (52.8)	32.4 (33.0)	13.9 (14.7)
Female	164.9 (NA)	64.5 (51.6)	9.5 (9.2)	5.8 (5.7)	3.8 (3.9)
Infectious syphilis	49.9 (NA)	34.7 (23.6)	29.0 (34.2)	17.5 (21.2)	6.7 (7.2)
Invasive pneumococcal disease	220.0 (151.7)	121.3 (78.0)	20.7 (14.5)	15.5 (10.3)	12.6 (8.5)
Salmonellosis (non-typhoidal *Salmonella*)	11.1 (31.4)	17.3 (21.2)	13.8 (17.7)	16.3 (18.2)	18.0 (17.2)
Shigellosis	233.1 (7.4)	98.8 (6.6)	19.2 (9.2)	13.0 (7.3)	6.2 (4.4)
Health care service utilization					
Acute health care service utilization as a percent of total episodes of utilization, 2006/07 compared to (2001/05-2005/06 average)[‖]					
HIV infections	NA	2.3% (1.8%)	0.6% (0.5%)	0.3% (0.3%)	0.1% (0.1%)
Injury, poisoning and toxic effect of drugs	NA	1.4% (2.1%)	1.5% (1.6%)	1.5% (1.6%)	1.6% (1.7%)
Mental diseases and disorders	NA	13.6% (12.7%)	6.4% (6.3%)	5.1% (5.0%)	4.4% (4.4%)
Multiple significant trauma	NA	4.6% (4.9%)	3.9% (3.8%)	4.0% (4.0%)	4.3% (4.2%)
Pregnancy and childbirth	NA	6.8% (6.8%)	9.2% (9.5%)	8.4% (8.7%)	7.4% (7.7%)

Prepared by: Vancouver Coastal Health, Public Health Surveillance Unit, January 20, 2009.

Notes:

1. The Vancouver Downtown Eastside (DTES) Core is not entirely contained within the Vancouver DTES local health area (LHA). The Vancouver DTES Core boundary is defined by the City of Vancouver, Central Area Planning Department.
2. The Vancouver Health Service Delivery Area (HSDA) is comprised of six LHAs. The Vancouver DTES LHA is one of these six areas.
3. Vancouver Coastal Health Authority region is comprised of three HSDAs: Richmond (1 LHA), Vancouver (6 LHAs) and Coastal (7 LHAs).
4. The Vancouver DTES Core socio-economic and demographic profile was calculated by combining data for four census tracts (CT) that fall within the Vancouver DTES Core boundary (CT 57.01, CT 57.02, CT 58.00 and CT 59.06). This data is the best available for the Vancouver DTES Core at the time of this summary. Updated information for the Vancouver DTES Core containing 2006 census data, will be released early in 2009 by the City of Vancouver in *Downtown Eastside Community Monitoring Report* .
5. Reportable communicable disease cases which reside in the Vancouver DTES LHA were geocoded using their postal code and the BC STATS Translation Master File (TMF), to determine whether they also reside within the Vancouver DTES Core.
6. Clients tested for sexually transmitted infections may be tested non-nominally and therefore an LHA can not be assigned. This testing may include clients residing in other regions of the Lower Mainland, outside of the Vancouver Coastal Health Authority region. For chlamydia and gonorrhea, 31% and 41% of Vancouver HSDA cases respectively were not assigned an LHA between 2004 and 2007.
7. For a definition of terms and calculations, refer to the attached "Glossary of Terms".
8. NA: Not available.

Data sources:

*Statistics Canada (2006 Census) via BC STATS Sharepoint site.

[†]BC Vital Statistics Agency, 2008 via Vancouver Coastal Health Authority Knowledge Base.

[‡]BC Primary Health Care (Diabetes Registry), BC Primary Health Care (Cardiovascular Disease Registry), and BC Primary Health Care (Chronic Obstructive Pulmonary Disease Registry), 2006/2007 via Vancouver Coastal Health Authority Knowledge Base. Chronic disease cases are notified to the various registries by primary care physicians and therefore may not truly reflect incidence.

[§]Communicable disease data are reported and collected through a mandatory notification system, legislated under the British Columbia *Health Act Communicable Disease Regulation 4/83 O.C. 6/83* . These diseases must be reported to the local public health unit by primary care physicians, laboratories, hospitals and institutions. 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; 3 – Health care providers do not always conduct laboratory tests. With the exception of sexually transmitted infections and annual BC summary data, disease data are provided by Vancouver Coastal Health, Public Health Surveillance Unit from the Primary Access Regional Information System (PARIS) for Richmond and Vancouver, and from the integrated Public Health Information System (iPHIS) for Coastal Urban and Coastal Rural. Sexually transmitted disease data and annual BC summary data are provided by the BC Centre for Disease Control (BCCDC). Disease data is current as of January 20, 2009.

[‖]BC Ministry of Health, Health Information & Modernization, Health System Planning Division (Discharge Abstract Database), 2008 via Vancouver Coastal Health Authority Knowledge Base.

Population sources:

With the exception of the Vancouver DTES Core, population data for all regions were obtained from BC STATS, Service BC, BC Ministry of Labour and Citizens' Services (P.E.O.P.L.E. 33 as of July, 2008). The population for the Vancouver DTES Core was calculated by combining the 2006 census population for four census tracts (CT) that fall within the Vancouver DTES Core boundary (CT 57.01, CT 57.02, CT 58.00 and CT 59.06).

Community characteristics, health outcomes and health care use

Vancouver Coastal Health Authority and British Columbia

Glossary of Terms

Definitions

Source: With the exception of Potential Years of Life Lost (PYLL), the following definition of terms are taken from the *Statistics Canada 2006 Census Dictionary* via the StatCan website at: http://www12.statcan.ca/english/census06/reference/dictionary/atoz.cfm

After-tax income
Refers to total income minus federal, provincial and territorial income taxes paid for calendar year 2005. Total income refers to income from all sources, including employment income, income from government programs, pension income, investment income and any other money income.

After-tax income of economic families
The after-tax income of an economic family is the sum of the after-tax incomes of all members of that family.

Economic family
Refers 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.

Economic family total income
The total income of an economic family is the sum of the total incomes of all members of that family.

Homeless People
Prior to Census Day, Statistics Canada developed lists of shelters to identify homeless shelters as distinct from other types of collective dwellings. In shelters and similar facilities, the eight short form questions were completed using administrative records, where possible. These are the same questions that were answered by every Canadian. In all cases, age and sex was noted.

Low income after-tax cut-offs
Measures of low income known as low income cut-offs (LICOs) were first introduced in Canada in 1968 based on 1961 Census income data and 1959 family expenditure patterns. At that time, expenditure patterns indicated that Canadian families spent about 50% of their total income on food, shelter and clothing. It was arbitrarily estimated that families spending 70% or more of their income (20 percentage points more than the average) on these basic necessities would be in 'straitened' circumstances. With this assumption, low income cut-off points were set for five different sizes of families. Subsequent to these initial cut-offs, revised low income cut-offs were established based on national family expenditure data from 1969, 1978, 1986 and 1992. The initial LICOs were based upon the total income before tax of families and persons 15 years and over, not in economic families.

In a similar fashion to the derivation of low income cut-offs based upon total income, cut-offs are estimated independently for economic families and persons not in economic families based upon family expenditure and income after tax. Consequently the low income after-tax cut-offs are set at after-tax

income levels, differentiated by size of family and area of residence, where families spend 20 percentage points more of their after-tax income than the average family on food, shelter and clothing.

Income from government sources
Refers to all transfer payments, excluding those covered as a separate income source (Child Benefits, Old Age Security pensions and Guaranteed Income Supplements, Canada or Quebec Pension Plan benefits and Employment Insurance benefits) received from federal, provincial, territorial or municipal programs during the 2005 calendar year.

Other money income
Refers to regular cash income received during calendar year 2005 and not reported in any of the other ten sources listed on the questionnaire. For example, severance pay and retirement allowances, alimony, child support, periodic support from other persons not in the household, income from abroad (excluding dividends and interest), non-refundable scholarships, bursaries, fellowships and study grants, and artists' project grants are included.

Potential Years of Life Lost (PYLL) Standardized Rate
PYLL highlights the loss to society as a result of youthful or early deaths and is the number of years of life lost when a person dies before a specified age (75 years). All deaths are assumed to occur at the midpoint of five-year age groups. The age-standardized measure of PYLL is expressed in terms of a rate per 1,000 population, adjusted to a standard population (1991 Canada Census).

Source: The above definition for PYLL is taken from: 1 - Last, J., "A Dictionary of Epidemiology", Oxford University Press, 2001; and 2 - BC Vital Statistics Agency, "Selected Vital Statistics and Health Status Indicators, Annual Report 2006" via the BC Vital Stats web site at:
http://www.vs.gov.bc.ca/stats/annual/index.html

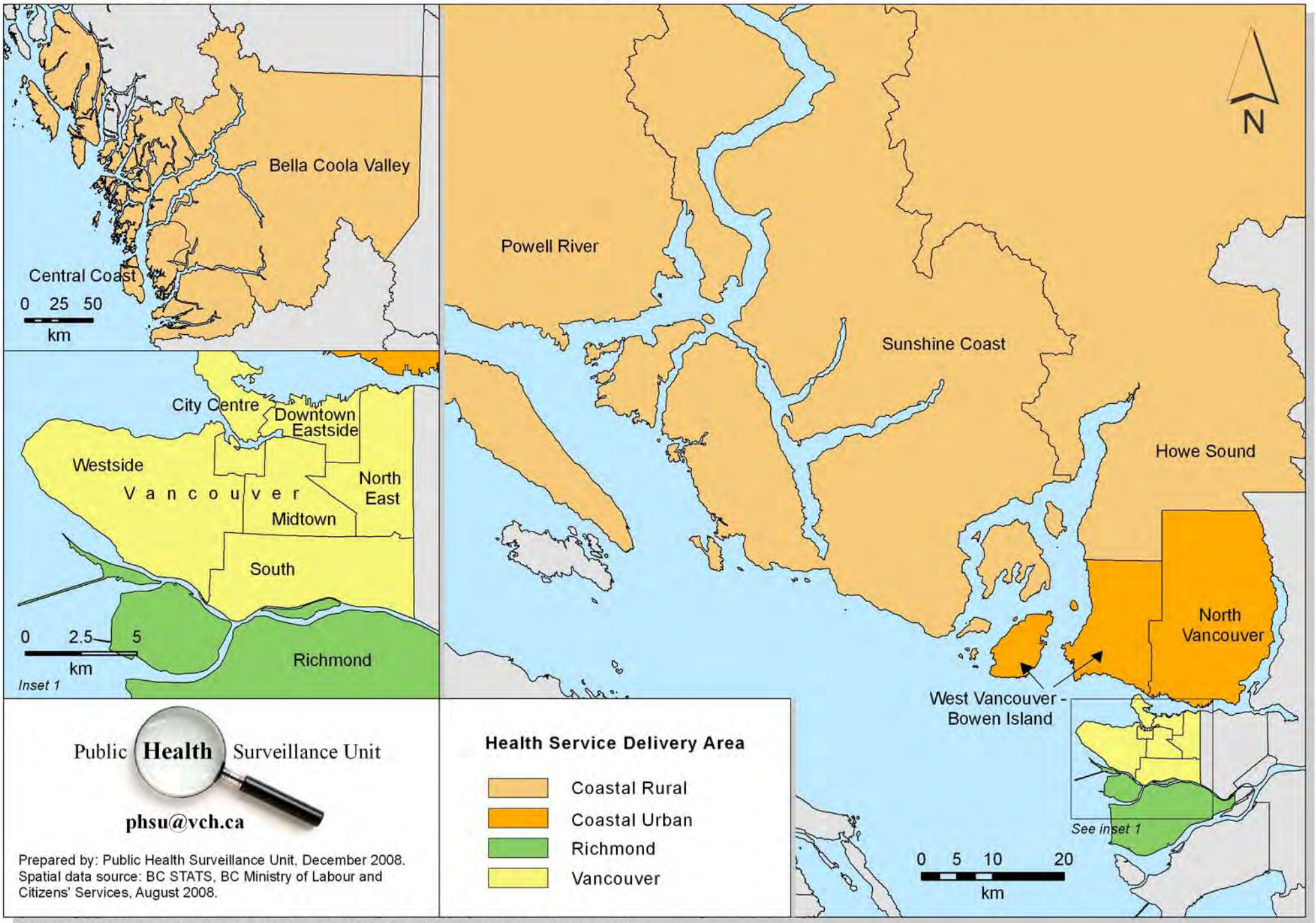
Calculations

Acute care utilization – Rate
Acute care utilization reported as a percent of total episodes of utilization in an acute care setting is calculated by taking the number of episodes of utilization for a particular service and then dividing it by number of all episodes of service utilization. This value is then converted to a percentage

Acute care utilization – Average rate
The average rate of acute care utilization reported as a percent of total episodes of utilization in an acute care setting is calculated by adding the yearly number of episodes of utilization for a particular service over a specified time period and then dividing it by the sum of all episodes of service utilization over the same specified time period. This value is then converted to a percentage.

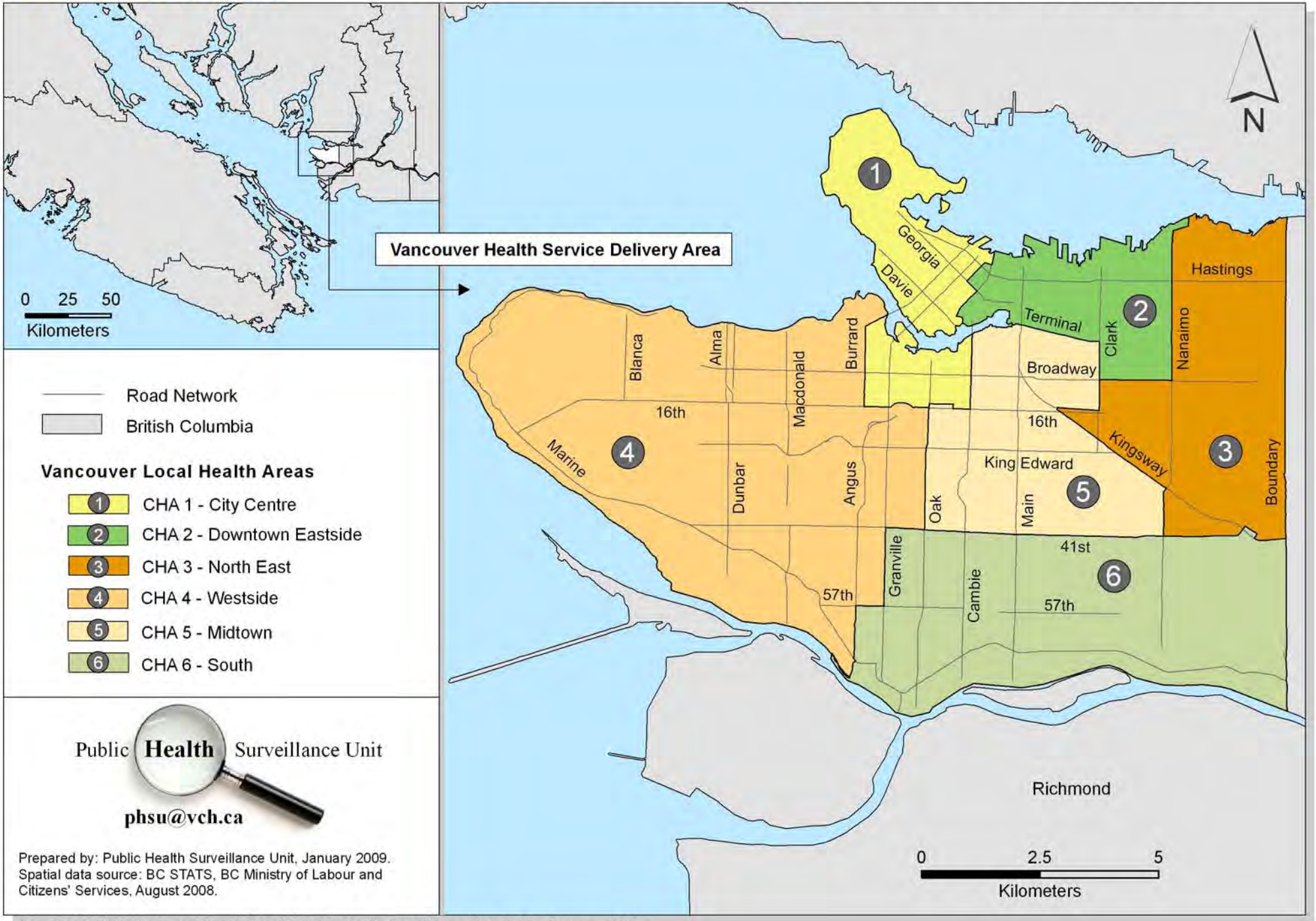
Chronic and communicable diseases – Average rate
The average rate is calculated by adding the yearly number of cases over a specified time period and then dividing it by the sum of the yearly population over the same specified time period. This value is then converted to a rate per 100,000 population.

Vancouver Coastal Health Authority
Health Service Delivery Areas and Local Health Areas



Prepared by: Public Health Surveillance Unit, December 2008.
Spatial data source: BC STATS, BC Ministry of Labour and Citizens' Services, August 2008.

Vancouver Coastal Health Authority
Vancouver Health Service Delivery Area and Local Health Areas

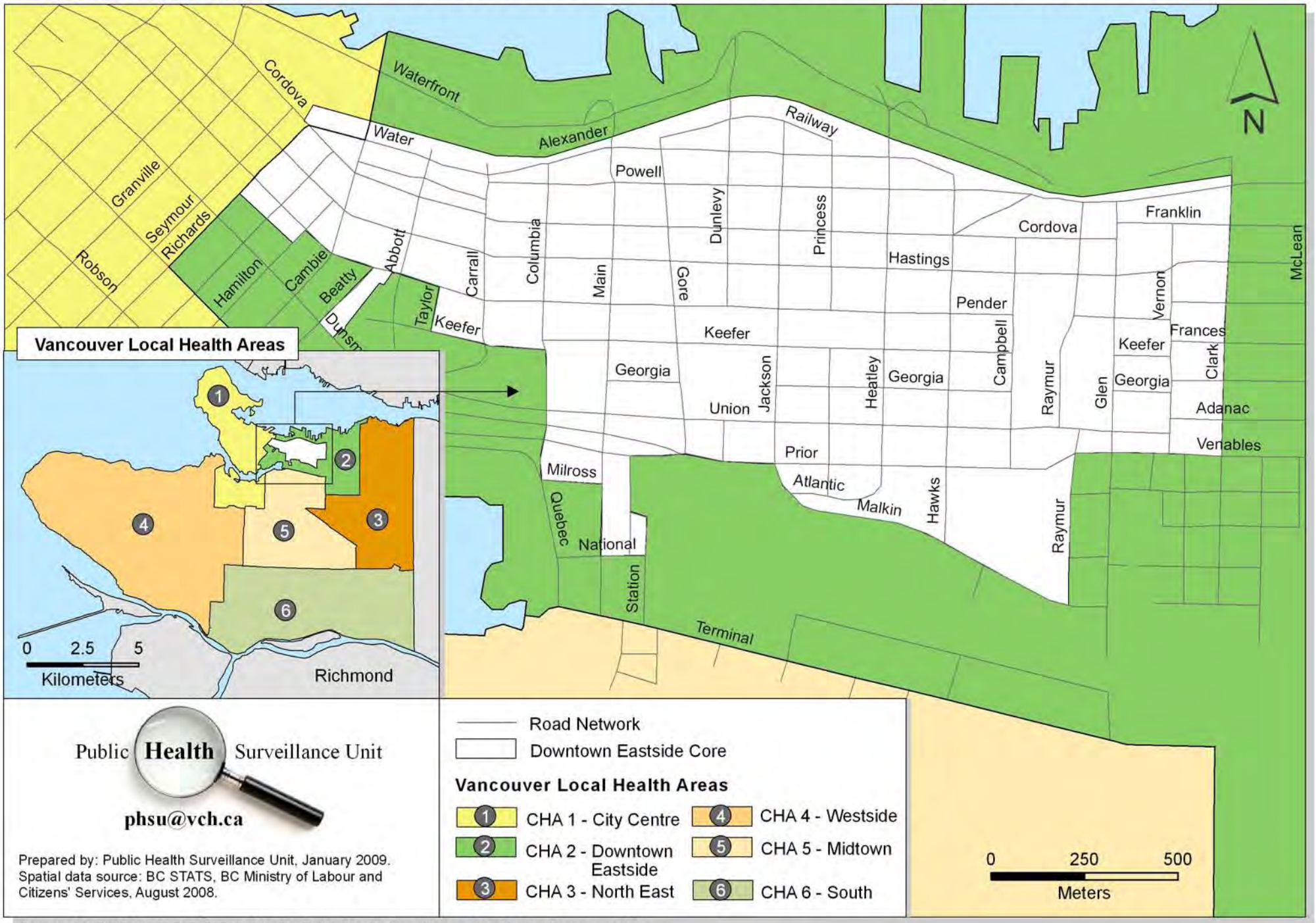


Public Health Surveillance Unit

phsu@vch.ca

Prepared by: Public Health Surveillance Unit, January 2009.
Spatial data source: BC STATS, BC Ministry of Labour and Citizens' Services, August 2008.

Vancouver Coastal Health Authority
Vancouver Local Health Areas and Downtown Eastside Core



Prepared by: Public Health Surveillance Unit, January 2009.
Spatial data source: BC STATS, BC Ministry of Labour and Citizens' Services, August 2008.

Appendix B

Cost of Eating in BC 2009 Media Backgrounder

- Dietitians of Canada

Dietitians of Canada
Les diététistes du Canada

MEDIA BACKGROUNDER

Low-income families can't afford healthy food – The Cost of Eating in BC 2009

The Facts:

- A family of four on income assistance would need more than 100% of their income for shelter and food. Buying healthy food alone requires almost 50% of income
- Food and shelter costs have increased significantly over the past decade, while income assistance rates have remained virtually unchanged and minimum wage has not increased
- Unemployment is rising, as is the number of clients receiving income assistance
- Many low-income residents face challenges purchasing healthy foods. In urban centres the high cost of housing leaves little money left for food; in geographically isolated communities there may be a limited variety of healthy foods and food is often more expensive than in urban centres
- Almost 90,000 people visited a food bank in BC in March 2009, the highest number on record and a 15% increase over 2008
- Most other provinces have established poverty reduction plans or anti-poverty legislation.

The Cost of Eating in BC 2009 report demonstrates that income assistance is too low to pay rent and buy healthy food. In the spring of 2009, dietitians throughout BC priced a standard basket of food at 134 randomly selected grocery stores. The basket contains 67 basic foods that require preparation. The cost of the food basket is then compared to disposable income for a number of family scenarios. For those on income assistance, shelter and food costs consume an unreasonable proportion of the income. For those with a low earned income ($11/ hour, $3 more than minimum wage), food costs also represent an unreasonable percentage of their income.

Monthly Costs	Family of 4 income assistance	Single parent 2 children income assistance	Family of 4 low earned income	Family of 4 average income
Disposable income	$1773	$1724	$2458	$4491
Cost of shelter	$1028	$1028	$740	$1293
% income needed for shelter	58%	60%	30%	29%
Cost of food	$872	$659	$872	$872
% income needed for food	**49%**	**38%**	**35%**	**19%**
% income ($) left for all other costs	-7% (-$127)	2% ($37)	34% ($846)	52% ($2326)

Quebec and Ontario have established anti-poverty legislation. Newfoundland/Labrador, Nova Scotia, New Brunswick and Manitoba have all adopted poverty reduction plans. It's time for BC to catch up and develop a plan with vision, targets and timelines that includes:

- Raising income assistance rates to account for the actual cost of healthy food and safe housing and indexing rates to the cost of living
- Raising the minimum wage to a level that supports an individual working full-time, full-year with an income above Statistics Canada low-income cut-off in a major urban centre
- Supporting a wide range of initiatives to ensure all British Columbians have access to safe and affordable housing
- Supporting initiatives that increase access to healthy food for all British Columbians, especially those living in rural and remote communities, or for whom access to food is difficult
- Building a system of high quality, affordable, accessible child care
- Measuring success by improvements in the health and social statistics of the most disadvantaged British Columbians.

1028 Scottswood Lane, Victoria, British Columbia, Canada, V8Y 2V1
Telephone 250 590 2429 Facsimile 250 590 2474 Email jmacdonald@dietitians.ca

Appendix C

Low Cost and Free Meals in the Community in Vancouver: DTES Only
July 2008

- Vancouver Coastal Health Authority

Low Cost And Free Meals In The Community

In Vancouver, July 2008 DTES ONLY

CONTENTS OF THIS LIST:

OTHER LISTS:

June 2009

Re: "Low Cost and Free Meals In the Community, Vancouver, 2008"

Please be advised that an error was recently discovered in the "Low Cost and Free Meals In the Community" list, revision date: June 2008. Please find attached a corrected version of the Low-Cost and Free Meals list. We ask that you immediately delete any electronic copies and/or destroy any print copies of previous versions of this list that you may have on file.

Please note that beyond the correction of this error, the rest of the information in this list has not been updated. VCH staff are currently reviewing the format of all of the Food Resource Lists and so these lists will not be updated in 2009. This information has been obtained from many local organizations whose services and programs change constantly. As the information contained in these lists is now at least one-year old, **we advise that you call ahead to confirm the accuracy of the information before referring any client to any one of the resources contained within.**

If you have used information from the VCH Food Resource Lists as the basis for your own list to hand out to clients, or are planning to do so, we encourage you to phone each of the providers on your list to ensure: 1) that the information you have included is still accurate; and 2) that the food provider is interested in being included on your list.

Thank you for your cooperation in this matter.

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Low-Cost Meals in the Community

Serves Health Area	Where	What
CHA 2 Eastside	**Carnegie Centre** 401 Main St. 604-665-2220 www.carnegie.vcn.bc.ca	Breakfast: 9 am $1.75 Lunch: 12 pm $1.85 Dinner: 5 pm $3 Open 7 days per week Volunteers will get free meal vouchers in exchange for chores
CHA 2 Eastside	**Evelyne Saller Centre** 320 Alexander St. 604-665-3075 www.cln.vcn.bc.ca/evelynesaller	Breakfast: 10 am $2 Lunch: 11 am – 2:50 pm $2 Dinner: 3:30 pm – 5:50 pm $2 Open 7 days per week including holidays
CHA 2 Eastside	**Lions Den Recreation Centre** (Wheels To Meals) 770 Commercial Dr. 604-718-5848 www.seniors.vcn.bc.ca/ldwelcome	**For adults 55+** Boundaries: Nanaimo to Clark, Waterfront to Broadway Hot lunch Tues – Fri: 12 pm – 1:30 pm $5 24 hours notice required

Low-Cost Meals in the Community

Serves Health Area	Where	What
CHA 2 Eastside	**Potluck Café** 30 W. Hastings St. 604-609-7368 Fax: 604-683-0071	Breakfast: served all day $6.95 Lunch: served all day $5.95 to $7.95 Coffee $1.00 Open 8 am to 4 pm
CHA 2 Eastside	**Strathcona Community Centre** 601 Keefer St. 604-713-1838	Second Wed of the month Lunch: 12 pm $4 Chinese meal Purchase a ticket by Tues

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FREE MEALS LIST FOR VANCOUVER

Free meals provide basic nutrition in a cafeteria-style setting. Often there are line-ups. Eligibility may be restricted.

Serves Health Area	Location	Food type	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
CHA 2 Eastside	**Aboriginal Mothers Society** 208-2019 Dundas St. 604-253-6262	**For women and their children** Lunch and Dinner	Lunch 12 pm Dinner 4 pm	Lunch 12 pm Dinner 4 pm	Lunch 12 pm Dinner 4 pm	Lunch 12 pm Dinner 4 pm	Lunch 12 pm Dinner 4 pm		
CHA 2 Eastside	**All Tribes Mission** 331Carroll St.	Soup and sandwiches				7 pm - 8 pm		2 pm	
CHA 2 Eastside	**Crabtree Corner** 533 E. Hastings St. 604-216-1650	**For parents and children** Breakfasts (available for daycare parents or groups) Snacks, Soup, or Hot Meal	8:45-9:45 am Lunch 2 pm - 3:15 pm	8:45-9:45 am Lunch 2 pm-3:15 pm	8:45 - 9:45 am Lunch 10:30 - 1:15 pm	8:45-9:45 am Lunch 2 pm - 3:45 pm	8:45-9:45 am Lunch 2 pm – 3:45 pm		
CHA 2 Eastside	**Door is Open** 373 E. Cordova St. 604-689-0498	Lunch	11 am	11 am	11 am Women Only	11 am	11 am	11 am	

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FREE MEALS LIST FOR VANCOUVER

Serves Health Area	Location	Food type	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
CHA 2 Eastside	**Downtown Eastside Women's Centre** 44 E. Cordova St. 604-681-4786 www.dewc.ca	**Women only** Hot Meal or Soup Dinner also available for women who attend the evening group	12:30 - 1:45 pm	12:30 - 1:45 pm	12:30 - 1:45 pm	12:30 - 1:45 pm	12:30 - 1:45 pm	12:30 - 1:45 pm	12:30 - 1:45 pm
CHA 2 Eastside	**Dugout** 59 Powell St. 604-685-5239	Soup, coffee and tea	7:15 – 8 am	7:15 – 8 am	7:15 – 8 am	7:15 – 8 am	7:15 – 8 am	7:15 – 8 am	8:45 - 9:15 am
CHA 2 Eastside	**First United Church** 320 E. Hastings St. 604-681-8365	Soup, coffee and sandwich	8:30-9:30 am	8:30-9:30 am	8:30-9:30 am	8:30-9:30 am	8:30-9:30 am Special Lunch on Fri 11 am	Special Meal Call first	

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FREE MEALS LIST FOR VANCOUVER

Serves Health Area	Location	Food type	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
CHA 2 Eastside	**Food on the Corner Society** Main St. and Cordova St. 604-943-5507 Or Rick Lewall at 604-943-0469	Sandwich, fruit and veggies						11am	
CHA 2 Eastside	**Franciscan Sisters of Atonement** 385 E. Cordova St. 604-685-9987	Soup and sandwiches	3:30 pm	3:30 pm		3:30 pm	3:30 pm		2 pm
CHA 2 Eastside	**Grandview Church** 1803 E.1 Ave. 604-253-6667	Dinner *Currently over capacity							

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FREE MEALS LIST FOR VANCOUVER

Serves Health Area	Location	Food type	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
CHA 2 Eastside	**Grandview Park** Off Commercial Dr. between William St. and Charles St.	Chili and vegetable soup		7 pm					
CHA 2 Eastside	**Harbour Light** Salvation Army 119 E. Cordova St. 604-646-6800	Lunch (with tickets only) Supper (with tickets only)	11 am – 12 pm 5 pm	11 am – 12 pm 5 pm	11 am – 12 pm 5 pm	11 am – 12 pm	11 am – 12 pm 5 pm	5 pm	5 pm
CHA 2 Eastside	**Lifeskills Centre** 412 E. Cordova 604-678-8278	Breakfast and lunch	Break-fast 10:30 am Lunch 2 pm Coffee/ Snacks 11 & 2:30 pm	Break-fast 10:30 am Lunch 2 pm Coffee/ Snacks 11 & 2:30 pm	Break-fast 10:30 am Lunch 2 pm Coffee/ Snacks 11 & 2:30 pm	Break-fast 10:30 am Lunch 2 pm Coffee/ Snacks 11 & 2:30 pm	Break-fast 10:30 am Lunch 2 pm Coffee/ Snacks 11 & 2:30 pm		

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FREE MEALS LIST FOR VANCOUVER

Serves Health Area	Location	Food type	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
CHA 2 Eastside	**Living Room** 528 Powell St. 604-255-7026	**For mental health members only** Supper	4 pm	4 pm	4 pm	4 pm	4 pm		
CHA 2 Eastside	**Mission Possible** 543 Powell St. 604-253-4469	Drop-in and snacks		1 pm – 3:30 pm	1 pm – 3:30 pm	1 pm – 3:30 pm Food for pets at 10 am	1-2 pm	Power Breakfast 9 am Line up for tickets	
CHA 2 Eastside	**New Beginnings** 1648 E. 1 Ave. 604-873-2100	Breakfast Closed for July and August				7 am - 8:30 am	7 am - 8:30 am	7 am - 8:30 am	

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FREE MEALS LIST FOR VANCOUVER

Serves Health Area	Location	Food type	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
CHA 2 Eastside	**Rainbow Mission** 135 Dunlevy Ave. 604-681-4377	Hot meals and sandwich	7:30 pm	7:30 pm	7:30 pm	7:30 pm	7:30 pm	12 pm	7:30 pm
CHA 2 Eastside	**Salvation Army Cross Culture** At Templeton St. and Pender St.	Dinner			5 pm Except on cheque day				
CHA 2 Eastside	**Sheway** 533 E. Hastings St. 604-216-1699	**Registered clients only (pregnant women and babies to 18 months)** Hot Lunch		12 pm	12 pm	12 pm	12 pm		
CHA 2 Eastside	**Street Church** 175 E. Hastings St. 604-681-1910 Or 778-231-5820	Dinner	7 pm	7 pm	7 pm	7 pm	7 pm	7 pm	

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FREE MEALS LIST FOR VANCOUVER

Serves Health Area	Location	Food type	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
CHA 2 Eastside	**Union Gospel Mission** 607 E. Hastings St. 604-255-7199	Coffee and Pastries Breadline Mon to Sun: 4 pm	6:30 am – 9 am	6:30 am – 9 am	6:30 am – 9 am	6:30 am – 9 am	6:30 am – 9 am		
CHA 2 Eastside	**Warehouse** 2650 Slocan St. 604-254-2489	Lunch on Sun only							12:30 pm
CHA 2 Eastside	**W.I.S.H.** 320 E. Hastings St. 604-681-9244	**For women sex trade workers only** Dinner	Dinner 6 pm-8 pm	Dinner 6 pm-8 pm	Dinner 6 pm-8 pm	Dinner 6 pm-8 pm	Dinner 6 pm-8 pm		
CHA 2 Eastside	**Youth Action Circle** 342 E. Hastings St. 604-602-9747	**Youth only** Breakfast, lunch, dinner	8:30 am 12:15 pm 4:30 pm	8:30 am 12:15 pm 4:30 pm	8:30 am 12:15 pm 4:30 pm	8:30 am 12:15 pm 4:30 pm	8:30 am 12:15 pm 4:30 pm	8:30 am 12:15 pm 4:30 pm	8:30 am 12 pm

Vancouver Coastal Health
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FREE MEALS LIST FOR VANCOUVER

Serves Health Area	Location	Food type	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
City-wide	**Greater Vancouver Food Bank Society** 150 Raymur Ave. 604-876-3601 www.foodbank.bc.ca <u>Also supports:</u> **Downtown Eastside Community Kitchen Project (DECK)** Leo Ramirez, Co-ord. 604-876-0659, ext 120	3-4 day food supplement Access once per week only To receive food: attend one of the 16 food depots in Vancouver. Register with name, address, phone number and ID for all family members. Basics for Babies: 604-280-9370							
City-wide	**City of Vancouver Emergency Food and Shelter** After-hours phone line 604-660-3194								

Appendix D

Shelter Listings for Metro Vancouver
January 2010

- Greater Vancouver Shelter Strategy

Shelter listings for Metro Vancouver, as of January 19, 2010: Please print on yellow paper.
Updates at www.gvss.ca Shelters are 24 hour beds, 3 meals unless otherwise specified.

Shelters

Greater Vancouver Shelter Strategy

Adults (all genders)

Aboriginal Shelter (open through March 31, 2010) – 201 Central Street, Vancouver …….…… 604-720-9761
5:30 pm – 10 am. 2 meals. No alcohol/drug use on site. Pets allowed; carts allowed. Wheelchair accessible.

First Baptist Church - 969 Burrard Street, Vancouver ……..... ……..... 604-683-8441
Tuesday nights only. Meal at 9:00 pm. Shelter priority for under 19. No alcohol/drug use on site.

First United Church (open through March 31, 2010) - 320 East Hastings St, Vancouver…….…..604-681-8365
Beds, pews & floor. Wheelchair accessible. Carts allowed. Closes for 1 hour. Harm reduction.

Gateway - 10667 135A Street, Surrey…….…….. 604-589-7777
Supper. After 5:00 pm. No alcohol/drug use on site.

Grandview Calvary Baptist Church (open Thanksgiving to Victoria Day) – 1803 E. 1st Ave....604-255-1411
Thursday nights only. Open 6:30 pm, supper; out at 8:00 am. No alcohol/drug use on site.

Hyland House – 6595 King George Highway, Surrey..…… …….…….. 604-599-8900
Curfew. No alcohol/drug use on site. Laundry facilities. Wheelchair accessible.

Hyland House Cloverdale – 17910 Colebrook Road, Cloverdale……..….604-574-4341
Curfew. No alcohol/drug use on site. Laundry facilities.

Lookout Downtown - 346 Alexander, Vancouver ..... ……..... 604-681-9126
Pets welcome. Wheelchair accessible. Referrals to needed services. Harm reduction.

MPA Shelter – 1642 West 4th Ave, Vancouver…… 604-568-5213
Harm reduction; shopping carts and pets ok. By reservation; 2 meals.

New Fountain (open through March 31, 2010) – 51B W. Cordova Street..……..……..604-331-1246
6 pm – 10 am; 2 meals. Harm reduction. Pets allowed; carts allowed.

North Shore – 705 West 2nd, North Vancouver……..…….....…….. 604-982-9126
Wheelchair accessible. Pets welcome. Referrals to needed services. Harm reduction.

RainCity East Broadway Shelter (open through April 30) - 677 East Broadway, Vancouver …604-417-2615
Harm reduction; shopping carts and pets ok. Wheelchair accessible. By reservation; 2 meals.

RainCity Granville Shelter (open through April 30) –1435 Granville…….. 604-306-4798
Harm reduction; shopping carts and pets ok. By reservation; 2 meals.

RainCity Cardero Shelter (open through April 30) – 747 Cardero St, Vancouver……..…….. 604-512-7457
Harm reduction; shopping carts and pets ok. By reservation; 2 meals.

Salvation Army Anchor of Hope (open Nov. 1 through March 31) – 134 E. Cordova, Van…... 604-646-6899
11:00 pm to 6:30 am. No admissions past 2:00 am. Mats. Coffee/bun, showers. Wheelchair accessible.

Salvation Army Belkin House – 555 Homer, Vancouver……604-681-3405
Dorms. No alcohol/drug use on site.

Salvation Army Caring Place - 22188 Lougheed Hwy, Maple Ridge……..Day: 604-463-8296 ext 102
Night: 604-807-8290 Registration at 7:30 pm. Wheelchair accessible. Laundry. No alcohol/drug use on site.

Salvation Army Crosswalk - 108 W. Hastings, Vancouver .....……..... 604-669-4349
Open 10:00 pm. No admissions past 2:00 am. Coffee/bun. Wheelchair accessible. No alcohol/drug use on site.

Salvation Army Cross Culture (seasonal, through April) – 1648 East 1st Ave, Vancouver….. 604-255-4463
Tuesday and Wednesday nights only, 9:30 pm – 8:00 am. 2 meals.

Salvation Army Gateway of Hope (new) – 5787 Langley Bypass, Langley……604-514-7375
Wheelchair accessible. Referrals to needed services. No alcohol/drug use on site.

Shelter listings for Metro Vancouver, as of January 19, 2010: Please print on yellow paper.
Updates at www.gvss.ca Shelters are 24 hour beds, 3 meals unless otherwise specified.

Greater Vancouver Shelter Strategy

Adults (all genders - continued)

Tenth Avenue Church - 11 West 10th Avenue, Vancouver…….…….…. 604 876-2181
Monday nights only. Registration 5:30 pm, meal ticket at 6:00 pm. Wheelchair accessible.

Triage - 707 Powell, Vancouver ..... …..... 604-254-3700
Harm reduction; needle exchange. Medication administration. Wheelchair accessible.

Tri Cities Cold/Wet Weather Mat Program (seasonal, Nov. 1 to March 31) Rotating locations.604-830-1528
10 pm – 7:00 am. Clients bussed to & from shelter: call for pickup points. Hot snack, breakfast, bag lunch.

Yukon Shelter - 2088 Yukon Street (at 5th), Vancouver..... ….....…….. 604-264-1680
Wheelchair accessible. Small pets welcome. Referrals to needed services. Harm reduction.

Women / Families (Please note: these facilities are not transition houses.)

412 Women's Emergency Shelter - Downtown East Side ……..……..... 604-715-8480
Single women. 11 pm – 8 am. Showers, laundry, soup and breakfast. Harm reduction.

Bridge Women's Emergency Shelter - Downtown East Side 604-684-3542
Single women. Harm reduction.

Cynthia's Place - Surrey ……...……..604-582-2456
Single women. Harm reduction.

Fraserside Emergency Shelter - New Westminster 604-525-3929
Families and single women. No alcohol/drug use on site. Not wheelchair accessible.

Liz Gurney's – New Westminster……..……..604-524-0710
Single women and women with kids. Harm reduction.

Powell Place - **St. James Community Service Society** – Downtown East Side 604-606-0403
Single women and lesbian couples. Harm reduction.

Salvation Army Belkin House – Vancouver…...…….. 604-694-6623
Single women and women with kids (no boys over 13). No alcohol/drug use on site.

St. Elizabeth's - **St. James Community Service Society** – Mount Pleasant ……...……604-606-0412
Female-headed families, single women, and lesbian couples. No alcohol/drug use on site.
Pets welcome. Laundry. Wheelchair accessible.

Sheena's Place - Surrey 604-581-1538
Single women or with children. 1 family per room; singles share. Harm reduction. Laundry.

Umbrella - **St. James Community Service Society** - Downtown East Side 604-606-0365
Single women and lesbian couples. Harm reduction.

Vi Fineday - Kitsilano 604-736-2423
Male or female headed families, childless couples or single women. No alcohol/drug use on site.

Welcome House for Immigrants – 530 Drake St, Vancouver 604-684-7498
Families and singles - priority to newcomers. Apartments - fee for service. Call 9:00 – 5:00.

Shelter listings for Metro Vancouver, as of January 19, 2010: Please print on yellow paper.
Updates at www.gvss.ca Shelters are 24 hour beds, 3 meals unless otherwise specified.

Shelters

Greater Vancouver Shelter Strategy

Men

Catholic Charities Men's Hostel - 828 Cambie, Vancouver 604-443-3292
Open at 4:00 pm, vacate by 7:30 am. 11:00 pm curfew. Food voucher.

The Russell – 740 Carnarvon Street, New Westminster……..604-529-9126
Harm reduction. Referrals to needed services.

Salvation Army Beacon – 138 E. Cordova, Vancouver.. …….. …….604-646-6846
Wheelchair accessible. 10:30 pm curfew. No alcohol/drug use on site.

Salvation Army Haven - 128 East Cordova, Vancouver 604-646-6806
10:00 pm curfew. No alcohol/drug use on site.

Salvation Army Richmond House - 3111 Shell Road, Richmond 604-276-2490
No alcohol/drug use on site.

Salvation Army Stevenson House - 32 Elliot Street, New Westminster 604-526-4783
Single night stay - registration first come first served at 4:30 pm, out at 9:00 am. No alcohol/drug use on site.

Union Gospel Mission – 616 East Cordova, Vancouver 604-253-3323
8:30 pm – 6:30 am. Mats. No alcohol/drug use on site.

Youth (all genders)

ASH (Aboriginal Youth Safe House) - Vancouver..... 604-254-5147
16-18 years. 72 hours clean/sober, no alcohol/drug use. Hot meals.

All Nations Youth Safe House – Surrey ……..…..604-584-2625
16-18 years, self-referral. Curfew. 72 hours hard drug free. Goal oriented: out 9:00 am – 4:00 pm.

Covenant House - 575 Drake, Vancouver 604-685-7474
16-22 years. 3 meals. No alcohol/drug use 12 hours prior; no detoxing. Curfew. Structured service.

Dusk to Dawn – Directions Youth Centre, 1134 Burrard Street, Vancouver……..…604-633-1472
21 years & under, 4 pm – 12 midnight, hot meal 8:00 pm. No sleeping. Laundry, showers, doctor/nurse access. After hours emergency services program, midnight – 8:00 am, coffee and snacks. No sleeping.

Iron Horse Youth Safe House - Maple Ridge ……..…… 1-877-435-SAFE (7233)
13-18 years. Laundry, referrals. Structured service. Curfew. No alcohol/drug use.

Marc's Place – Southwest Vancouver (after 10:00 pm call After Hours, 604-660-4927)……..……604-261-7827
13-15 years. Referral via social worker or After Hours. Requires parent/guardian consent.
Family setting, serving teens not in care who ordinarily live in Vancouver, Richmond or North Shore.

North Shore Youth Safe House – North Vancouver……..…… 1-877-78-YOUTH (96884)
14-18 years. Hard drug free, goal oriented, self referral.

Walden Safe House – Vancouver…….. 604-877-1234
16-18 yrs. 3 meals. Hard drug-free. Goal-oriented.

Shelter Information - All Ages and Genders

Inform Vancouver – A region-wide referral line for shelter and other essential services……..604 875-6381

Prepared by the Greater Vancouver Shelter Strategy - www.gvss.ca
To report errors please email: james(AT)prattconsulting(DOT)ca
The GVSS receives core funding from:
BC Housing, United Way of the Lower Mainland, and the Vancouver Foundation

Appendix E

List of DTES Community Kitchens

- Fresh Choice Kitchens

DTES Community Kitchens
www.communitykitchens.ca

Program Name:	Vancouver Agreement Case Coordinator Program
Regional Location:	Vancouver Coastal Health Region
Agency:	Tradeworks Training Society
Focus:	Budgeting Skills; Cooking Skill Building; Grocery Shopping or Bulk Food Shopping; Low Income; Nutrition Education/Healthy Eating; Substance Abuse and Addictions; Unemployed

Program Name:	Community Cooking
Regional Location:	Vancouver Coastal Health Region
Agency:	Community Builders, Dodson Rooms
Focus:	Community Kitchens; Cooking Skill Building; Low Income

Program Name:	Community Cooking
Regional Location:	Vancouver Coastal Health Region
Agency:	Community Builders, Jubilee Rooms
Focus:	Community Kitchens; Cooking Skill Building; Low Income

Program Name:	Potluck Community Kitchen
Regional Location:	Vancouver Coastal Health Region
Agency:	Potluck Cafe Society
Focus:	Budgeting Skills; Community Kitchens; Cooking Skill Building; Nutrition Education/Healthy Eating

Program Name:	Community Kitchen
Regional Location:	Vancouver Coastal Health Region
Agency:	Downtown Eastside Neighbourhood House (DTES NH)
Focus:	Community Kitchens; Cooking Skill Building; Homeless/Underhoused; Low Income; Mental Health and Illness; Nutrition Education/Healthy Eating; Sex Trade Workers; Substance Abuse and Addictions

Program Name:	Downtown Eastside Community Kitchen Project
Regional Location:	Vancouver Coastal Health Region
Agency:	Greater Vancouver Food Bank Society
Focus:	Diabetes; Hepatitis; HIV/AIDS; Low Income; Mental Health and Illness; Substance Abuse and Addictions

Program Name:	Family Food For Fun
Regional Location:	Vancouver Coastal Health Region
Agency:	Ray-Cam Community Association

Focus:	Budgeting Skills; Cooking Skill Building; Families; Grocery Shopping or Bulk Food Shopping; Immigrants and Refugees; Low Income; Nutrition Education/Healthy Eating; Youth
Program Name:	Strathcona Community Cookery Project
Regional Location:	Vancouver Coastal Health Region
Agency:	Strathcona Community Centre Association
Focus:	Budgeting Skills; Community Kitchens; Cooking Skill Building; Developmentally Challenged or Physically Challenged; Employment and Career Skills; English as a Second Language (ESL); Families; Food Safety; Low Income; Nutrition Education/Healthy Eating
Program Name:	Aboriginal Diabetes Awareness, Prevention and Training Community Kitchen Project
Regional Location:	Vancouver Coastal Health Region
Agency:	Vancouver Native Health Society
Focus:	Aboriginals; Diabetes; Low Income; Meal Planning
Program Name:	CHIUS Community Kitchen
Regional Location:	Vancouver Coastal Health Region
Agency:	Community Health Initiative By University Students
Focus:	Community Kitchens; Cooking Skill Building; Meal Planning; Mental Health and Illness
Program Name:	DTES NH Nutritional Nexus
Regional Location:	Vancouver Coastal Health Region
Agency:	Downtown Eastside Neighbourhood House (DTES NH)
Focus:	Cooking Skill Building; Homeless/Underhoused; Low Income; Mental Health and Illness; Nutrition Education/Healthy Eating; Sex Trade Workers; Substance Abuse and Addictions
Program Name:	DERA Food Share
Regional Location:	Vancouver Coastal Health Region
Agency:	DERA (Downtown Eastside Residents Association)
Focus:	Children, Preschool; Children, School-Aged; Community Kitchens; Cooking Skill Building; Developmentally Challenged or Physically Challenged; Homeless/Underhoused; Low Income; Nutrition Education/Healthy Eating; Seniors

Appendix F

Food Security and Housing in Vancouver's Downtown Eastside

- Centre for Sustainable Community Development, SFU
Vancouver Coastal Health, Population and Health Team

Food Security and Housing in Vancouver's Downtown Eastside

Prepared by: Christiana Miewald, PhD
Centre for Sustainable Community Development, SFU

with research assistance from Katie Tweedie and John Hu

August 2009

Prepared for Vancouver Coastal Health, Population and Health Team

Contents

Executive Summary

The purpose of this report is to document the housing and food security needs of the hard to house population in Vancouver's Downtown Eastside and to provide population-specific suggestions for policies to address these needs. The intersection between food security and housing has seen an increasing amount of activity in terms of programming but little in the way of research or policy. The report provides three categories of evidence: 1) academic research findings regarding the relationship between food security and health among vulnerable populations, 2) interviews with residents of the DTES regarding the food security issues they face and 3) focus groups and interviews with food and housing providers in the DTES on what types of infrastructure, programming and building contexts are most critical for enhancing food security and housing in the neighbourhood.

Research findings on food security among vulnerable populations, such as the homeless, those with HIV/AIDS, drug users and people with mental and physical health issues, have found that these populations tend to suffer from micro and macronutrient deficiencies which contribute to higher rates of morbidity and mortality. In addition, some individuals may also suffer from the over-consumption of calories and fat, resulting in diseases such as diabetes and hypertension. Finally, the type and quantity of food consumed can also have an effect on mental status and behaviour. To date, interventions aimed at improving health and behaviour through food provision have focused on increasing the intake of specific nutrients such as omega-3 polyunsaturated fatty acids and folate, which have been found to improve mental health. Blood glucose may also play a role in self-control and therefore a low glycemic index diet may improve some behaviours.

Survey and interview results from residents of the DTES found that although access to food is generally not a barrier given the large number of food providers in the area, there are several conditions that contribute to food insecurity. These include problems accessing food on weekends, holidays and at night, when most food programs are closed. Other barriers are health problems that make accessing food difficult, such as mobility, mental health issues as well as drug addictions that reduce appetite and interest in food. Finally, housing or lack thereof can have an effect on food access. Those respondents who are homeless or marginally housed are the most dependent upon free or low cost food providers. Providing food in-house reduces the need to go outside of the building to access food and improves food security as well as mental and physical health.

Food and housing providers recommend that programs should be developed that provide nutritional support that is sensitive to an individual's needs and capabilities with the understanding that these will change over time. For those with severe addictions and/or mental health issues, this means on-site food provision. This can be accomplished through a cafeteria in the building or a food delivery program. It was also noted, however, that as people's physical and mental conditions improve, it is important to provide them with a range of options to access food, including in-room cooking facilities and/or community kitchens. Community kitchens can provide an important transition between reliance on food provision and cooking for oneself. They also provide opportunities to learn skills and socialize. Recommendations for in-room facilities are that there should be *at minimum* a bar fridge and a microwave. Having access to these items provides an opportunity for residents to store and heat meals. For individuals with greater interest in cooking for themselves, kitchenettes allow for greater autonomy. Finally, it is critical to pay attention to amenities available within the neighbourhood. Without easy access to free or inexpensive food in close proximity to their building, residents are likely to become more food insecure. A summary of the policy recommendations for housing and food security in the DTES are:

- All contracts for new or refurbished housing should include a plan for ensuring food security for residents. This plan should take into account the physical and mental health issues of the resident population as well as the available resources within close proximity of the site. Food programs within the building should be evaluated regularly to assess 1) whether they are meeting the nutritional needs of the residents, 2) whether the food is acceptable to the residents, and 3) if residents are obtaining new skills and knowledge through food programs (e.g., cooking skills through a community kitchen).

- Support food programs that deliver meals or provide meals in-house to improve access for those who have active addictions and/or physical or mental health issues that make accessing food providers or cooking difficult. Where appropriate and feasible, utilize a community development model that involves residents in meal planning and cooking.

- Make cooking facilities a part of basic housing infrastructure. At minimum, provide a refrigerator and microwave.

- In situations where in-room cooking facilities are not feasible, provide staffed communal kitchens where residents can plan meals and cook together on a regular basis.

- Make healthy food available with no barriers and where people are (e.g., the street) because the hard to house are often not housed.

- Promote greater linkages between harm-reduction and nutrition, as addiction is a prime contributor to homelessness *and* food insecurity.

- For housing outside the DTES, ensure that a range of free and low-cost food is easily accessible.

In addition, research should be conducted in the following areas to better refine these recommendations.

- What is the current nutritional status of residents of the DTES in terms of macro and micronutrient intake and how does nutritional status vary according to housing situation and drug use?

- What is the nutritional value of meals provided in the DTES in terms of macro and micronutrients? What types of foods might be beneficial for residents of the DTES given the current research on nutrition, health and behaviour?

- How can healthy food be provided at a cost that agencies can afford? There are a number of food programs that could be assessed regarding the potential cost-benefits of meal provision.

- What are the best models for food provision for those with addictions? The drug-induced anorexia is likely to have significant effects on the long-term health of these people. Finding a food provision model that works for them could result in significant savings of health care and other costs.

In order to assist researchers with examining the current literature on the relationship between housing, health and food security for vulnerable populations, an annotated bibliography on this topic has been created. For a copy, please contact

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Introduction and Background

The purpose of this report is to 1) demonstrate the relationship between food security and housing for vulnerable populations, 2) present an overview of the current state of food security among residents of Vancouver's Downtown Eastside (DTES), 3) provide models of food provision for those living in the DTES and 4) to present recommendations on the infrastructure, programming and building context for new or renovated housing for the individuals that are hard to house. The intersection between food security and housing has become an increasing concern, especially for those working with vulnerable populations, yet there remains little research or policy focus on the issue. In this report, the focus is on individuals who are hard to house, a population that have difficulty maintaining stable housing and therefore may be marginally housed or homeless. While this report focuses on a specific population, the research framework lends itself to other populations, such as seniors or low-income families.

Methodology

The methodology used in this report includes 1) article and document review on issues related to food security among individuals who are hard to house, particularly in terms of health, 2) focus groups and interviews with food and housing providers in the DTES and 3) structured interviews with residents of the DTES who are currently or have previously been homeless or marginally housed. The purpose of these interviews was to document the specific factors that contribute to food security within this population. This information was organized using a research framework (see Appendix A) that organizes the research into 1) framing, 2) context and 3) policy. The framing data, which focuses on the relationship between nutrition and health, helps to build the case that food is an important component of health for people with multiple barriers and that food provision is a cost-effective way to health promotion. The context data provides support for the argument that the "hard to house" population in the DTES is food insecure in very particular ways that can best be addressed by population-specific strategy. Finally, the policy-level information provides specific recommendations on how best to support food security through housing.

Background on Nutrition, Housing and Health

The following literature review outlines some of the nutritional and health issues that are of particular concern to individuals who are "hard to house". The term "hard to house" should be understood as a description of an individual's situation at a specific time and place and not a personal attribute. People who are hard to house in one situation may not in another. People considered hard to house often have "multiple challenges such as a severe mental illness or mental disability combined with a substance

addiction and a physical disability or illness such as Hepatitis C and HIV/AIDS. The combination of issues makes these people virtually ineligible for most social housing."[1] These conditions also mean that people are often "hard to feed"; paradoxically they often require *high quality* nutrition but often suffer from malnutrition.

Homelessness, the Marginally Housed and Nutrition

Homelessness is a major contributor to poor health outcomes. In general, the homeless tend to suffer higher than average rates of nutritionally-related disease, such as diabetes, anaemia, obesity, and hypertension.[2] This is in part due to their lack of regular access to nutritious food which leads to malnutrition and micronutrient deficiencies. For example, homeless youth in Ontario were found to have inadequate intakes of folate, vitamin A, vitamin C, magnesium, and zinc and, and females were also lacking vitamin B-12 and iron.[3,4] Other studies have found that, for the majority of homeless people, the issue is often not a lack of food, but a lack of access to nutritious food. One study found that 29% of the homeless were malnourished, 22.7% of the homeless were obese and almost one-third suffered from a nutrition-related disorder.[5] In a study comparing chronically homeless (homeless more than one year) to transitionally homeless (homeless less than one year), chronically homeless people exhibited a greater prevalence of eating infrequent meals, fasting, inadequate food, subsistence eating, and unaffordable food.[6] This suggests that the longer someone is homeless, the more likely they are to be food insecure. When comparing housed and homeless youth Tarasuk, Dachner and Li found that homeless males had lower intakes of energy and all nutrients, and homeless females had lower intakes of most nutrients. In addition, homeless females obtained a greater proportion of their energy from alcohol while homeless males consumed less energy as carbohydrate or protein, but more as alcohol, compared with housed males.[7]

There are a number of studies that have found that individuals relying on charitable food (e.g., food banks and free meals), whether homeless, living in shelters or in temporary housing are often not adequately nourished. Tarasuk et al. found that for street youth, 87% of males and 89% of females had made at least some use of charitable meal programs, with drop-in centres the most common source of meals.[8] Another study found that the dietary intake of female shelter residents did not meet USDA requirements. In particular, their percent energy gained from fat and their total daily fat intake exceeded the USDA recommendations, while consumption of fiber and fruits/vegetables fell below recommendations.[9] Another study from Ontario found that on average, charitable meals provided to

homeless people are below the average daily requirements in energy and nutritional content. Milk and fruits and vegetables are often lacking from these meals.[10] A study of homeless men who utilized soup kitchens found that 94 per cent suffered from lack of nutrients, resulting in weakness, fatigue, depression and other emotional problems.[11] Finally, a New York study of the marginally housed found that although most participants said that they could find enough to eat, their diets showed a high intake of sodium, saturated fat and cholesterol. According to the authors, these poor dietary conditions likely contribute to healthy and behavior problems.[12]

Mental Illness and Nutrition

Mental illness, including depression, schizophrenia, and bipolar disorder, is a prevalent problem for people who are hard to house. Mental health issues can give rise to behavioural problems, including antisocial behaviour, particularly for those with dual or concurrent diagnoses (e.g., also having a drug addiction). These behavioural issues may make it more difficult for this population to find stable housing and food, thereby increasing their vulnerability to additional health and social problems. There is growing evidence that, in particular, homeless people with mental illness suffer from more physical health problems, both acute and chronic. Sullivan et al. found that almost one in five people with mental illness reported problems finding adequate food. In particular, homeless people with mental illness were more likely to get their food from garbage cans or dumpsters. Moreover, when homeless persons experience difficulties accessing food or shelter, these needs generally demand their full attention and hinder them from seeking mental health treatment.[13]

Persons with serious mental illness are more likely to have other medical conditions than persons in the general population. The odds of diabetes, lung diseases, and liver problems are particularly elevated.[14] This may be in part due to metabolic disorders which include symptoms associated with obesity, dyslipidaemia, insulin insensitivity, and hypertension often found in people with psychiatric disorders. In addition, antipsychotic drugs have been associated to the development of obesity and metabolic disturbances such as diabetes mellitus, dyslipidaemia and increased coronary risk.[15] Finally, there is a relationship between bipolar disorder and eating disorders, in particular bulimia nervosa and bipolar II disorder, which may result in under-nutrition for this population.[16] Thus, nutrition is of particular concern for those with mental illness. However, people with mental illness are often unable to manage their nutrition due to a relative lack of shopping, cooking and budgeting skills and/or opportunities, and due to the substance abuse issues that are prominent in this population. These issues are compounded by underuse of services and food access problems among this population.[17]

Drug Addiction and Nutrition

Drug users are among the populations most vulnerable to malnutrition because of drug-induced anorexia, changes in dietary patterns associated with drug dependency and the related lifestyle, poverty and infectious disease.[18,19] In addition, one of the dangers of malnutrition among injection drug users (IDUs) is the increased risk of infection, including HIV.[20] One study found that among injection drug users, all anthropometric measurements, except height, were significantly lower, suggesting calorie and protein malnutrition as well as possible micronutrient deficiencies.[21] Malnutrition among drug users has been found to be more prevalent among the females and increases with more frequent drug use.[22,23,24] For example, Tarasuk, Dachner and Li found that among females, heavy drug use was associated with significantly lower intakes of vitamin B-6, folate, thiamin, niacin, magnesium, and zinc, and lower mean BMI.[25] The prevalence of malnutrition can be due to a number of factors. One survey of IDUs found that 52% reported that they did not have enough to eat because of a lack of money, 60% reported that they did not eat the quality or quantity of food they wanted because of a lack of money, and 65% reported not eating or drinking enough because of an extended drug 'run'.[26]

Drug use can also affect the quality or types of food consumed. Use of opiates tends to result in individuals replacing foods that are rich in fat and proteins with foods rich in sucrose and relatively poor in vitamins and minerals.[27,28] Heroin users have been found to have low intakes of vitamin A, iron, thiamin, ascorbic acid and calcium; low body mass index (BMI); protein-energy malnutrition; higher and delayed insulin response; and altered glucose tolerance and metabolism.[29] Nakha et al. found that among heroin users 45% were deficient in vitamin B6, 37% were folate deficit and between 13 and 19% were had thiamine, vitamin B12, riboflavin deficiencies.[30] Several studies have examined the nutritional intake of methadone users and found that there is a greater consumption of low-nutrition sweets and a lower intake of complex carbohydrates, fish and vegetable fats.[31] Those on methadone also had a significantly higher body mass than controls and had a high prevalence of a dental caries and chronic constipation. Finally, cocaine use has been associated with anorexia and eating disorders and may have influence energy intake, energy requirements or immunity that differ from the effect of opiates.[32,33]

HIV and Nutrition

Nutritional status is an important predictor of progression to AIDS and survival of HIV-infected patients.[34] The WHO recommends that a person with HIV must consume 10% more calories in the asymptomatic phase, 20 to 30 % more in the symptomatic phase, and 50 to 100% more in the symptomatic phase where there is accompanying weight loss.[35] There are a number of ways in which food insecurity affects the health of those infected with HIV, including malnutrition, reduced drug effectiveness and adherence, a compromised immune system and increased mortality. Food insecurity can result in malnutrition, which can increase susceptibility to and exacerbating the effects of HIV/AIDS.[36] In addition, several protease inhibitors require food for maximal absorption, and the absence of food may negatively influence the effectiveness of these drugs. However, studies have found that HIV-positive individuals who were severely food insecure are less likely to adhere to their medication, which increases their risk of secondary infections.[37] Finally, individuals who were food insecure and underweight (BMI <18.5) were almost twice as likely to die as those who were neither food insecure nor underweight.[38] Even a 5% weight loss over a 6 month period has been shown to increase mortality. Tang et al. conclude that "attention to weight loss in the current HIV climate, where patients are maintaining more normal clinical status, remains important."[39]

The rate of food insecurity among those with HIV/AIDS in North America varies. Studies in BC have found between 52% and 70% of HIV positive individuals to be food insecure. In these studies food insecurity was associated with low-income, a history of injection drug and/or alcohol abuse, and living in *an unstable housing situation* and having a lower CD4 cell count.[40,41] One Ontario study found that 57% of people with HIV experienced difficulty in buying enough food over the previous year and 57% received food bank services in the previous 3 months.[42] Finally, another Vancouver-based study found that food security and stable housing are linked to better clinical outcomes among individuals receiving highly active antiretroviral therapy (HAART). The authors conclude that "This suggests that food security and stable housing may be important neighbourhood-level risk factors for poor treatment outcomes for people living with HIV/AIDS and should be considered in the implementation of drug treatment programs."[43]

HIV, Drug Use and Nutrition

Because injection drug use is a risk factor for HIV infection, the co-occurrence of HIV and drug addiction is high. The B.C. Centre for Disease Control estimates that approximately 30 to 40% of IDUs in the DTES

have HIV. The combined issues of drug use and HIV infection can further exacerbate nutritional deficiencies and weight loss. HIV-related wasting continues to occur among HIV- infected drug users, even among HAART recipients.[44] For example, involuntary weight loss of more than ten pounds in the previous six months was self-reported in 5% of HIV negative drug users and 16% of HIV positive drug users, suggesting that drug use compounds nutritional problems in persons infected with HIV.[45] One study found that BMI was lower among HIV positive drug users than for HIV positive non-drug users, and was lowest in cocaine users.[46]

BMI has also directly associated with CD4 count, which can indicate lowered ability to resist infection. Quach et al. conclude that "HIV-infected cocaine users may be at higher risk of developing malnutrition, suggesting the need for anticipatory nutritional support."[47] Another study of HIV-infected drug users found that food insecurity and viral load were the only independent predictors of wasting.[48] The danger is that drug users with HIV may have difficulty maintaining or regaining weight following bouts of illness, putting them at risk of mortality. There is also evidence that IDUs with HIV may suffer from nutritional deficiencies. This is a concern because micronutrients such as vitamin B-12, zinc, and selenium have been associated with mortality risk in HIV-positive populations.[49] The diets of both HIV positive and negative IDUs have shown low plasma levels of vitamins A, E, and Bs and zinc. In particular, vitamin A was consumed below the RDA levels. The low intake may be of special concern for HIV positive individuals, because low levels of serum vitamin A have been associated with more rapid HIV disease progression and decreased survival.[50,51]

Other Nutritionally-Related Chronic and Infectious Diseases

There are also a number of chronic and infectious diseases which are directly and indirectly affected by diet. Within Vancouver, the Downtown Eastside (CHA2) has the highest rates of nutritionally-related disease including colorectal cancer, diabetes, and diseases of the circulatory system.[52] These conditions may be in part a result of the diet. Homeless people who eat shelter-provided meals have been found to have high rates of hypertension and obesity and diets containing high amounts of saturated fats and cholesterol.[53] Being overweight is a contributing factor to Type 2 Diabetes, which is associated with complications that include coronary heart disease and kidney, nerve, and retinal damage. Aboriginal people are particularly vulnerable to food-related disease because of their socioeconomic status, typically poorer access to health care, and their predisposition to diabetes. Another disease closely linked to diet and/or nutritional deficiencies is cancer. Studies have linked the consumption of fresh

fruits and vegetables to a decrease in cancers of the lung, esophagus, mouth, stomach, colon, and pancreas.[54] Finally, tuberculosis has been associated with malnutrition and nutritional deficiencies, especially among those with HIV/AIDS.[55] In 2006, the rate of tuberculosis infection was 36 per 100,000 in the DTES, which was double that of any other area of the city.[56] Improved nutrition may help alleviate these conditions, improve the quality of life for residents and ultimately reduce health care costs.

Nutritional Interventions

Nutritional interventions—providing or promoting enhanced nutrition in order to improve health status—have been used in a variety of research and applied settings. There are numerous suggestions for addressing the nutritional issues described above. In general terms, Davis et al. makes the following recommendations about the quality of food served at charitable programs, such as shelters and soup kitchens: 1) Serve a variety of nutritious, tasty foods low in fat, high in fiber, and skillfully prepared, seasoned, and presented; 2) Encourage collaboration among clients, chefs, administrators, and food bank managers to acquire more nutritious donations and emphasize nutrition improvement as a fundraising priority; 3) Develop a chef training program to teach cooking and catering as a job skill and to operate a catering business with profits designated to improve shelter meal quality; 4) Create a community garden to grow fresh fruits, vegetables, and herbs for food preparation and resident participation in food production; 5) Establish a community kitchen with storage space for personal groceries, thus encouraging greater resident autonomy in food preparation and choices and meal in times/locations; 6) Distribute meal vouchers and bus tokens for occasional visits to nutritious restaurants.[57] There are also recommendations for nutritional interventions among specific populations. For those with HIV/AIDS, Godfry notes that, "Ensuring that patients have adequate meals during an extended course of treatment in the outpatient clinic or that dieticians have meals available in group settings or through home-delivery services may be the most appropriate nutrition intervention in these high-risk patients."[58] Additional recommendations for addressing these issues include increasing the intake of fruits, vegetables, and milk or milk products to ensure diet adequacy for this population and the creation of culturally appropriate nutrition interventions incorporated into drug treatment, HIV/AIDS prevention, street health outreach, syringe exchange, homeless shelters, drop-in centres, and other programs that provide services to IDUs.[59]

Nutritional interventions can also include targeting specific nutrients. There is growing evidence that nutritional intake can have a significant effect on mental health status. For example, the consumption

of omega-3 fatty acids, as well as some vitamins and minerals have been found to be related to improved mental health and behaviour. While none of the nutritional interventions can be recommended as the only treatment, they may play an important role in improving mental health status, particularly for people who are malnourished or are not willing to take other medications.

One promising area of research has focused on fish consumption, and specifically on the intake of omega-3 polyunsaturated fatty acids often found in oily fish and some vegetable oils. Several studies conclude that fish consumption is significantly associated with higher self-reported mental health status and fish oil.[60,61,62] Fish oils have also been shown to reduce aggression.[63] Buydens-Branchey suggests that low levels of some polyunsaturated fatty acids contribute to aggressive disorders. For example, a comparison of the levels of aggressive and non-aggressive cocaine users found that aggressive patients had significantly lower levels polyunsaturated fatty acids in their bodies.[64]

Vitamin and mineral deficiencies may also have a negative effect on mood and behavior. Deficiencies of folate, vitamin B12, iron, zinc, and selenium tend to be more common among depressed than nondepressed persons.[65] In particular, folate deficiencies may lead to an increased risk of depression and poorer antidepressant treatment outcomes, as well as an increased risk of dementia and folic acid supplements each have been used to successfully treat depression and self harming behaviours.[66,67] Furthermore, low selenium (an essential micronutrient found in nuts, cereals, meat, fish, and eggs) is associated with depressed mood, anxiety, and cognitive decline.[68] Selenium therapy has been found to decrease anxiety in HIV+ drug users who exhibit a high prevalence of psychological burden.[69] In addition, multi-vitamin and mineral supplementation can decrease the incidence of violent and non-violent anti-social behaviour.[70] Bodnar and Wisner conclude that, "Greater attention to nutritional factors in mental health is warranted given that nutrition interventions can be inexpensive, safe, easy to administer, and generally acceptable to patients."[71]

Finally, researchers have found a link between glucose levels and self-control behaviours including stress, impulsive actions and criminal and aggressive behaviour. According to Gailliot and Baumeister, "It is possible that part of the well-established link between poor self-control and criminality may be exacerbated by poor dietary habits."[72] Problems with self-control are more likely when glucose levels are low from either a lack of food or eating food with a high glycemic index. Foods with a high glycemic index, such as white bread, potatoes, and processed cereals, quickly raise blood glucose prompting an

insulin response to reduce the level of glucose. The result of eating high glycemic index food can be low blood glucose levels. In addition, alcohol reduces glucose and impairs self-control. Therefore, a poor diet combined with alcohol consumption can result in low glucose levels and problems with self-control. Furthermore, problems with self-control are most likely later in the day when blood glucose levels are lowest. Restoring glucose to a sufficient level typically improves self-control. Many of the foods currently being served in the DTES, such as white bread and donuts, have a high glycemic index. Increasing the availability of low glycemic index foods, such as fruit, vegetables, whole grain bread and low-fat dairy, may help with behavior control.

Housing and Food Security for the in the DTES

Food security can be defined as: "when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food which meets their dietary needs and food preferences for an active and healthy life."[73] There is currently little known about the relationship between food security and housing among individuals who are hard to house. While there has been research on the food security status of homeless populations, less has been written about those who are marginally house, for example, living in SROs or similar conditions. Nor has there been much research on the relationship between housing and food security. There is abundant research, however, to suggest that housing positively influences health status and a few studies have found a correlation between food insecurity and unstable housing.[74,75] Yet, there are a number of questions that have not been addressed in the literature. For example, are people who are adequately housed more food secure? What kinds of food programs work best for populations in who are hard to house and how can providing food and housing together improve health? While the literature on providing housing mentions food as an important "hook" for attracting and engaging with clients, there are typically no specific recommendations about how this food should be provided.[76]

There are approximately 16,000 residents of the DTES, many of whom are homeless or living in unsupported SROs. Approximately 13% of this population is "in crisis" meaning that they have no permanent home, have behavioral and health problems and are not well connected to services.[77] The *Downtown Eastside Demographic Study of SRO and Social Housing Tenants* provides an even more detailed socio-demographic and economic profile of residents living in DTES SROs. Its findings conclude that residents of SROs tend to be male, Caucasian and live in single person households. Approximately half (52%) had previously been homeless, approximately one-fourth (28%) assessed their health as poor or terrible; and the majority (79%) reported health concerns. In terms of health status, 22% of SRO residents indicated that they suffered from HIV/AIDS and/or Hep C and/or TB and 30% had a mental illness.[78] A survey of residents of the Portland Hotel found that 34% have a diagnosed mental illness, 33% are HIV positive, 88% have a drug or alcohol addiction and 73% are injection drug users.[79]

Among the homeless population, men also make up the majority, they are also predominantly single.[*] The majority of the homeless population has at least one health problem; 33% percent of homeless had

[*] These statistics are for the homeless population throughout the entire Metro Vancouver region, not only the DTES.

a mental illness, 46% had a physical health conditions and 61% reported a drug addiction.[80] Public health personnel interviewed for this report noted high rates of cancer and uncontrolled diabetes among the DTES population. In short, these statistics suggest that both the marginally housed and the homeless in the DTES suffer from a number of conditions that affect their food security status

Within the DTES, there are several types of housing and shelter. This includes seasonal and all year shelters that provide at minimum a place to sleep and one to two meals for those that stay there. There are also a number of Single Room Occupancy Hotels (SROs). SROs typically consist of one room about 10 x 10 feet, with shared bathrooms and cooking facilities. SROs that are managed by non-profit societies often provide better maintained facilities than those of unregulated providers.[81] While some privately-run hotels are in poor condition and lack services or amenities, those run by non-profits often provide services or links to services within the community. These units also tend to be better maintained. For example, when PHS renovates a hotel, they make every effort to include a bathroom and kitchen in the rooms.[82] Many SROs managed by a non-profit society have adopted a "housing first approach", which is focused on providing housing before other services and is low-barrier. Some of the SROs in the DTES also serve as supported housing, in which services are made available for individuals who have serious, persistent issues that may make them vulnerable to homelessness including drug addiction, mental and physical illness or disability (see Appendix B for a list of supportive/low-barrier housing mentioned in this report). . There are also residential treatment facilities that provide both housing and a meal program. These programs are typically time-limited and residents must find other accommodations once their treatment is finished.

Interview Results with DTES Residents

The following section provides the results of structured interviews conducted with 47 individuals who participate in the Lifeskills Centre or who reside in one of PHS Community Services' hotels.[†] The Lifeskills Centre is a low-barrier resource centre providing job training, community kitchen groups, free laundry, showers, internet and phones. The purpose of the interviews was to gather information on the food security issues that affect this population, many of which are or have been homeless or marginally housed. The findings suggest that housing plays a key role in overall food security. Those without housing or were marginally housed without access to an in-house meal program or cooking facilities were most reliant on charitable food providers. This reliance means that they are not necessarily able to access the food when they needed it. This is particularly true for individuals addicted to drugs who may not be able to stand in line-ups or attend meal programs at particular times. Having access to food where they live can improve overall nutrition, behaviour and well-being.

Interview questions included basic demographics (gender and age), chronic health conditions, history of drug use, current and previous housing situation, where individuals access food, ease of access, and their opinions regarding the quality of food provided in the DTES. If those interviewed had a history of drug use and/or homelessness, they were asked to talk about food access during these times and if they differed from when they were housed and/or not using drugs. Interviews took between 10 and 40 minutes and were recorded, transcribed and categorized into themes. The names or any other identifiers are not included in this report to protect the confidentiality of respondents.

Demographics

The majority of those interviewed were Caucasian men, although efforts were made to include women and representatives from other ethnicities (see Figure 1). The average age of the participants is 42. A number of respondents reported having a health problem, including Hep C, mental illness, arthritis or other mobility issues, HIV/AIDS, and digestive disorders. In addition, 89% reported current or former drug use. The most commonly used drugs were cocaine/crack, heroin, crystal meth, alcohol and marijuana.

[†] This sample is not intended to be representative of all residents of the DTES or the hard to house. For example, those with severe mental illness were not included in this survey. Rather, the intention is to reflect *some* of the realities for *some* residents of the neighbourhood.

Figure 1

Gender	**Number**	**Percent**
Male	31	66%
Female	16	34%
Total	47	100%
Ethnicity		
Caucasian	24	51%
Aboriginal/Metis	16	34%
African/African Decent	4	9%
Latino	3	6%
	47	100%

In terms of their current housing situation, 55% are living in an SRO, 23% have no fixed address (either they are living on the street, in a shelter or 'couch surfing'), 15% are in a supported SRO or treatment facility and 6% are in an apartment. Overall, this sample reflects the diversity of housing situations that are experienced in the DTES. While those living in apartments or treatment facilities may no longer be defined as "hard to house", all had been homeless in the past and were included in this study because they represent a population that has moved from being very housing insecure to relative stability. Housing instability is one of the defining features of the "hard to house" population. In this sample, 85% of respondents had experienced at least one period of homelessness and, for many; their time in the DTES is typified by a series of SRO rooms interspersed with homelessness and/or time in a treatment facility. For example, of those currently living in an SRO, 73% had been there for less than 1 year.

Where Food is Accessed

Food security is comprised of a number of different factors, including how available and accessible food is within a given community. In terms of food availability, the DTES can be viewed as a "high resource" food environment, with some 50 different organizations offering free or reduced-cost meals. At the same time, there are high rates of food insecurity within the DTES, creating a contradiction between

food availability and food security. This section describes the various ways that respondents said that they accessed food.

When asked where they eat most of their meals, the majority of respondents (59%) reported using the free or low-cost food providers in the neighborhood. One respondent described their typical day,

> "I start the morning at eight thirty at United Church. They serve you vegetables and soup. And then somehow I end up here (Lifeskills) at ten o'clock and eat here. The food here is good and it's filling. Then I go next door to the Lookout, and then I go to the United Church or Union Gospel [Mission]. It's the "Hasting Shuffle," there's a lot of places to eat and some of them aren't that healthy but most of them are."

Another 13% said that they utilized food programs and their own cooking facilities equally, while another 13% reported that they primarily cooked in their residence. Those living in a supported SRO or treatment facility had three meals provided for them and therefore ate exclusively at that location (15%). Almost all respondents used free or low-cost meal providers at least some of the time with the exception of those in a treatment facility. Among the most commonly cited locations to access food are the United Gospel Mission (UGM), Lifeskills Centre, First United Church, the Sisters of Atonement, and the Evelyn Saller Centre ("the 44"). Respondents particularly liked the Evelyn Saller Centre because they were able to choose what they wanted from a selection of items rather than simply being given what was available. This issue of choice is a critical one to creating a food program that meets the needs of different populations within the DTES.

When asked about other sources of food, 19% said that they used a food bank. Food bank use was usually infrequent because in 2008 the Vancouver Food Bank closed its DTES depot, yet some programs still provide food bags for their clients or in exchange for volunteering. 53% had attended a community kitchen. Finally, 83% reported shopping at least occasionally for food. Purchasing food may be a strategy preferred by some groups. For example, Gaetz et al. note that among homeless street youth in Toronto "food purchasing was preferable [to charitable meals] because it gave them a choice over when, where, and what they ate…"[83] In the DTES, low-cost food is available from a number of stores such as Quest, the Washington Community Market and Sunrise, all of which respondents who shop for

groceries reported using. In addition, food can also be purchased on the street for relatively little money.

Restaurants in the DTES are also an important place for accessing food. 63% said that they occasionally ate at restaurants when they had the money. Most commonly cited were Flowers Café, pizza shops and McDonalds. Flowers Café was chosen because it serves large portions at an inexpensive price. Residents report that they prefer to go to a restaurant if they have money because they get better food and can order what they want. Restaurants also serve as an option for those who have money from working in the informal or underground economy, but for whatever reason do not want to stand in the line-ups.

> "A lot of the working girls eat restaurant food. They get their payoffs on a daily basis and they don't have the time or the patience [to stand in line]. A lot of the working girls, they have issues with standing in line where everyone can look at them and judge them. That's why a lot of them eat at restaurants…'cause they can afford it."

Being able to go to a restaurant is also a form of empowerment. According to one community advocate in the DTES, "There is the dignity of being a real customer and that someone is there to cater to you. It's an issue of power relations. Being able to afford a meal is good for people's self esteem." In addition, restaurants are part of the economic vitality of the neighborhood and they are places where various populations within the community can interact. While they serve a diversity of people, many try to cater to those who have limited funds.

There are also a number of alternative ways that respondents said they accessed food, including trading, sharing, stealing and getting food from bins.

> "If you don't have any food and you have the drugs, people will trade. See, like I had the drugs and they had the food or it was the other way around, they had the drugs and I had the food. So they were hungry and I needed my fix for the day, so I traded with them and it turned out good. He got full and I got what I wanted. And if we didn't have anything like that here, we would probably starve and die from all the drugs."

> "Like the week before welfare, we go through our fridge and cupboards and stuff that we've collected from food banks or Loving Spoonful [and if we won't eat it]…we give it away."

> "I've been doing dumpster diving for years. Well, [a fast food chain] and stuff like that, they throw out stuff every night and they usually put it beside the garbage too for you and they usually have it all wrapped up for you too. Mainly downtown here, and [a coffee chain] they do the same thing sometimes they'll wrap up stuff and put it near the bins for you."

In the next section, the report provides information on the various factors that can affect food security in the DTES. These include 1) how food is provided, 2) health and other conditions that influence if and how food is accessed, 3) food quality—is it acceptable and healthy? and 4) housing conditions.

Food Provision and Barriers to Food Security

When asked if it was easy or difficult to get enough to eat on a typical day, 83% of the interview respondents said it was easy. Respondents frequently said that there is generally enough food in the area, "you can't starve in the DTES", especially when compared to other cities in BC. At the same time, there are gaps and restrictions within the current system. Saturdays, Sundays, long weekends, the week before welfare Wednesday (especially in a long month) and night-time were noted as being difficult times to find food. For example, while there are meals provided on the weekends, there are fewer available, which increases the demand on those providers who do offer food on those days.

> "Yesterday it was difficult for being a holiday, long weekend. There were four places that hand out food were shut down because of the holiday. It was hard to get some decent food because that means all the other food line-ups are doubled up and they run out."

> "Near, close to welfare. Like all this week, when it's a 5-weeker [it's hard] because the welfare is only geared for 4 weeks. So a 5-weeker is when the line-ups are long, long, long. [I think] 'Well I'll just go home and have bread.'"

Those with physical or mental limitations may find it difficult to stand in line. There is also the threat of violence and harassment within the line-up, which is particularly difficult for women.

> "I don't go to [free food provider] because it's too rough in the food-lines. At 3 in the afternoon, they're burned out, they're tired, they're angry."

> "You spend so much time in line, it's awful. Places that are open all day [are better] cause when people stand line, there are fights in the line, it's horrible."

Some food providers have restrictions on behaviour and will either ban individuals from using the service or will stop serving food.

> "At [free food provider], if there's an incident 20 people ahead of you, one person's acting up, the whole line gets shut down. Nobody gets nothing, they just close the door."

Another deterrent to food access are restrictions that some food providers place on individuals that are under the influence of drugs or alcohol.

> "The problem is that if you're hungry, you're hungry. If you happen to be fucked up at the time, at least they're trying to get something to eat but [low-cost meal provider] is really bad for [barring people on drugs]. My partner went there on prescription medication and they're like, "you're drunk" and she's like "I don't drink". They're like "no, you're drunk, get out"."

> "Everyone is in a vulnerable position to begin with then you add on no sleep and drugs and whatever and you have created the most vulnerable person and you're denying them service. That's just fucked up".

When asked why they chose certain places to eat over others, most respondents said that it was because they were comfortable in that location and/or it was a place where they could access other services such as laundry or a shower. For individuals who are hard to house, that is most often places with a "no barrier" approach to food provision. In addition, women were inclined to prefer "women only" food providers as they protected them from harassment and generally had a calmer environment than places open to men. At the same time, being treated badly or being judged was a reason not to use a particular service.

> "If you go there [women only service provider] as transgender you have to be identified as a woman. You have to look like a woman. You can't go there with a shadow showing. A few times I went with my shadow showing and they told me that I could not eat there. You have to be dressed up to be going out, you can't just go in there and say, 'I work as a transgender.'"

Respondents also noted that the practice of "red zoning" constrains their ability to access food. "Red zoning" involves restrictions put on people by the police after they have been arrested. The intent is to keep them away from "triggering" (typically areas where there is a high degree of drug trafficking or prostitution) areas of the city but these restrictions often exclude them from areas where food and other services are available.

> "Even if you're in a food line-up across the street getting a sandwich and a coffee and that's your red-zone, they'll pull you out of the line."

Health-related Conditions that Affect Food Security

There are also a number of health-related conditions common in the DTES that affect diet. These include dental problems, which make eating hard food difficult, digestive diseases such as colitis and inflammatory bowel disease that can restrict diet, and mental health issues that make it difficult for people to eat around others.

> "We get a lot of apples down here but a lot of people don't have teeth or they have partial plates or whatever and a lot of them can't eat apples so they need a lot more softer fruit."

Being HIV positive also influences diet. Some respondents said they need a full stomach in order to take their medications while others noted that they need more energy and their metabolism seems to have "sped up" because of either their medications or the disease itself.

Finally, addictions to drugs often resulted in severe and profound food insecurity. This was particularly true for those using cocaine. All respondents who reported using cocaine said that their diet was significantly worse and they ate fewer meals when they were using than when they were not using. Respondents noted that when they were using drugs, their appetite decreased markedly and they were less concerned with eating and drinking; often missing opportunities to access food from providers.

Those with addictions also said that they were often too busy trying to get money for drugs to stand in the food lines. This resulted in weight loss, anorexia, malnutrition and dehydration.

> "Sometimes I'd go 7, 8, 9 days without a meal. I'd eat candy, dope and booze and that would be it, for days and days. 'Cause with the dope, you don't need anything. Your body doesn't want for anything."

> "Honestly, I'd be lucky if I ate an actual meal every three days. Yeah, I'd steal little bits, a chocolate bar, very unhealthy but actual cooked food very seldom. Even though there's lots here, I wouldn't have the time 'cause I'd always have to be making money for heroin. You can't take a day off, it's a full-time job."

When individuals stopped using drugs, they reported that their diet improved and their weight increased.

> "I've come off powder [cocaine], I've come off rock [crack cocaine]. So my diet has changed 'cause I eat now and before I didn't eat. I would eat maybe one [meal] every couple of days. It's crazy, with addictions you totally forget about eating and you totally forget about drinking something. I went down to 98 pounds…"

In addition, those using drugs are also less likely to purchase food. Food line-ups, community kitchens and fast food become a critical source of food for this population.

> "People are drug addicts down here. They don't want to spend their money on groceries. They spend their money on a 10 dollar toot and get a piece of pizza afterward."

> "I spend all of my money on drugs. Whenever I get money, I spend it on drugs. I need to have meals like this [community kitchen] and the line-ups just so I eat. I never have money to buy groceries and I hate cooking."

A few respondents said that they were aware of the problems of severe weight loss and dehydration while using drugs and had developed strategies to try to avoid the worst effects. This could include

drinking Gatorade or Ensure to avoid dehydration or buying food to ensure that they had something to eat if they weren't able to access food providers.

> "Once I touch it, the food doesn't matter. That's why I try every month I go and do my groceries first off for stuff for the month like powered milk and canned stuff and peanut butter so that I have enough through the month."

> "I take a lot of vitamins myself too and drink a lot of Gatorade if I'm on a long jag smoking crack. You've got to keep your body hydrated. You gotta make sure, even if you're losing the weight, that you're getting essential vitamins and stuff you need 'cause that's what will cause more long term damage or problems with mental breaks."

> "I would try to eat once a day and I was drinking a lot of Ensure. I would go to the 44 and order a double but I could never finish it all because I was too impatient to get back to work. But it was really difficult to make myself eat because I was never really hungry. In the past, I would binge for a day or two and then afterwards I would eat non-stop as much as I could for a few days to replenish what I'd lost, but the [last] binge never ended."

In addition, many of the food providers serve extra meals prior to welfare Wednesday in order to ensure that people are nourished.

> "Day before welfare day [is good] because they know that everybody gets their welfare cheque tomorrow. So for 3, 4, 5 days nobody will eat because they have money for dope. So all these places they know that so they try to fill them up today so that they have food and vitamins in their stomach."

However, the cycle of drug induced anorexia and eating large quantities of food before and after the drug binge, can result in disordered eating.

Food Quality

When asked about the quality of food they received, the majority of respondents said that it was "good" both in terms of taste and healthiness. At the same time, respondents commented that their diet was often monotonous, being heavy on sandwiches, pastries and bread.

> "Their hearts are in it but the food is not the best…We get a lot of peanut butter. Most of us are sick of peanut butter. But like I said, their hearts are in it and if you get hungry, you eat. "

> "You get a lot of bread. I eat a lot of bread. It's better than nothing but it gets monotonous and I'm not sure how healthy it is to just fill up on bread."

> "I could do without sandwiches for a while. Maybe if they could serve something else. But it's low-cost and it's easy on people's budgets so you can't complain. Beggars can't be choosers."

One respondent noted that constipation is a perennial problem for those who use drugs and additional fibre in the diet may be of benefit.

> "The diet that I was eating primarily at [low-cost food provider] is not really a high fiber diet. It's a little bit greasy, it's a lot of processed, overcooked food…They don't need to have such a high fat, high protein diet for every meal. There's bacon and eggs and these big pancakes. A lot of bleached flour, there's no real fiber in any of it. You can ask for brown toast but I'm pretty sure it's wonder bread. It not really the healthiest diet but it's better than no diet."

Some also felt that the food they received lacked high enough proportions of meat, as well as of fruits and vegetables, although a number commented that the quality of food had improved over the past few years.

> "For free food and donated food, wow it's a far cry from the old days. There's a lot more fruit and vegetables coming out."

Among those that received the highest marks for good food were UGM, Lifeskills and the Evelyn Saller Centre. Women also reported that the food was better and healthier at "women only" places.

> "Just about all the women's places give fruit and vegetables with their meals, that's why it's good to eat at those places because they don't really care about doing it at the men's places because a lot of the men will throw the vegetables away and throw the fruit away. They only want the meat and potatoes."

When asked about fruit and vegetable consumption, most respondents said they ate these nutritious foods between once and twice a day. These items would either come through meal programs (e.g., vegetables in soup or salad) or occasionally from purchasing fruit from the local stands (e.g., Sunrise market). While it is beyond the scope of this research to evaluate whether or not this population is meeting the recommended intake of 7 to 10 servings of fruits and vegetables per day, it is likely that a significant proportion are not. This is particularly true for those who had reduced dietary intake due to their addictions.

Finally, access to water is another issue faced by the homeless and marginally housed.

> "I find a lack of water down here. I've heard that from a few people. Your body is like a motor and if you don't give it water it seizes up, eh. And my body is seizing up 'cause I don't drink enough water. "

Food providers noted that residents would typically drink coffee or tea, which are dehydrating and that access to water is limited. Similar findings of chronic dehydration have been made in Toronto among street involved youth.[84]

Housing and Food Security

Finally, housing conditions can have a significant effect on an individual's food security. Factors such as cooking and food storage facilities, as well as the building's safety and cleanliness, can all contribute to a person's ability to access food. In this study, 77% of respondents reported that they had some access to cooking facilities, either in their room/apartment or shared kitchen in their building. 11% had a full kitchen, although these were primarily respondents who were living in an apartment. Of those that had access to cooking facilities, 72% of respondents said that they used them at least once a week. Commonly prepared foods were rice, potatoes, pasta and hamburger. Even in situations where people

only had a fridge and a microwave, they were used to store and heat meals obtained from food providers, which is a benefit when food providers were closed.

Homelessness

Homelessness can have a number of detrimental effects on food security. Lack of access to cooking and food storage means that homeless individuals are more dependent upon food providers. During bouts of homelessness, some individuals reported that their drug use increased in order to deal with the discomforts of living on the street or in shelters. This, in turn, which further decreased their food intake.

> "When I was homeless, the problem was because I was homeless I was getting high and drinking a lot and I missed the meals because I didn't show up at the right time or whatever so I'd go without food a lot longer."

Having access to housing allows people greater flexibility in their ability to manage their own diets.

> "Having a home, a place to stay and be healthy and to store food [is important]. Like before I weigh 190 lbs now and before when I was homeless I weighed 135. I was very, very skinny. Very not healthy. Yeah, there's a big difference. Basically getting rest. Being able to wake up in the morning and eat. If we're sick, we're able to stay home and take care of ourselves. Prior to having a place, it was very bad."

Compared to those with stable housing, access to cooking facilities is quite different for homeless people. Only 2 homeless respondents reported having access to cooking facilities; one individual had a camp stove and the other had a shared kitchen at the shelter where they were staying. Storing food is also impossible on the street or in a shelter. In shelters food and other personal items may be stolen so residents rarely bring in more than snacks.

> "I buy munchies for myself and take it to the shelters but it's really bad because people take things that aren't theirs."

While those residing in shelters may have better access to food than those on the street, they are still more vulnerable to food insecurity than most who are living in an SRO or other housing.

SROs

For those living in SROs, there are considerable challenges, including the lack of cooking and storage facilities and pests. A 2005 survey of SROs in the DTES found that only a small percentage had contained housekeeping rooms (although the facilities varied), or communal kitchens. The majority allowed some type of cooking in their rooms, yet it was often up to the resident to supply a hotplate or other cooking device (microwave, toaster or rice cooker).[85] The lack of cooking and other facilities in many privately run SROs forces people into streets, which in turn, contributes to drug use and social disorder.[86]

For the population surveyed for this report, there was a range in the quality of living conditions within their SRO. In those SROs that are managed by non-profits, facilities are generally well-maintained and there may be some services provided. Unregulated SROs, those which are privately run, typically offer no services or building maintenance. In terms of access to cooking facilities, 92% of those living in an SRO said that they had access to cooking facilities and 92% had a fridge in their room (often a small bar fridge), 50% had access to a microwave, 38% had a hotplate, and 23% had a shared kitchen in their building. Access to cooking facilities was often dependent upon the type of SRO; newer buildings (e.g., the Lux and the Pennsylvania) may come equipped with a kitchenette within the room but in most instances residents have to purchase their own equipment. One resident of the Pennsylvania Hotel described how he uses the cooking facilities there:

> "I cook for myself about 4 days a week, something simple or I'll heat up something…I make spaghetti and sauce, Kraft dinner or I'll get some ground beef and make hamburger helper."

Housing that is of poor quality, infested with vermin, and unsafe could have a negative effect on residents' ability to store and cook food. One study found that 39.6% of SRO residents reported that pests were a significant problem where they lived.[87] Another found that 77% of SROs had rodents and/or cockroaches.[88] Among those who participated in this study, food storage was also a problem, especially for those who lived in older, poorly maintained buildings.

> "At the [SRO], there's no way to eat at home there. There's too many rodents and cockroaches in the room to even think about storing food in my room. I didn't have a fridge. So food in my room was not an option. My room was so insecure that people were breaking in all the time. It was a nightmare there."

Often, residents with infestation problems kept food in their refrigerator or in sealed containers or only kept cans. For many, having enough space to store food was also an issue as rooms can be extremely small. At the same time, those living in the newer building reported having sufficient storage space and no problems with vermin, thereby increasing their ability to store food.

Finally, the cost for a room in an SRO can affect an individual's ability to purchase food. A study by the Carnegie Community Action Project found that 40% of the SROs they surveyed changed $425 a month for rent, which is $50 more than the shelter allowance provided to people on social assistance.[89] This forces residents to use a portion of their subsistence payment to cover their rent, resulting in less money for food and other essentials.

Supported SROs and Treatment Facilities

For this study, 6 people who are currently in a treatment facility for addictions or in a supported SRO were interviewed. Five of these individuals received 3 meals a day, plus snacks, at their residence, while one, who was living in the supported SRO, received one daily meal. For those going through recovery, meals that are provided can be an important factor in restoring their health.

> "I'm maintaining, with minimal effort, 190 to 195 pounds. I went on a 3 year bender and I went down to 155, 160 and came in at 158. My appetite has stabilized a bit. I get three squares where I'm at now and if I want more, there's more to eat. The kitchen is always open and there's all this food in the fridge so food is not a problem for me now. In the beginning, when I came into stabilization, into detox, I just ate as much food as I could put into myself. I put on 10 pounds a week, boom, boom, boom. Actually, I put on my first 20 pounds in 10 days, 2 pounds a day."

In addition, meal provision allows people to have the time to work on other issues in their lives and focus on their future.

> "I'm kind of liking the time, the extra free time I get not having to cook my own food. I'm thinking I might do another treatment centre next or I might go to a supported living type place or even a shelter for a month or two where I can continue to be fed, like a little child (laughs). I

like to have the time to do the things that I need to work on myself. Eventually, I'm going to have to join reality but I'm in no rush."

"Coming down here [supported SRO], it's quite a plus. Healthy body, healthy mind. The road to recovery was a lot easier here. I'm situated now that I might look for a part-time job. Being in a clean environment, having good meals all the time, going back to work is a possibility in my future. It's going to be a little easier on the government if a lot of people are able to go back to work, even work part-time."

In short, food provided as part of a detox program can be a critical component of the recovery process.

Housing Outside of the DTES

While most of the respondents of this survey lived in the DTES, a few had moved out of the area to live in apartments. While living outside of the neighborhood was helpful for some as it enabled them to escape old habits, it could also create a problem if they weren't adequately supported. Since the DTES provides the majority of free/low-cost food and other services, former residents are motivated to make occasional visits to the area.

"I finally got subsidized housing so I had to move out of the area, which really screws me in the sense that now I'm away from all the services. But at least I have a decent place to live…If we come downtown, it's a chore, right, it costs me money to take the bus down here."

"Everybody always wants us out of the area but all the resources are here. It doesn't make much sense to live a couple hours away and then we don't have the resources. I get a fair amount now on support but it's still not a lot when you spread it over the course of the month. I need the free laundry. There's still a lot of costs, so we pretty much have to stay down here."

It is critical that providers of new housing outside of the DTES take into account access to food services, such as free and low-cost meals and inexpensive grocery stores.

Focus Group and Interview Results with Food and Housing Providers

The rest of this document provides specific recommendations for newly built supported housing or remodelled SROs based upon responses from both housing and food providers in the DTES. These recommendations focus on the areas of 1) building infrastructure, 2) service provision and 3) the building context. These recommendations were derived from focus groups and interviews.

There are few specific recommendations about food provision in supported housing within the current literature. Recommendations regarding appropriate infrastructure vary according to the needs of the individuals. Patterson et al. suggest that meal programs for low barrier housing residents may differ depending up on the level of support they require. Those requiring minimal support, including those with less problematic behavior but with significant health issues, active yet moderate addictions, and untreated or marginally effectively treated mental illness, may not require a meal program. Instead, Patterson et al. suggest "an off-site, low-cost meal program available nearby, or via delivery". Those requiring high levels of support – those with complex health issues including active and severe addictions and untreated or marginally effectively treated mental illness – they suggest that because this population will likely not access regular meals because they are barred from meal services or likely will not pay for a meal, "an on-site meal service is the best option for ensuring people are getting proper nutrition, though it is also expensive."[90]

In order to develop specific recommendations for Vancouver's DTES, food and housing providers in the neighborhood were asked to participate in either a focus group or one-on-one interview. In total 18 individuals participated in this part of the research representing a wide range of expertise (see Appendix C). Participants were asked to comment on the current state of food and housing provision in the DTES and which models appear to work best for individuals who are hard to house. In interviews and focus groups, respondents noted that, for individuals with the most severe health and behavioral issues, a meal program ensures that nutritional needs are being met.

> "Some people just need food. They are unable to take part in anything other than eating. Those who are more stable can access other opportunities. It's inappropriate to send an active, low-functioning addict to a community kitchen or garden. "

> "A certain percentage of people living in the DTES are living in a very self destructive state and are unlikely to take advantage of an opportunity to prepare healthy food and will depend on the service providers. "

Anecdotal evidence from program and housing staff in the DTES suggests that when healthy meals are provided, there are a number of benefits. For example, when the food provided at the Lifeskills Centre was improved from pastries to full meals (breakfast and lunch), staff reported an improvement in behaviour, including increased attention span and reduced aggression, which in turn, has reduced the amount of time staff has to devote to intervening in conflicts. Staff at the PHS Hotels, where one meal a day is delivered, have noticed that there is reduced anxiety about accessing food, health and weights have improved and that residents look forward to these meals.[91,92,93] It is also possible that meal provision has contributed to the decline in critical incidence reports to some of the hotels where meals are provided.[94] On-site food provision may be especially important for women as going out for food can be dangerous if they get caught up in street activities and if they are fed in-house, they are less likely to give their food to their partner.[95]

At the same time, it is important to give people options, including communal and individual kitchens.

> "There are some people who would [cook] if they have skills. You need to give people an opportunity to do all 3 things; cook for themselves, learn and just be fed."

> We don't want to create dependence. Sometimes people need food provided for them but we shouldn't do that *carte blanche*. If you provide the infrastructure for people to cook for themselves, good things can happen."

Finally, there is the reality that there is no one model that will work for all members of this population.

> "The idea of moving up the continuum is based on an assumption that there is a preferable place in it—this may not be accurate. It may be that people enjoy eating breakfast alone, lunch with a friend and supper with community … Independence is held as an important value but in a situation where most people are single and live alone, in terms of cooking, does this mean that

each person would need a stove and fridge and cooking skills in order for the highest value to be achieved?"

While there must be an awareness that one type of program will not work for all residents of the DTES, it is recommended that new or refurbished housing should *include a plan for ensuring food security for residents*. This plan should be based on the physical and mental health issues of the resident population (e.g., HIV/AIDS, drug addiction, PTSD) as well as the available resources within close proximity of the site. For example, what other food resources exist that can be easily accessed and are they appropriate for that population. Food programs within the building should be evaluated regularly to assess 1) whether they are meeting the nutritional needs of the residents, 2) whether the food is acceptable to the residents, and 3) if residents are obtaining new skills and knowledge through food programs (e.g., cooking skills through a community kitchen).

The following sections provide more specific recommendations regarding building infrastructure, program and services and building context.

Building Infrastructure

Building infrastructure refers to the physical resources that may be used to prepare and provide food. This can include individual, communal or commercial kitchens as well as space for eating and growing food.In a scan of housing providers in Vancouver's Downtown Eastside, there were 5 different models of food provision. The type of model utilized often depends upon the type of residents housed and the facilities and funding available for food provision. These models also differ in their approach. Some utilize a service delivery model in which food is provided by employees of agency managing the residents. Others have adopted a community development model that involves residents in various aspects of food provision. These models are:

1. **No meal service or cooking facilities provided**. This model is often found in unsupported, privately-owned SROs. In this type of housing, people access meals on their own. Cooking facilities may or may not be allowed in the room and if they are allowed, residents must provide these on their own. In this situation, residents often rely on charitable and other low-cost food in the neighbourhood. Problems with this situation include lack of ability to store perishable food safely, if there is no refrigerator, and a lack of choice regarding what and when to eat. The risk of malnutrition is high.

2. **Communal cooking facilities provided**. In a communal kitchen, cooking facilities—refrigerator, stove, sink, microwave—are available for communal use. Communal kitchens can either be

unstaffed and simply open to anyone to use or organized by staff members with resident participation. For example, the Hampton, run by MPA, has a communal kitchen that is open to residents to use but it is not organized. In some SROs, weekly community kitchens are organized by the Downtown Eastside Community Kitchen (DECK). In these cases, food and cooking utensils are provided by DECK while participants do the meal planning. Food is typically made in large quantities so that other residents of the hotel can also share in the meal.

3. **In-room cooking facilities provided**. In this model, each room is equipped with personal cooking facilities which vary in terms of size and type of cooking equipment. Refrigerators can be bar-sized or full. Cooking equipment may be a full-sized oven, a 2 burner stove or hotplate or a microwave. While some private SROs allow cooking facilities in their rooms, often it is the responsibility of the resident to purchase these items. Some of the newer SROs (e.g., the Pennsylvania and the Lux) come equipped with kitchenettes which reduce the burden on residents to provide this equipment themselves.

4. **In-house cafeteria.** In some supportive housing, meals are provided through an in-house cafeteria. In this model, residents have reliable access to at least one meal a day, sometimes more. At the Portland Hotel (PHS Community Services Society), one meal per day is provided by the Potluck Café, which can either be eaten in the cafe or in the resident's room. These meals are provided free of cost to residents. This program will be enhanced with smoothies on a 7 month trial. At the Windchimes Apartments (Raincity Housing) residents are provided 3 meals a day for a cost of $150 a month which is taken out of their public assistance cheques. At the Hazelton Residence (Lookout Emergency Aid Society) meals are available for purchase at on-site dining room for $125 per month for 3 meals and 3 snacks per day. There is also an option to purchase one or two meals per day.

5. **Delivered meal program.** Similar to the in-house cafeteria, some supportive housing provide meals through a delivered meal program. In other instances, agencies such as A Loving Spoonful, provide frozen meals to hotel residents. Residents typically have to store and heat these meals in their rooms. This can be problematic if meals are delivered weekly since residents may have difficulty storing this amount of food. Since July, 2007, the Portland Hotel Society has been providing a meal delivery system for the residents in the hotels it manages, several of which do not have cooking facilities. These meals are cooked at the Smith-Yuen Building and then delivered by bike to

residents of 6 PHS-run hotels in the DTES (the Washington, the Sunrise, the Roosevelt, the Stanley, the Pennsylvania and the Rainer). Currently, only one meal a day is provided to around 305 residents. The meals are around 12 oz in size and consist of dishes such as butter chicken, macaroni and cheese or shepherd's pie. In some instances, there is a combination of delivered food and food prepared on-site. For example, Potluck catering provides residents the Rainer recovery program with two meals a day, lunch and dinner. However, simple breakfasts are prepared on-site by staff.

On-site Cafeteria or Meal Delivery Program

Those who are in need of the greatest support or who require stabilization, can be provided with prepared meals; ideally with the option of engaging in communal meals or eating alone in their room. This can be done through an on-site cafeteria or delivered meal program. Having a delivered meal program reduces the need for each residence to have its own commercial kitchen however it also requires additional costs in terms of transporting the food to various locations.

In focus groups with food and housing providers, they noted the importance of providing meals for individuals who are hard to house is because they are the least likely to access food on their own. Providing food ensures that they are receiving appropriate nutrition. One respondent recommended that there be,

> "At least three full meals per day, prepared and consumed on site in the residences or shelters, and high protein, high nutrition snacks, such as good sandwiches, available 24 hours per day. If on-site preparation is impossible, on-site consumption should still be the goal."

Other housing and food providers also promoted the idea of on-site food provision for those with addictions or mental health issues in order to ensure they can access food.

> "The hard to house should also have access to an on-site cafeteria. Those who are addicted or with several mental health problems will eat whatever is available and that's usually not healthy."

> "People struggling with all of these issues come in and out of competence around managing their food. For example, those with mental illness, especially schizophrenia, often cycle through

periods when they are very capable, and others when they aren't. If food is available on-site, or some kindly person brings it to them, they eat. If not, they don't."

On-site food provision is especially important for women as going out for food can be dangerous if they get caught up in street activities. Furthermore, if women are fed in-house, they are less likely to give away their food to their partner.[96]

On-site Communal Kitchens

Another model is to provide communal kitchens that can be accessed by residents. Typically, there is one kitchen per floor. While providing a communal kitchen does enhance access to cooking facilities for those without in-room facilities, there are several drawbacks with this model. Many SROs have communal kitchens but they are often not utilized because they are in poor condition or residents worry that their food will be stolen.[97] Furthermore, residents may not be motivated to cook on their own and may lack the needed utensils and ingredients. For individuals who are hard to house, a communal kitchen may be best used as a community kitchen with outside support that can provide some of the organizational and material support.

Individual Kitchens

The *Housing Plan for the Downtown Eastside* recommends "that SRO replacement housing units should contain … cooking facilities. A small kitchen allows the resident to prepare snacks and basic meals."[98] The Carnegie Community Action Project also recommends that all new housing in the DTES contain kitchens. Among focus group and interview respondents, it was largely agreed among food and housing providers that, at minimum, rooms should have a refrigerator and a microwave or hotplate. This would allow residents to purchase, store and prepare some food. In some situations, microwaves may be preferable because they reduce the fire danger from stoves and hotplates and are less costly than stoves. According to one housing provider,

"For the hard to house, under 20% regularly use stoves. Refrigerators are more useful. The best would be some kind of fridge and a microwave; they're easy to use and easily replaced if they're damaged. "

As people become more stable, providing a full kitchen would allow them to prepare meals themselves. However, it was noted in the interviews that simply providing cooking facilities was often not enough. Providing in-room cooking facilities also requires appropriate food storage infrastructure in order to avoid contamination by insects and rodents. Buildings should be free of vermin and residents need somewhere to store food that is safe from cockroaches. This includes shelving that is rat/mice proof and well-sealed refrigerators. Also important is a sink for food washing and hygiene. Furthermore, in order to cook, people need access to pots, pans, bowls, knives and other cooking implements as well as basic ingredients, spices and recipes. The Pennsylvania Hotel has rooms with cooking facilities and residents are given some basic implements such as a frying pan and a cooking pot. In addition, the Lifeskills Program has developed a cookbook that is designed for individuals with a minimum of cooking facilities (e.g., a hotplate). A planned evaluation of cookbook on cooking and dietary habits is planned for September 2009. Finally, it is critical to have access to free or low-cost, healthy food from a grocery store or food bank (see below).

Programming

In conjunction with physical infrastructure, there is a need to provide the personnel and programming to utilize the facilities. These can range from cooks and kitchen managers in a commercial-grade kitchen/cafeteria set-up to support staff who help run a community kitchen or other cooking programs.

For a commercial kitchen where meals are provided to residents, it is important to have a system of meal planning that takes into account both nutritional needs and resident preferences. For example, at Cordova House, the residents' council meets once a month at to review the menu and suggest changes. These suggestions are addressed as long as they meet recommendations in the Canada food guide. It is also vital to have a kitchen manager who has experience with meal planning. According to one food provider,

> "Poor food quality is the result of a lack of organization and a poor use of dollars. A good infrastructure prevents loss of money due to disorganized buying, buying fast foods due to lack of time, food loss due to poor portioning and leftovers or poor storage etc."

Having a trained and knowledgeable kitchen staff will ensure that meals are both healthy and appealing to residents.

One alternative to the traditional supportive services model, in which support staff manage and implement programs, is a community development approach. This approach involves residents in food preparation and delivery and provides the additional benefit of training and employment opportunities for residents. Using a community development model also helps with addressing power inequalities between service providers and recipients by providing opportunities for people to become directly involved with food provision. The Carnegie Cafeteria is one example of this model. Volunteers who work in the kitchen are provided free meals in exchange for their work. The PHS' DTES Lunch Delivery also utilizes several volunteers for food preparation and delivery.

In instances where there is no direct meal provision but there is access to communal cooking facilities, staff may work with residents in communal kitchens. There are also a number of hotels that have weekly community kitchens run by DECK. However, community kitchens may not work for all populations, particularly those with multiple issues and they typically require close supervision and conflict resolution by staff and volunteers. In addition, because they are typically only offered once a week, they do not contribute substantially to the overall diet of those involved. Due to poor storage facilities in their rooms, participants often cannot take additional food with them.

Despite these difficulties, community kitchens have a number of benefits. A recent survey of DECK participants found that the majority said that the program increased their access to food and cooking skills and facilities.[99] One advantage of a residence-based community kitchen is that it provides an opportunity for residents to interact with one another and with support staff. According to on community kitchen facilitator,

> "The purpose of a kitchen is to give people social opportunities, to be with other people. Many people already know how to cook but don't like to do that for themselves – they aren't motivated. This gives them a chance to use their skills."

One community kitchen participant also said that even though he takes part in a community kitchen, he does not cook for himself.

> "I never cook at home. I go to the food lines, the soup lines. It's too much work to cook. I have a stove and fridge but I don't use them. I never feel like cooking [for myself]."

In situations like this, community kitchens provide an opportunity for individuals to engage in cooking when they otherwise would rely solely on food providers.

The DECK-run community kitchens not only provide food for the participants, but typically meals are made for all residents of a hotel. However, for this quantity to be prepared, it is necessary to have adequate cooking facilities (e.g., two ovens). One benefit of this system is that DECK provides the cooking utensils and food (supplied by the Vancouver Food Bank or purchased), which reduces the costs on the facility. While a weekly community kitchen cannot address the nutritional needs of residents, it does provide an opportunity for participants to learn menu planning and food preparation skills that can be utilized in other contexts.

An unconventional twist to the traditional community kitchen model is the Roving Community Kitchen that the DTES Neighborhood House has started. This program visits various sites throughout the DTES to provide smoothies and teach people how to make them. The smoothies are created in order to be healthy by using a variety of fresh fruit and are easy for people to ingest if they are sick due to drug use or lack teeth. Because the timeframe is short and does not require extensive participation or food preparation, it works as a good model for individuals who are hard to house.

Building Context

The building context refers to the surrounding amenities that residents can easily access. This is a critical issue for buildings serving individuals who are hard to house as this population is unlikely to go far to access resources, due to their lack of transportation and other barriers. Increasingly, residential buildings have commercial space on the first floor, which provides a number of food-related opportunities.

The resources needed in the surrounding area are somewhat dependent upon the facilities within the building. For example, for buildings that lack a cafeteria, it is critical that some type of free or low-cost cafeteria be easily accessible. Even for residents who have cooking facilities, the ability or interest to cook may be low and having a cafeteria within easy access provides another option. In addition to

providing healthy meals, it is advisable that the cafeteria provide the option for people who prefer privacy to take their meals back to their rooms.

Other amenities include easy access to low-cost grocery stores or a food bank, especially if the building provides cooking facilities. Other options are to have a “food store” integrated within the building or to involve residents in a buying club or good food box program. Buying clubs and good food boxes provide low-cost groceries to residents with the added benefit that they are often delivered. In addition, there are other food-related programs that residents can participate in, including community gardens within the community.

Conclusion

This report provides an overview of the housing and food security needs of individuals who are hard to house residing in the DTES. Food and housing intersect in a number of ways— for example, poor nutrition can play a role in exacerbating behaviour issues, which can contribute to homelessness. In turn, homelessness and drug addiction can contribute to increased food insecurity, malnutrition and disease. In contrast, access to healthy meals can play a significant role in alleviating many of these issues. Thus, proper nutrition must be part of both a housing and a harm reduction strategy. There are however, a number of areas that remain to be explored within both the research and policy arenas.

1. What is the current nutritional status of residents of the DTES in terms of macro and micronutrient intake and how does nutritional status vary according to housing situation and drug use?

2. What is the nutritional value of meals provided in the DTES in terms of macro and micronutrients? What types of foods might be beneficial for residents of the DTES given the current research on nutrition, health and behaviour?

3. How can healthy food be provided at a cost that agencies can afford? There are a number of food programs that could be assessed regarding the potential cost-benefits of meal provision.

4. What are the best models for food provision for those with addictions? The drug-induced anorexia is likely to have significant effects on the long-term health of this population. Finding a food provision model that works for them could result in significant savings of health care and other costs.

Appendix A: Research Framework on Housing and Food Security

	Framing	Context	Policy
Questions	What role does food play in supporting the health of residents of the DTES who have multiple barriers? • Food and Chronic and Acute Disease (HIV/AIDS, Hep C, Diabetes) • Food and Mental Health/Behaviour (e.g., violence) • Food and Addiction	What is the current food security status of the "hard to house" in the DTES?	What are the optimal programming, design and locational supports for the "hard to house" population living in the DTES? • What are the most effective types of food-related programming to support food security in this population? • What is the most effective housing design to support food security? • What influence does location have on the food accessed?
Purpose	To investigate the argument that food is an important component to health for people with multiple barriers.	To document the barriers to food security among the "hard to house" population in the DTES.	To provide specific policy recommendations on how best to support food security through housing.
Data Sources	Literature review	Survey of residents living in the DTES.	Focus groups and interviews with housing and food providers in the DTES.

Appendix B: Low-Barrier Housing in the DTES

In the DTES, low barrier housing or "housing first" is the main form of supportive housing. These are a mix of non-market apartment and hotel rooms (SROs). Table 2 provides a listing of some of the supportive and low-barrier housing in the DTES with details on the cooking and food provision services available. While some buildings are made up entirely of supportive units, others such as the Silver/Avalon Hotel and the Bridget Moran Place are only partially supportive.

SUPPORTIVE/LOW-BARRIER HOUSING in the DTES	**Service Provider**	**Number of Supportive Units**	**Kitchen /Food Provision Facilities**	**Resident Profile**
Avalon Residence (SRA)	Lookout Emergency Aid Society	35	Communal cooking area (stove only) on each floor. Private individual contracts with the hotel owners to provide breakfast and lunch each day. Breakfast $3.25 per day, lunch $4.25 per day.	Mental illness and dual diagnosis
Bridge Housing (Non-market housing)	Bridge Housing Society	36	Common kitchen and dining room, self-contained apartments. Have community kitchen twice a week.	Women with mental illness/dual diagnosis
Bridget Moran Place (Non-market housing)	RainCity Housing and Support Society (formerly Triage)	26	Self-contained studio apartments with kitchens. DECK community kitchen	People with mental illness
Cordova House	St. James Community Services	66	On site cafeteria offering three meals and two snacks per day for residents.	45 years and older
Cordova Residence (SRA)	Lookout Emergency Aid Society	34	One shared kitchen. Also provide food pantry.	Addictions and physical and mental health problems.
Hampton Hotel (SRO)	Motivation, Power & Achievement Society (MPA)	46	Self-contained suites. Also has a communal kitchen.	Mental illness

Hazelton Residence (SNRF)	Lookout Emergency Aid Society	39	Meals available for purchase at on-site dining room. $125 per month for 3 meals/3 snacks a day. Option to purchase one or two meals a day (may include lunch which is the big meal of the day) at $65 per month.	Multi or dual diagnosis
Jeffrey Ross Residence (non-market housing)	Lookout Emergency Aid Society	37	Self-contained apartments. Have a monthly community meal.	65+ with mental illness
Jim Green Residence (non-market housing, "third stage" support)	Lookout Emergency Aid Society	66	Self-contained apartments. Courtyard with gardens.	Mental illness, physical health problems, disability.
Molson's Bank Building/Roosevelt	PHS Community Services	45	No in-room cooking facilities. One delivered meal (PHS)	Individuals with multiple barriers.
Pennsylvania Hotel (non-market housing)	PHS Community Services	44	Self-contained studios with cooking facilities. One delivered meal a day (PHS)	Individuals with multiple barriers.
Portland Hotel (non-market housing)	PHS Community Services	86	Self-contained apartments and single rooms. Full service cafeteria, community kitchen. One meal provided in cafeteria.	Singles in need of support
Princess Rooms (SRO)	RainCity Housing and Support Society	45	Single rooms with kitchenettes (some removed). RainCity also provides 1 meal week.	Individuals with dual diagnosis
The Rainer	PHS Community Services	41 units (20 unit detox program, 21 low-barrier housing)	Rooms with fridges. Communal cooking facilities. 1 delivered meal provided (lunch). Three meals provided to detox units.	Women recovering from addiction.

Sakura So (non-market housing, transitional)	Lookout Emergency Aid Society	38	Each room has two-burner stove, sink, fridge. One community shared meal in communal kitchen weekly at a minimum.	Individuals with mental illness and physical health problems.
Santiago /Cecilia Apts (non-market housing)	St. James Community Services	32	Self-contained studios with kitchens.	Second stage and independent apartments for people with mental illness.
Sereena's House	Bridge Housing Society	58	Single rooms with fridges. 2 communal kitchens. Recently started a once a day meal program.	Women with addiction, street involved.
Stanley/New Fountain (non-market housing)	PHS Community Services	65	Single rooms without cooking facilities. DECK community kitchen. One delivered meal a day (PHS)	Low-barrier
Sunrise Hotel (non-market housing)	PHS Community Services	52	Single rooms without cooking facilities. One delivered meal a day (PHS)	Individuals who are low-income with complex needs
Tamura House	Lookout Emergency Aid Society	35	Two shared kitchens on each floor. DECK community kitchen on Wednesdays.	People with mental illness and lack of social skills.
Vivian House (Transitional housing)	RainCity Housing and Support Society	24	One communal kitchen in building. Rooms have bar fridges.	Women with mental illness and addictions
Washington Hotel (non-market housing)	PHS Community Services	84	Single rooms without cooking facilities. Grocery store on the ground floor. 1 delivered meal a day (PHS)	People with low-income with complex needs
Windchimes Apts (non-market housing)	RainCity Housing and Support Society	27	Self-contained studios. Can access Triage Emergency Shelter cafeteria for $150 month	People with mental illness.
Yukon Apts (Long-	Lookout	37	Self-contained units.	People with mental

term transitional housing)	Emergency Aid Society			illness and dual diagnosis
The Lux	RainCity Housing and Support Society	24	Self contained with kitchens, also communal kitchens on each floor.	People with mental illness and dual diagnosis.

Appendix C: Organizations Participating in the Research

Atira Housing

Atira Women's Resource Society is a community-based organization that supports all women, and their children, who are experiencing the impact of violence committed against them and/or their children. Atira aims to be inclusive and barrier-free in their services, as the target population of their housing and food services often include women who are actively involved in the sex trade, drug-addicted, and/or suffering mental and physical health issues (e.g., HIV, Hep C, and cancer). Food services in Atira's housing projects vary according to the capacity of the organization and of the residents. These services include a mixture of provision of free for residents to cook, provision of refrigerators in rooms, community kitchens programs, meal programs, and staff-assistance in purchasing and preparation of food.

Carnegie Cafeteria

The Carnegie Cafeteria provides 3 meals a day: breakfast (serve around 50) for $1.75, lunch (serve around 200) for $1.75 and dinner (serve around 100) for $3.00. The cafeteria also always has soup and sandwiches, baked goods, yogurt etc. for sale. All volunteers at the Carnegie Centre receive food tickets for meals in the cafeteria. Most customers are single, poor, homeless or living in unstable conditions, while some also suffer mental health issues. The Carnegie strives to provide healthy, nutritious, and affordable meals; the cafeteria currently has a vegetarian and vegan night that is slowly gaining popularity among those who struggle with multiple health issues.

Carnegie Community Action Project

The Carnegie Community Action Project is a project of the board of the Carnegie Community Centre Association with about 5000 members who live mostly in the DTES. CCAP works on getting better and more housing and better incomes for area residents. It is also working to involve residents in developing a low-income resident-driven plan for the neighbourhood.

DECK (Downtown Eastside Community Kitchen)

The Downtown Eastside Community Kitchen Project helps people form groups where they can learn the necessary skills to cook nutritious meals together. The target population includes many with challenging health conditions such as diabetes, hepatitis C, HIV/AIDS, and various addictions. DECK participants are provided with all food and cooking supplies, as well as assistance in locating and securing a community cooking space. Residents also gain the confidence and community connections that help them feed themselves well. They become less isolated by working together and sharing meals. They also receive education on food safety through DECK. Currently, DECK's community kitchens operate on a weekly

basis, with groups from 5 participants upwards. Approximately 70% are men and 30% women. Most significantly, food that is prepared is typically shared with other residents of the building; in total, 230 residents of DTES benefit from the DECK community kitchens, either through direct participation or by receiving food prepared.

The Downtown Eastside Neighbourhood House

The DTES Neighbourhood House opened its storefront in 2007. Since its inception, it has maintained a strong emphasis on food, including a food philosophy that considers such conditions as diabetes, Hep C, and HIV/AIDS. The NH has a number of food-related programs including the Banana Beat; providing bananas to residents standing in line for their social assistance cheques and the Roving Community Kitchens; in which members of the NH make smoothies at various sites in the DTES. The Neighbourhood House has also participated in the BC Farmers Market's Coupon Project since 2007.

Lifeskills Centre

Lifeskills is resource centre for high risk drug users and women in survival sex trade. Peer run, and low threshold, the centre provides opportunities to reconnect with culture and community while participating in job training, community kitchen groups, free laundry, showers, internet and phones. The Centre provides 2 free meals a day to the community. It has also developed a resource guide and map for free and low-cost meals in the DTES and a cookbook for people with limited resources. The Lifeskills Centre provides volunteers to the PHS' DTES Lunch Delivery Program.

Lookout Emergency Aid Society

Lookout Emergency Aid Society provides services to the homeless, especially those living with multiple disabilities. Lookout operates a 24-hour emergency shelter service that assists 3,065 homeless individuals annually. They also operate a Supportive/2nd Stage Housing program which provides permanent housing for the chronically homeless, youth with multiple-barriers, and individuals living with multiple disabilities. On top of the housing programs, Lookout has a Living Room Drop-In program to engage individuals living with mental illnesses in community living. Specifically, those who are not formally involved with the mental health system are encouraged to participate. The meal program at the Living Room Drop-In feeds 100~150 per day.

Loving Spoonful

A Loving Spoonful operates The Daily Meals program, a supervised Daily Meals Program, a family Pantry Program, and an emergency Service Program aiming to help individuals living with HIV/AIDS maintain a healthy nutritional level. Many of these patients also suffer from mental illnesses and addictions that

further prevent them from accessing safe, healthy, and sufficient food. Through weekly delivery of nutritious entrees, milk, yogurt, juice, bread and fresh fruit, the Daily Meals Program helps patients too ill to shop, plan, and prepare food themselves to be able to stay healthy in their homes without taking up hospital beds.

Motivation, Power & Achievement Society (MPA)

The MPA Society provides housing, community resource, court service, advocacy, supported housing and licensed housing services within and beyond DTES. Participants can access medication information, symptom management, referrals for treatment, health & fitness services, as well as life skills training which includes home management, budgeting, and cooking. Currently, the Hampton has the most established food program: it offers 1 meal per day through an in-house commercial kitchen, and a community kitchen program free of charge to the residents. Each room is equipped with a fridge and freezer; additionally, the hotel receives donations from Starbucks every day. Staff at the Hampton will also provide additional, informal food services if the needs of the residents cannot be met with existing services. Currently, MPA is currently developing a similar food service program at the Savoy Hotel.

Potluck Café

Potluck operates a professional Café and catering enterprise that reinvests its revenue back into its 4 community social programs. These include 1) an Integrated Food Services & Life Skills Training and Employment Program that has trained and employed dozens of DTES residents with barriers to employment, 2) a daily Meal Program that provides over 26,000 free meals annually to residents of the DTES suffering with severe physical and mental health and addictions challenges, 3) a Community Kitchen Program that allows DTES residents to learn basic cooking and nutrition skills, and 4) a Recipes for Success Outreach Program that shares best practices for successful social and community employment with other employers interested in successfully maintaining employment for hard to employ inner city residents.

RainCity Housing

RainCity Housing provides a wide variety of housing services in the DTES, including emergency housing, supported housing, women's housing, and long-term housing. Like other housing services in the area, the type of food services present varies with the capacity of the organization and the residents. RainCity current provides a mixture of in-site cafeterias offering three meals a day, meal programs paid with social assistance cheques, in-unit kitchen facilities, and communal kitchens. They are also currently expanding and modifying existing food services to better serve the needs of the diverse residents.

St James Community Services

St. James Community Service Society provides the Adult Guardianship Program, Mental Health Housing, Home Support Services, Hospice Care, Women-and-Children's Services, and Low-cost Supported Housing. Cordova House in the DTES provides housing and food services to the hard-to-house aged 65+. Residents are provided with 3 meals and 3 snacks a day, which is served within the cafeteria.

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Appendix G

DTES Resident Survey

- DTES Kitchen Tables Project

DTES Kitchen Tables

DTES Residents Survey

1. Gender _____ 2. In what year were you born? _____

3. What's your ancestry? _____

4. How's your health? Excellent __ Very Good __ Good __ Poor __ Very Poor__

5. Which best describes your diet? Excellent __ Very Good __ Good __ Poor __ Very Poor__

Time & Resources

6. What's your housing situation?

Social Housing	_____
Supported SRO	_____
Unsupported SRO	_____
Co-op	_____
Shelter	_____
Homeless	_____
Other	_____

7. What's your monthly income? _____

8. How much money can you spend on food? Daily $_____ or Weekly $_____

9. How many times do you eat? a day _____ a week _____

10. How many hours do you spend a day looking for food? _____

11. What if you could get food at places where you do a lot of waiting. eg; United We Can, Health Clinic, Why would that be good or bad? _____

Duplication & Redundancy

12. How many places do you visit a day searching for food? _____

Food Distribution & Purchasing Methods

13. To get enough food to eat in a day, is it easy or difficult? (circle) Easy or Difficult

If difficult, why? _____
_____
_____

14. Is food available as often as you'd like? (circle) Yes or No

15. Do you ever line up for food? (circle) Yes or No

16. What do you like about food lineups? (eg; socializing, etc) _____

17. What do you NOT like about food lineups? _____

DTES Kitchen Tables

18. Do you get food from the following places? (mark with X all that apply)

	Check	Which places?
Free Meal Programs eg; UGM		
Low Cost Meal Programs eg; Carnegie		
Food Bank		
Grocery Stores eg; Sunrise		
Convenience Stores		
Delivered Meal Programs eg; Loving Spoonful		
Cafes or Restaurants eg; Potluck		
Community Food Gardens		
Mobile Food Vendors		
Other (eg; Bins, Street, Friends, Family)		

19. Are there medications you take, that you need to eat before? (circle) Yes or No

How does this work out? _____

20. Are there certain foods you need or want that are difficult to get?

____No ____Yes, which foods and why?_____

Nutritional Food Standards & Education

21. Ideally, how many times a day would you like to eat? _____

22. How much do you think your health would improve by eating *better quality* food?
Not at all ___ Somewhat ___ A lot ___

23. How much do you think your health would improve by eating food *more often* every day?
Not at all ___ Somewhat ___ A lot ___

24. How many times a day do you eat:

Potatoes _____
Bread _____
White rice _____
Pastries _____

25. How many times a day do you eat fruit? _____
Which fruits? _____ Where do you get fruit? _____

26. How many times a day do you eat vegetables? _____
Which vegetables? _____ Where do you get vegetables? _____

27. How many times a day do you eat:

Meat _____
Eggs _____
Milk _____
Cheese _____
Tofu _____

28. Where do you find those things? _____

29. How many times a week do you eat soup? _____

30. Have you ever been sick after eating free food?

Never_____ 0 to 4 times _____ 5 to 10 times _____ More than 10 times _____

31. Are you satisfied with the *nutritional quality* of the food you get? (circle) Yes or No

32. Are you satisfied with the *quantity* of the food you get? (circle) Yes or No

33. Are you satisfied with the days and times food is available in the DTES? (circle) Yes or No

Community Capacity Building (Education, Skills, Knowledge, Jobs, Income)

34. Do you have access to the following cooking tools? (mark with X all that apply)

	Check	How often do you have access to these each week?
Full Kitchen		
Shared Kitchen		
Stove Oven		
Toaster Toaster Oven		
Microwave		
Hot Plate		
Electric Frying Pan		
Fridge		
Blender		
Cooking Pots & Utensils		

35. Do you have access to safe, cold, food storage? (mark with X all that apply)

	Check	How often do you have access to these per week?
Freezers		
Fridges		
Storage Containers (eg; Tupperware)		
Ice Packs		

36. Do you have regular access to safe, clean water for cooking? (circle) Yes or No

37. Do you have regular access to safe, clean water for drinking? (circle) Yes or No

38. In the last week, how many times did you prepare your own meals? _____

What did you make for yourself?_____

39. If you had the choice, would you choose to cook your own meals? (circle) Yes or No

DTES Kitchen Tables

40. Do you have access to the following food resources or programs? (mark with X all that apply)

	Yes	No	I participate in this	I do not participate in this
Community Kitchen				
Community Food Garden				
Prepared Meal Program				

41. Please say if you agree or disagree with the following: (mark with an X)

	Agree	Disagree
The quality of fresh fruit and vegetables I can access is good		
The choice of fresh fruit and vegetables I can access is good		
Fresh fruit and vegetables are expensive in the DTES		
The quality of meat and protein I can access is good		
Meats and proteins in the DTES are expensive in the DTES		
The quality of the grocery stores in the DTES is good		
There is a good choice of different types of grocery stores in the DTES		
I do most of my grocery shopping in the DTES		
It's difficult to grocery shop in the DTES		

42. Which of the following statements best describes the food you've eaten in the past year? (mark with an X)

You always had enough of the kinds of food you wanted to eat	
You always had enough to eat, but not always the kinds of food you wanted to eat	
Sometimes you didn't have *enough* to eat.	
On a regular basis, you didn't have *enough* to eat.	

Open Questions

What's been your worst food experience in the DTES?

_____
_____
_____

What's your best food memory, ever?

_____
_____
_____

What does the word "meal" mean to you?

_____
_____
_____

If you had a magic wand to improve food in the DTES, what would it create?

_____
_____
_____

If you has a magic wand, what would you list as your top 3 priorities for food in the DTES?

1. _____
2. _____
3. _____

1	Gender	
	n/a	1
	Male	217
	Female	156
	Transexual	
	Transgendered	2
2	Year of Birth	
	n/a	6
	1940-1949	20
	1950-1959	70
	1960-1969	156
	1970-1979	94
	1980-1989	18
	1990-1999	2
3	Ancestry	
	n/a	29
	Canadian	110
	Aboriginal	129
	Asian	7
	European	95
	African	1
	South American	3
	East Indian	2
4	Health Status	
	n/a	3
	Excellent	25
	Very Good	50
	Good	163
	Poor	87
	Very Poor	39
5	Diet	

	n/a	8
	Excellent	13
	Very Good	42
	Good	127
	Poor	150
	Very Poor	27
6	Housing Situation	
	n/a	9
	Social Housing	73
	Supported SRO	63
	Unsupported SRO	83
	Co-op	14
	Shelter	18
	Homeless	67
	Other	42
7	Monthly Income	
	n/a	90
	0	17
	$1-99	2
	$100-199	6
	$200-299	25
	$300-399	4
	$400-499	7
	$500-599	27
	$600-699	25
	$700-799	21
	$800-899	16
	$900-999	29
	$1000-1099	15
	$1100-1199	5
	$1200-1299	10
	$1300-1399	2
	$1400-1499	1
	$1400-1499	1
	$1500-1599	4
	$1600-1699	
	$1700-1799	1
	$1800-1899	2
	$1900-1999	
	$2000-2099	7
	$2,500	1
	Disability	17

	Income Assistance	1
8a	$ Spent on Food Daily	
	n/a	92
	$0-5	205
	$4-10	30
	$11-15	6
	$16-20	14
	$21-25	1
	$30	1
	$50	3
8b	$ Spent on Food Weekly	
	n/a	169
	$0-10	57
	$11-20	16
	$21-30	20
	$31-40	19
	$41-50	26
	$51-60	20
	$61-70	2
	$71-80	5
	$81-90	
	$91-100	13
	$101-110	6
	$111-120	
	$121-130	
	$131-140	1
	$141-150	
	$151-160	
	$161-170	
	$171-180	
	$181-190	
	$191-200	3

9a No. of Times Eating Daily

n/a	70
0	1
1	60
2	112
3	111
4	12
5	6
6	3
7	1

9b No. of Times Eating Weekly

n/a	187
0	2
5	2
6	
7	62
8	1
9	
10	17
11	1
12	8
13	
14	35
15	7
16	2
17	3
18	
19	6
21	33
28	5
35	2
42	1

10 Hours Spent Looking For Food

	n/a	64
	0	55
	0.5	6
	1	86
	2	56
	3	36
	4	43
	5	5
	6	6
	7	6
	8	10
	12	3

	Food Where You Often	
11	Wait	
	n/a	102
	Good	235
	Bad	39

	No. of Places Visited Daily	
12	Looking for Food	
	n/a	93
	0	30
	1	50
	2	72
	3	66
	4	44
	5	8
	6	8
	7	1
	8	
	10+	4

	To Get Enough Food			
13a	Everyday is			
	n/a	63		
	Easy	180	but not healthy	3
	Difficult	133		

13b	If Difficult, Why	
	n/a	169
	too much competition	35
	not enough free meals	7
	not enough low cost meals	2
	not enough money	25
	don't know where to go for food	2
	too much work	4
	cold	6
	providers run out of food	28
	inconsistent scheduling of free meal programs	2
	no food on weekends	4
	accessiblity in a wheelchair	5
	long line-ups	61
	make people listen to religious sermons to get food	2
	not enough time to work and look for food	2
	not healthy enough to line-up for food	11
	food not available at necessary times	8
	not healthy food	3

14	Is Food Available As Often As You Would Like	
	n/a	47
	Yes	119
	No	210

15	Do You Ever Line Up for Food	
	n/a	49
	Yes	251
	No	76

16	What Do You Like About Food Line-Ups			
	n/a	93		
	Socializing	93		
	Nothing	170		
	Free food	13		
	Something to do	2		
	Fresh air	2		
	Networking for information	3		
17	What Do You Not Like About Food Line-ups			
	n/a	48		
	Everything	63		
	Violence	63		
	Intimidation	44		
	Long	108		
	Cold	53		
	Degrading	10		
	Unhygenic	1		
	Physically can not stand in a line do to health issues	7		
	No food left	22		
	No where to sit and eat	2		
	Having to listen to preaching	23		
	People	9		
	Addicts and Drunks	3		
18	Do You Get Food From the Following Places			
	n/a	35		
	Free Meal Programs	231	UGM	60
			Harbour Light	41
			Sisters	34
			DTES Women's Centre	25
			WISH	33
			Mission Possible	4
			First United	21
			Native Health	5

		Crabtree	7
		Lookout	2
		Dugout	10
		Collingwood NH	2
		Lifeskills	18
		Open Door	2
		Potters	3
Low Cost Meal Programs	137	Carnegie	27
		44 Club	32
		Co-op Foods	1
		Potluck	1
Food Bank	103		
Grocery Stores	134	Sunrise	35
		Quest	11
		Donald's Market	1
Convenience Stores	104		
Delivered Meal Programs	46	Loving Spoonful	9
		VAFC Shelter	2
Cafes/Restaurants	83	Potluck	13
		Skylight	1
		Kent's Kitchen	2

	Community Food Gardens	28		
	Mobile Food Vendors	54		
	Other	145	Bins	26
			Street	30
			Friends	61
			Family	54

19a	Do You Need to Eat Before Medication	
	n/a	49
	Yes	135
	No	192

19b	If So, How Does This Work Out	
	n/a	241
	Okay	25
	Not Good	110

20a	Are there certain foods you need or want that are difficult to get	
	n/a	43
	Yes	234
	No	99

20b	If yes, which foods	Too expensive and not accessible	30
	n/a	92	
	meat	116	
	fruit	55	
	vegetables	53	
	dairy	62	
	fish	14	
	any healty food	11	
	value	1	
	fresh	5	
	organic	4	
	lactose free	1	
	grains	1	
	sweets	1	
	Ensure	5	

21	How many times a day would you like to eat	
	n/a	16
	1	2
	2	23
	3	223
	4	56
	5	36
	6	14
	7	3
	As many as I like	3

22	How would health improve with better quality food	
	n/a	28
	Not at all	7
	Somewhat	111
	A lot	230

23	How would health improve with more food

	n/a	53
	Not at all	9
	Somewhat	109
	A lot	205

24a	How many times a day do you eat potatoes	
	n/a	27
	0	25
	1	280
	2	34
	3	6
	4	
	5	
	6	1
	too many times a week	3

24b	How many times a day do you eat bread	
	n/a	66
	0	11
	1	164
	2	80
	3	35
	4	9
	5	4
	6	
	7	1
	too many times a week	6

24c	How many times a day do you eat white rice	
	n/a	143
	0	69
	1	145
	2	11
	3	4

	4	1
	5	
	6	
	too many times a week	3
	How many times a day do	
24d	you eat pastries	
	n/a	87
	0	24
	1	117
	2	57
	3	44
	4	5
	5	29
	6	4
	7	2
	too many times a week	7
	How many times a day do	
25a	you eat fruit?	
	n/a	98
	0	30
	1	175
	2	32
	3	7
	4	4
	5	2
	6	
	7	1
	per week 2-3 times	28
25b	Which fruit	
	n/a	109
	apples	104
	oranges	93
	bananas	105
	strawberries	1
	peaches	4
	fruit cocktail	5
	grapes	6

	other	27
25c	Where do you get the fruit	
	n/a	100
	Free with meals	148
	Buy	88
	Low-cost meals	2
	Bins	14
	Family/Friends	6
	Food Bank	18
26a	How many times a day do you eat vegetables	
	n/a	97
	0	10
	1	168
	2	70
	3	19
	4	3
	5	
	6	1
	2-3 time a week	8
26b	Which vegetables	
	n/a	138
	brocolli	17
	spinach	6
	carrots	61
	cauliflower	20
	frozen mixed	66
	salad	22
	in soup	2
	potatoes	22
	rice	3
	peas	3
	tomatoes	5
	yams	1
	peppers	2
	mushrooms	1
	corn	2
	garlic	1
	onion	3
	celery	1

26c	Where do you get the vegetables	
	n/a	93
	Free with meals	168
	Buy	81
	Low-cost meals	3
	Family or friends	2
	Food Bank	17
	Bins	12
27a	How many times a day do you eat meat	
	n/a	91
	0	78
	1	176
	2	27
	3	2
	4	2
	5	
	6	
27b	you eat eggs	
	n/a	95
	0	148
	1	122
	2	8
	3	3
	4	
	5	
	6	
27c	How many times a day do you drink milk	

	n/a	100
	0	135
	1	115
	2	13
	3	9
	4	1
	5	
	6	1

27d	How many times a day do you eat cheese	
	n/a	92
	0	171
	1	100
	2	9
	3	4
	4	
	5	

27e	How many times a day do you eat tofu	
	n/a	85
	0	256
	1	32
	2	2
	3	1
	4	
	5	
	6	

28	Where do you find the foods from ques. 27	
	n/a	65
	Free meals	166
	Low cost meals	18
	Buy from store	88
	Not available	16

	Friends	3
	Food Bank	14
	Bins	6
29	How many times a week do you eat soup	
	n/a	72
	0	18
	1	17
	2	57
	3	42
	4	31
	5	36
	6	15
	7	70
	8	1
	9	
	10	10
	14	1
	Too often	6
30	Number of times you have been sick eating free food	
	n/a	50
	Never	78
	0-4 times	206
	5-10 times	40
	More than 10 times	2
31	Satisfied with the nutritional quality of the food you acccess	
	n/a	25
	Yes	91
	No	260
32	Satisfied with the quantity of food you access	
	n/a	63
	Yes	92

	No	221

33	Satisfied with the days and times food is available	
	n/a	96
	Yes	91
	No	189

34	Do you have access to the following kitchen tools	

Full Kitchen		Access per Week	
n/a			
Yes	79	1	1
No	297	2	
		3	
		4	1
		5	
		6	
		7	30

Shared Kitchen		Access per Week	
n/a			
Yes	80	1	
No	294	2	1
		3	
		4	1
		5	2
		6	
		7	17

Stove/Oven		Access per Week	
n/a			
Yes	114	1	
No	262	2	
		3	
		4	
		5	
		6	
		7	34

Toaster/Toaster Oven		Access per Week	
n/a			
Yes	107	1	
No	269	2	
		3	
		4	
		5	
		6	
		7	32

Microwave		Access per Week	
n/a			
Yes	157	1	
No	219	2	
		3	1
		4	
		5	
		6	
		7	44

Hot Plate		Access per Week	
n/a			
Yes	74	1	
No	302	2	
		3	
		4	
		5	
		6	
		7	5

Electric Frying Pan		Access per Week	
n/a			
Yes	59	1	
No	317	2	1
		3	
		4	
		5	
		6	
		7	15

Fridge	Access per Week

	n/a		
	Yes	160	1
	No	216	2
			3
			4
			5 1
			6
			7 40
	Blender		Access per Week
	n/a		
	Yes	58	1
	No	318	2
			3
			4
			5
			6
			7 15
	Cooking Pots and Untensils		Access per Week
	n/a		
	Yes	163	1
	No	213	2
			3
			4
			5
			6
			7 30
35	Do you have access to safe, cold food storage		
	Freezers		Access per Week
	n/a		
	Yes	115	1
	No	261	2
			3 1
			4
			5
			6
			7 30
	Fridges		Access per Week

	n/a		
	Yes	181	1
	No	195	2
			3
			4 1
			5
			6
			7 38
	Storage Containers		Access per Week
	n/a		
	Yes	111	1
	No	265	2
			3
			4 1
			5 1
			6
			7 23
	Ice Packs		Access per Week
	n/a		
	Yes	65	1
	no	311	2
			3 1
			4
			5
			6
			7 8
	Access to safe, clean water		
36	for cooking		
	n/a	60	
	Yes	230	
	No	86	
	Access to safe, clean water		
37	for drinking		
	n/a	70	
	Yes	205	
	No	101	

38a	Last week how many times did you prepare own meals	
	n/a	79
	0	130
	1	16
	2	33
	3	46
	4	14
	5	15
	6	5
	7	17
	8	2
	9	1
	10	10
	21	8
38b	What did you make	
	n/a	117
	Kraft Dinner	35
	Noodles	28
	Pasta	25
	Soup	30
	Pork Chops	1
	Tuna Salad	1
	Cereal	1
	Ensure	1
	Fish	3
	Sandwich	19
	Salad	2
	Protein	19
	Veggies	17
	Bacon and Eggs	8
	Hamburger and Fries	2
	Healthy Meals	17
	Frozen Meals	3
	Stir Fry	4
	Potatoes	8
	Rice	10
	Stew	11
	Canned Food	1
	Hot Dogs	2
	Vegetarian Meals	1
	Dinner	17
	Burger	2
	Pizza	1

	TV Dinner	1			
	Would you chose to make				
39	your own meals				
	n/a	56			
	Yes	274			
	No	47			
	Do you have access to the				
40	following				
	Community Kitchen		Participate		
	n/a	90			
	Yes	94	Yes	21	
	No	192	No	22	
	Community Food Garden		Participate		
	n/a	141			
	Yes	46	Yes	4	
	No	189	No	12	
	Prepared Meal Program		Participate		
	n/a	117			
	Yes	70	Yes	13	
	No	189	No	14	
	The quality of fresh fruit				
	and vegetables I access is				
41a	good				
	n/a	47			
	Agree	152			
	Disagree	177			
	The choice of fruits and				
41b	vegetables I access is good				
	n/a	92			
	Agree	103			
	Disagree	181			

41c	Fresh fruits and vegetables are expensive in the DTES	
	n/a	173
	Agree	113
	Disagree	90
41d	The quality of meat and protein I can access is good	
	n/a	110
	Agree	90
	Disagree	176
41e	Meats and proteins in the DTES are expensive	
	n/a	47
	Agree	251
	Disagree	78
41f	The quality of grocery stores in the DTES is good	
	n/a	161
	Agree	83
	Disagree	189
41g	There is a choice of different types of grocery stores in the DTES	
	n/a	90
	Agree	90
	Disagree	196
41h	I do most of my shopping in the DTES	
	n/a	91
	Agree	152
	Disagree	133

41i	It's difficult to grocery shop in the DTES	
	n/a	121
	Agree	211
	Disagree	44
42	Which statement best describes food you've eaten in the past year	
	n/a	66
	You always had enough of the kinds of food you wanted to eat	19
	You always had enough to eat, but not always the kinds of foods you wanted to eat	74
	Sometimes you didn't have enough to eat	120
	On a regular basis you didn't have enough to eat	97
43	What's been your worst food experience in the DTES	
	n/a	145
	None	5
	Bad, moldy food	59
	Sick from food	89
	No food at all	33
	Dirty place	2
	Scary clients	3
	No vegetarian food	1
	Harbour Light	4
	UGM	1
	First United	1
	Cold	2
	Line-up	10
	Save on Meats closing	1
	Seeing others hungry	1
	No food on weekends and holidays	5
	Undercooked meal	4

	Free meal program	2
	Too many people	4
	Still hungry	3
	Being alone on the holidays	1
44	What is your best food memory, ever	
	n/a	146
	Naming a particular food	38
	Holiday meal with family	70
	Restaurant	9
	Meal in the DTES	40
	Holiday meal in the DTES	52
	"Hard to say-I'm hungry"	1
	When I get fruit	2
	Stranger bought me a meal	3
	Having own kitchen	1
	None	2
	Finding something good a bin	1
	Eating with friends	3
	Home	8
45	What does the word "meal" mean to you	
	n/a	151
	Four food groups	42
	Everything	1
	Nothing	2
	Healthy	20
	Warm, healthy, sit-down	20
	Something to eat	1

	Food	45
	Hungry	1
	Togetherness	2
	Full stomach	32
	Energy	1
	Full plate of food	4
	3 meals a day	7
	Homecooked	8
	Must have everyday	1
	Three course meal	5
	Nutritious	17
	Healthy, hot cooked	16
	Quality meals for people with health conditions	2
	Dinner	2
	Eating	17
	Satisfied	4
	KFC	2
	Food for everyone	4
	Soup and sandwich	2
	Family	3
	Peaceful meal	3
	Hospitality	2
	Variety	1
46	If you had a magic wand to improve food in the DTES, what would it create	
	n/a	186
	Healthy food available 24 hours a day	56
	Cheap meals	4
	24 hour restaurant with free food	23
	Food to take home and cook	1
	Nutritional help/info	2
	Shorter line-ups	1
	Free fish and meat	3
	Enough food for everyone	19
	Proper nutrition	1
	Vitamins	1
	Healthier food	30
	Cheap large grocery store	5

	Warm place to eat	2
	No more line-ups	29
	Hot food	4
	Sit down	2
	More money	4
	Access to food at night	1
	More than soup and sandwiches	1
	Affordable food stores	3
	Unexpired free food	3
	Everyone has own kitchen	1
	Community Gardens	1
	Choices	1
	More food banks	4
	Free grocery store	3
	Cheap healthy food	3
	More meat	3
47	Top 3 Food Priorities in the DTES	
	n/a	175
	Meat, dairy, veg, fruit	170
	Heatlhy	10
	Accessible	10
	Warm place to eat	8
	Community gardens	3
	Steak, ribs, fries, gravy	1
	Spaghetti, lobster	1
	Free Safeway	8
	Help cooking	1
	Good snacks	1
	No exclusions	1
	Housing with cooking facilities	2
	Good grocery stores	1
	More nutrition	1
	More protein	2
	More vitamins	1
	Clean place to eat	5
	More food	10
	Food accessible at night	5
	No locked garbage bins	1
	Homecooked Meal	7
	No more expired food	4
	Vegetarian options	2
	No line-ups	1

Work for food	1

Appendix H

DTES Kitchen Tables Stakeholders Lunch and Share Sessions
Invitees and Participants List

- DTES Kitchen Tables Project

ORGANIZATION	ATTENDEE
24-Nov-09	
AIDS Vancouver	Mike Fraser
DT Community Clinic	Ellie Schmidt
United We Can	Seann Dory
30-Nov-09	
Street Nurses	Tuan Luu
City Council	Andrea Reimer
Quest	Kyle Burgess
Carnegie Community Centre	Ethel Whitty
Carnegie Community Centre	Catriona Moore
Positive Women's Network	Bronwyn Barrett
A Loving Spoonful	John Britton
Downtown Community Court	Sharon Belli
Crabtree Housing	Benita Ho
Strathcona Community Centre	Tom Baker
Edible Planet Catering	Marilyn Kopansky
1-Dec-09	
United Gospel Mission	Paul Zelinski
AHA Media	April
AHA Media	Hendrick Beune
Oppenheimer Park	Sandy McKeigan
Zoteck Food Advice	Chris Beall
Quest	Shannon Alteman
Second Mile Society	Annie Yu
Second Mile Society	Catherine Yau
Go2 Industry Training	Dennis Green
Cordova House-St James Community Ser	Noorjahan Rana
7-Dec-09	
Vancouver Native Health Society	Cease Wyss
Nutritionist	Karen Geisbrecht
Corpus Christi College	Karen Cooper
SFU	Chris Miewald
Farm Folk, City Folk	Jeff Nield

City of Vancouver	Kira Gerwing
City of Vancouver, Social Policy	Mary Clare Zak
Public Health Agency of Canada	Denise Weber
Provicial Health Services Authority	Deepthi Jayatilaka
Jewish Family Services	Lisa Ross
SPARC BC	Matt Thomson
Catholic Charities	Scott Small
WISH	Kate Gibson
DTES Centre for the Arts	Dalannah Bowen
Chef	Chris Moran
First United Church	Sandra Severs
Vancouver Coastal Health	Maria Burglehaus
DTES Women's Centre	Ruth Inglis
Lifeskills	Sarah Common

STAKEHOLDER MEETING INVITEES	
ORGANIZATION	CONTACT
PHYSICIANS AND HEALTH PROVIDERS	
Downtown Community Health Clinic	Ellie Schmidt
Pender Clinic	Carolyn Hall
Vancouver Native Health Society	David Tu
	Cease Weiss
PHS Medical Staff	Dr. Joe
Street Nurses	David
	James
	Carolyn Blunt
	Liz
	Janine
	Sarah Levine
	Tuan Luu
AIDS Vancouver	David Swan
	Mike Fraser
Freelance Nutritionist	Karen Geisbrecht
VCH	Maria Burglehaus
RESEARCHERS	
UBC	Jim Frankish
	Yona Sipos
	Graham Riches
	Karen Cooper
SFU	Chris Miewald
Farm Folk, City Folk	Jeff Nield
POLICY	
COV	Judy Graves
COV-City Planning	Kira Gerwing
COV-Social Policy	Mary Clare Zak
COV-Social Planning	Vickie Morris
COV-Housing	Jill Davidson
City Council	Andrea Reimer
	Heather Deal
BC Housing	Darlene Richardson

Public Health Agency of Canada	Denise Weber
	Moffat Clarke
PHSA	Deepthi Jayatilaka
Tides Foundation	Samara Brock
SPARC	Matt Thompson
Food Policy Council	Joanne Bays
GROWERS AND SUPPLIERS	
Vancouver Farmer's Market	Tara Macdonald
Quest	Shelley
	Kyle Burgess
	Shannon Alteman
Food Bank	Diane Collis
	Doug Aason
	Leo Ramirez
	Cheryl Prepchuck
COMMUNITY FOOD PROVIDERS	
Jewish Family Services	Lisa Ross
DTES Women's Centre	Ruth Inglis
United Gospel Misson	Paul Zelinski
	Bill Mollard
Salvation Army/Harbour Light	Jackie Franson
PHS	Liz Evans
	Mike Bodner
	Coco Culbertson
Carnegie	Ethel Whitty
	Catriona Moore
	Diane Brown
HAVE	Amber Anderson
Dugout	Jackie Smith
Truckstop Dining	Tara Mcateer
Jen's Kitchen	Jen Allan
Raincity Housing	Danille Nakouz (at the Luxe)
	Leslie Remund
	Amelia Ridgway(at the Vivian
	Mark Smith

St James Community Services	Jonathan
Powell Shelter Place for Women	Trudi Shymka
Lifeskills	Sarah Common
Lookout Emergency Aid Society	Noreen
Catholic Charities	Scott Small
First United	Sandra Severs
	Jillian Rhodes
Evelyn Saller	Alex Chisholm
Atira	Janice Abbott
	Deanna Decker
Crabtree Corner	Nancy Cameron
MPA Society	Sue Baker
Positive Woman's Network	Bronwyn Barrett
WISH	Kate Gibson
Lookout Emergency Aid Society	Karen O'Shannacery
Carnegie Community Action Project	Wendy Pedersen
	Jean Swanson
	Andy Yan
Oppenheimer Park	Sandy Mackeigen
Loving Spoonful	John Britton
	James Koch
	Rani Wangsawidjiya
NON-FOOD COMMUNITY ORGS.	
United We Can	Brian Dodd
	Sean Dory
PACE	Kerry Porth
Watari	Deno Hurst
DTES Seniors Centre	Steve Chan
DTES Centre for the Arts	Dalannah Bowen
DT Community Court	Sharon Belli
Vancouver Second Mile Society	Catherine Yau
	Annie Yu
SOCIAL HOUSING	
Urban Native Youth	Chuck Lafferty
	Dixie Lee Vance
	Robert
	Gil Lerat
Crabtree Housing	Benita Ho

Mavis McMullan Housing Society	Nikki Scott
Manager Lore Krill Housing Co-op	Liz
Strathcona Community Centre	Tom Baker
DAMS	Linda Dewar
Cordova House	Noorjahan Rana
CAFES AND RESTAURANTS	
Nuba	Aaron
Edible Planet	Marilyn Kopansky
Go2	Dennis Green
Zoteck Consulting	Chris Beall
Restaurant Manager	Peter Baker
Chef	Chris Moran

Appendix I

DTES Stakeholder Organization Surveys

- DTES Kitchen Tables Project

DTES Kitchen Tables Survey November 2009
RESEARCHERS

Organization Name:

Survey Respondent Name:

Survey Respondent Role:

Phone: **Email:**

Time & Resources

1. What are the resources you have available for DTES food research activities?

   No. of Researchers

   Budget

2. In your opinion, are these resources adequate?

3. If not, what additional research would you like to see done in the DTES?

4. What would this additional research accomplish?

5. Does your food research work in the DTES specifically consider people living with:

   HIV/AID Yes or No

   Hep. C Yes or No

   Diabetes Yes or No

6. Do you know where food research materials on the DTES can be found?

7. Do you think it would be beneficial to all stakeholders and DTES residents to have some kind of central, food information resource or hub for the DTES?
   (please circle) Yes or No

8. If so, do you have any suggestions how this could be created?

9. If so, can you suggest who could organize and monitor such a food information hub?

Duplication and Redundancy

10. In your opinion, are there effective researchers or research projects in Vancouver who are making progress on food on behalf of the DTES community?

    (please circle) Yes or No

    If yes, please describe:

    If no, how could research be stronger and more influential to improve food in the DTES?

11. In order to make food a priority for policy makers and other organizations, can you please suggest existing research initiatives where DTES food policy research could be best piggybacked? (eg; green initiatives, economic development, social housing, etc.)

12. In what ways do you think researchers could work together to analyze the DTES food ecosystem in order to reduce redundancy and maximize cost savings and other advantages? (please mark with an X)

Purchasing Food	Growing Food	Transporting Food
Transport of Meals	Cold Food Storage	Dry Food Storage
Food Program Staffing	Food Safety Education	Funding/Fundraising
Food Program Delivery	Menu Development	

    Other:

Nutritional Food Standards & Education

13. Do you think food research conducted in the DTES should examine nutritional food standards? (please circle) Yes or No

    Please describe:

14. Against what guidelines should those nutritional food standards be examined?

Food Distribution/Purchasing Methods

15. What are the gaps you see in your food research work on behalf of the DTES?

Community Capacity Building

16. Should food research include an examination of community capacity building factors in addition to access to food? eg; jobs, skill building, supporting the economy
(Please mark with an X all that apply)

    Food Safety Training & Jobs

    Menu Creation Training & Jobs

    Food Procurement Purchasing & Jobs

    Food Preparation Training & Jobs

    Food Distribution Jobs

    Health Education

    Purchasing Local Food

17. Does your research work consider education to the community on health and nutrition?
(please circle or mark with X) Yes or No

    If so, how?

18. How could your research work accomplish influence better education of DTES residents on health and nutrition?

Open Questions

19. If you had a magic wand what would your food research work in the DTES accomplish?

20. What is your biggest frustration about food research in the DTES?

21. What do you think is the biggest misconception about food or food research in the DTES?

22. If you had a magic wand what would you list as your top 3 priorities for food research in the DTES?

Thank you for your feedback!

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OR

Please FAX your completed survey to: **Johanna Li**
Fax: 604.683.0071

DTES Kitchen Tables Survey November 2009
FOOD POLICY

Organization Name:

Survey Respondent Name:

Survey Respondent Role:

Phone: **Email:**

Time & Resources

1. In your organization today, what are the staff and resources you have available for food policy related activities in the DTES?

   No. of Staff

   Budget

2. In your opinion, are these time and resources adequate?

3. If not, what additional staff and budget would you like to see added?

4. What would these additional resources accomplish?

5. Does your food policy work specifically consider specifically people living with:

   HIV/AID Yes or No

   Hep. C Yes or No

   Diabetes Yes or No

6. In your opinion, who should be responsible for achieving greater food security for DTES residents? Please list all stakeholders that apply…

Duplication and Redundancy

7. In your opinion, is there a collaborative and effective group in Vancouver who is making progress on food policy at various levels of government on behalf of the DTES community? (please circle) Yes or No

If yes, please describe:

If no, would a collaborative and focused policy advocacy group be useful and if so how?

8. In order to make food a priority for decision makers in your organization, can you please suggest existing policy areas or departments where DTES food policy advocacy could be best piggybacked? (eg; green initiatives, economic development, social housing, etc.)

9. In what ways do you think DTES food policy makers could work together more efficiently to reduce redundancy and maximize cost savings and other advantages? (please mark with an X)

Purchasing Food	Growing Food	Transporting Food
Transport of Meals	Cold Food Storage	Dry Food Storage
Food Program Staffing	Food Safety Education	Funding/Fundraising
Food Program Delivery	Menu Development	

Other:

Nutritional Food Standards & Education

10. Do you think food policy created for the DTES should incorporate nutritional food standards? (please circle) Yes or No

    Please describe:

11. Who or what should determine those nutritional food standards?

12. Do you think food safety training and certification is important for all employees/volunteers that prepare food in the DTES? (please circle) Yes or No

13. If so, who should pay for this training and certification?

Food Distribution/Purchasing Methods

14. What are the gaps you see in your food policy work on behalf of the DTES?

15. How do you think DTES food providers could work together more efficiently to *purchase* food more effectively and efficiently?

16. How do you think DTES food providers could work together more efficiently to *distribute* food more effectively and efficiently?

Community Capacity Building

17. Should food policy include community capacity building goals in addition to access to food? eg; jobs, skill building, supporting the economy
(Please mark with an X all that apply)

    Food Safety Training & Jobs

    Menu Creation Training & Jobs

    Food Procurement Purchasing & Jobs

    Food Preparation Training & Jobs

    Food Distribution Jobs

    Health Education

    Purchasing Local Food

18. Does your policy work consider education to the community on health and nutrition?
(please circle or mark with X) Yes or No

    If so, how?

19. How could your policy work accomplish better education of DTES residents on health and nutrition?

20. Would you welcome the creation of a mechanism that allows DTES food providers to collaborate on the procurement, preparation and distribution of food?
(please circle or mark with X) Yes or No

Open Questions

21. If you had a magic wand what would your food policy work in the DTES accomplish?

22. What is your biggest frustration about food policy in the DTES?

23. What do you think is the biggest misconception about food or food policy in the DTES?

24. If you had a magic wand what would you list as your top 3 priorities for food policy in the DTES?

Thank you for your feedback!

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Please FAX your completed survey to: **Johanna Li**
Fax: 604.683.0071

DTES Kitchen Tables Survey
FOOD PROVIDER ORGANIZATIONS

Organization Name:

Survey Respondent Name:

Survey Respondent Role:

Phone: **Email:**

Time & Resources

1. How much money does your organization annually on:

Food	$	per year
Food Preparation Staff	$	per year
Other Food Related Programming	$	per year
Total Budget	$	per year

2. To pay for food programs does your organization receive funding or fundraise?

   Funding Sources:

   Fundraising Activities:

3. How many paid staff and/or volunteers do you require *monthly* for the delivery of your food programs (administration, cooks, etc.)?

No. of Paid Food Prep Staff	P/T	F/T
No. of Paid Administrative Staff	P/T	F/T
No. of Volunteers		

4. What % of your organization's time spent on the delivery of its food programs?

   Approximately %

5. Do you have adequate resources to deliver your food programs in these three areas?

Food	Yes	or	No
Funding	Yes	or	No
Staffing	Yes	or	No

   If so, please describe your challenges?

If not, please describe what could be improved?

Duplication and Redundancy

6. In what ways do you think DTES food providers could work together more efficiently to reduce redundancy and maximize cost savings and other advantages? (please mark with an X)

Purchasing Food	Growing Food	Transporting Food
Transport of Meals	Cold Food Storage	Dry Food Storage
Food Program Staffing	Food Safety Education	Funding/Fundraising
Food Program Delivery	Menu Development	
Other:		

Nutritional Food Standards & Education

7. Does your organization currently have nutritional standards?
(please circle or mark with X) Yes or No

8. Would your organization welcome the development of nutritional standards?
(please circle or mark with X) Yes or No

9. Do you invest time in menu planning?
(please circle or mark with X) Yes or No

10. Do you develop your menus considering people living with:

HIV/AID	Yes	or	No
Hep. C	Yes	or	No
Diabetes	Yes	or	No

11. Would your organization welcome a pool of menu resources?
(please circle or mark with X) Yes or No

12. Of the food you purchase, what % of this food includes the following?

Protein	%	eg; meat, milk, cheese, tofu
Starch/Carbohydrates	%	eg; rice, potatoes, bread

Fruits		%	eg; bananas, apples
Vegetables		%	eg; carrots, broccoli
Desserts		%	eg; muffins, pastries, donuts, cakes, cookies
Other		%	(please describe)
Total	100	%	

13. Of the food donations you receive, what % of this food includes the following?

		(Please Describe)
Protein	%	
Starch/Carbohydrates	%	
Fruits	%	
Vegetables	%	
Desserts	%	
Other	%	
Total	%	

14. Are you satisfied with the food donations you receive?
(please circle or mark with X)

In terms of its *Nutritional Quality* to meet community needs	Yes	or	No
In terms of its *Volume* to meet community needs	Yes	or	No
In terms of its *Frequency* to meet community needs	Yes	or	No

15. Do you think there is a need for food donors to be educated on nutritional standards for the benefit of DTES residents?
(please circle or mark with X) Yes or No

Food Distribution/Purchasing Methods

16. Where do you buy food?

	(Please Describe)
Food Suppliers	
Farmers/Gardeners	
Grocery Stores	

Quest

Other

17. From whom do you receive food donations? (please circle of mark with X)

    Food Runners

    Restaurants

    Quest

    Food Suppliers (eg, Sysco, Yen Bros.)

    Farmers

    Food Bank

    Private Individuals

    Faith-based Organizations

    Grocers

18. How many people do you feed?

    Daily Weekly Monthly

19. How many people would you like to feed?

    Daily Weekly Monthly

20. How do you deliver food to them?
    (eg; lineups, sit down meals, during your programs, etc)

21. How do you think DTES food providers could work together more efficiently to *purchase* food more effectively and efficiently?

22. How do you think DTES food providers could work together more efficiently to *distribute* food more effectively and efficiently?

DTES Kitchen Tables

Community Capacity Building

23. Do your volunteers and staff receive:

    Food Safety Training

    Food Preparation Training

    Menu Creation Training

    Nutritional Standards Training

24. Would you welcome professional expertise in:

    Food Distribution

    Food Preparation

    Food Procurement

    Menu Planning

25. Do you provide education to the community on health and nutrition?
    (please circle or mark with X) Yes or No

    If so, how do you go about this?

26. How could you better educate DTES residents on health and nutrition?

27. Would you welcome the creation of a mechanism that allows DTES food providers to collaborate on the procurement, preparation and distribution of food?
    (please circle or mark with X) Yes or No

Open Questions

28. If you had a magic wand what would your food program accomplish?

29. What is your biggest frustration as a food provider?

30. What do you think is the biggest misconception about food in the DTES?

31. If you had a magic wand what would you list as your top three priorities for food in the DTES?

Thank you for your feedback!

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DTES Kitchen Tables

DTES Kitchen Tables Survey November 2009
Non Food Provider Organizations

Organization Name:

Survey Respondent Name:

Survey Respondent Role:

Phone: **Email:**

Time & Resources

1. Although you aren't a recognized DTES food provider, do you end up spending any money annually on:

Food	$	per year
Food Preparation Staff	$	per year
Other Food Related Programming	$	per year
Total Budget	$	per year

2. Why did you take on the responsibility for finding and distributing food to your members?

3. Is the food you distribute: Meals Snacks

4. To pay for this food, does your organization receive funding or fundraise?

   Funding Sources:

   Fundraising Activities:

5. How many paid staff and/or volunteers do you require *monthly* to deal with the food you gather and distribute?

No. of Paid Food Prep Staff	P/T	F/T
No. of Paid Administrative Staff	P/T	F/T
No. of Volunteers		

6. What % of your organization's time is spent on sourcing this food?

   Approximately %

7. Does including food in your programming drain your staff and volunteer resources from your regular programming? Yes No

   If yes, please describe.

8. If you receive solicited or unsolicited food donations, what % of this food includes the following?

		(Please Describe)
Protein	%	
Starch/Carbohydrates	%	
Fruits	%	
Vegetables	%	
Desserts	%	
Other	%	
Total	%	

9. If you accept food donations, are you satisfied with what you receive? (please circle or mark with X)

In terms of its *Nutritional Quality* to meet community needs	Yes	or	No
In terms of its *Volume* to meet community needs	Yes	or	No
In terms of its *Frequency* to meet community needs	Yes	or	No

10. How many people receive food from you?

    Daily Weekly Monthly

11. How many of your members need food which you can't supply?

    Daily Weekly Monthly

12. How do you deliver food to them?
    (eg; lineups, sit down meals, during your programs, etc)

Duplication and Redundancy

13. From what you know about DTES organizations, food providing or non-food providing, in what ways do you think they could work together more efficiently to reduce redundancy and maximize cost savings and other advantages? (please mark with an X)

    Purchasing Food Growing Food Transporting Food

Transport of Meals	Cold Food Storage	Dry Food Storage
Food Program Staffing	Food Safety Education	Funding/Fundraising
Food Program Delivery	Menu Development	
Other:		

Nutritional Food Standards & Education

14. To your knowledge, do DTES food and non-food providers such as your organization have nutritional standards?
(please circle or mark with X) Yes or No

15. Do you believe that DTES food providers and non-food providers *should have* nutritional standards?
(please circle or mark with X) Yes or No

16. If yes, should food menus be developed in consideration of people living with:

HIV/AIDS	Yes	or	No
Hep. C	Yes	or	No
Diabetes	Yes	or	No

17. Do you think there is a need for food donors (both private and corporate), to be educated on nutritional standards, for the benefit of DTES residents?
(please circle or mark with X) Yes or No

18. How do you think DTES food providers and non food providers such as your organization could work together more efficiently to *purchase* food more effectively and efficiently?

19. How do you think DTES food providers and non food providers could work together more efficiently to *distribute* food more effectively and efficiently?

Community Capacity Building

20. If there was a system established for the delivery of high quality, wholesale food ingredients to your organization, would you be willing to accept and prepare or distribute it to your members on a daily basis? (eg, fruits, vegetables, meat, bread)
(please circle or mark with X)

Yes No Unsure (please explain)

21. If there was a system established for the delivery of high quality, ready-to-eat food/meals to your organization, would you be willing to accept and distribute it to your members on a daily basis? (eg, smoothies, sandwiches, healthy snacks)
(please circle or mark with X)

Yes No Unsure (please explain)

With adequate funds, would you be willing to purchase these meal services for your members? (please circle or mark with X) Yes or No

22. Do you offer health and nutrition programs to DTES residents? (please circle or mark with X) Yes or No

    If yes, please describe

23. How would you improve your health and nutrition programs?

Open Questions

24. If you had a magic wand, what would DTES food delivery programs accomplish?

25. What is your biggest frustration regarding food in the DTES?

26. What do you think is the biggest misconception about food in the DTES?

27. If you had a magic wand, what would you list as your top three priorities for food in the DTES?

Thank you for your feedback.

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DTES Kitchen Tables Survey November 2009
Health Care Providers

Organization Name: *
**** If you prefer to answer anonymously, please do so***

Survey Respondent Name: *
**** If you prefer to answer anonymously, please do so***

Survey Respondent Role:

Phone: **Email:**

Time & Resources

1. Although you are not a recognized food provider, do you end up spending any money annually on:

Food	$	per year
Food Preparation Staff	$	per year
Other Food Related Programming	$	per year
Total Budget	$	per year

2. If your answer to #1 is yes, when and why do you offer your patients food?

3. Is the food you distribute: Meals Snacks

4. What % of your organization's time is spent on the delivery of this food?

   Approximately %

5. Do you have adequate resources to organize this food sourcing and distribution?

Food	Yes	or	No
Funding	Yes	or	No
Staffing	Yes	or	No

   Please describe the challenges?

   Please describe what could be improved?

6. Do you prescribe Ensure for your patients? Yes No

7. If yes, how often and in what quantities?

8. Are you satisfied with the nutritional quality of Ensure? Yes No

Duplication and Redundancy

9. In what ways do you think DTES food providers could work together more efficiently to reduce redundancy and maximize cost savings and other advantages? (please mark with an X)

Purchasing Food	Growing Food	Transporting Food
Transport of Meals	Cold Food Storage	Dry Food Storage
Food Program Staffing	Food Safety Education	Funding/Fundraising
Food Program Delivery	Menu Development	

Other:

Nutritional Food Standards & Education

10. Do you know if DTES food providers have nutritional standards?
(please circle or mark with X) Yes or No

11. If yes, what are those nutritional standards?

12. If no, should they develop nutritional standards? Yes No

Who or how should nutritional standards be developed?

13. Do you believe DTES food provider menus should be designed according to the needs of people living with:

HIV/AIDS Yes or No

Hep. C Yes or No

Diabetes Yes or No

14. On average, how often do your patients talk to you about food?
(please circle or mark with X) All the time Sometimes Rarely

15. What are the typical words your patients use when they talk about food?

16. To your knowledge, of the food your patients eat, what % of this food includes the following?

Protein		%	eg; meat, milk, cheese, tofu
Starch/Carbohydrates		%	eg; rice, potatoes, bread
Fruits		%	eg; bananas, apples
Vegetables		%	eg; carrots, broccoli
Desserts		%	eg; muffins, pastries, donuts, cakes, cookies
Other		%	(please describe)
Total	100	%	

17. In relation to your patients' health status, which foods do you most often encourage them to eat **more o**f?

	(Please Describe)
Protein	
Starch/Carbohydrates	
Fruits	
Vegetables	
Desserts	
Other	

18. In relation to your patients' health status, which foods do you most often encourage them to eat **less o**f? (please circle or mark with X)

	(Please Describe)
Protein	
Starch/Carbohydrates	
Fruits	
Vegetables	
Desserts	
Other	

19. In relation to your patients' health status, please asses the following:

    Nutritional Quality of food available meets patients' needs Yes or No

    Volume of food available meets patients' needs Yes or No

    Frequency of food available meets patients' needs Yes or No

20. Do you think that food donors need to be educated about the nutritional needs of your patients? (please circle or mark with X) Yes or No

21. With what frequency do you refer your patients to meal or nutrition programs in other organizations? (eg Positive Women's Network, Loving Spoonful)
    Never Rarely Often

22. For the medications your organization typically prescribes, what % of the time is it important that your patients take their meds with food? (please mark with X)

    Never 25% of the time 75% of the time 100% of the time

Food Distribution/Purchasing Methods

23. If your organization sometimes buys food (at Christmas, for example), where do you buy it?
    (Please Describe)

    Food Suppliers

    Farmers/Gardeners

    Grocery Stores

    Quest

    Other

24. If your organization sometimes receives food donations, where do they come from? (please circle of mark with X)

    Food Runners

    Restaurants

    Quest

    Food Suppliers (eg, Sysco, Yen Brothers)

    Farmers

    Food Bank

    Private Individuals

    Faith-based Organizations

Grocers

25. On these occasions (eg Christmas), how many patients do you feed?

    Daily Weekly Monthly

26. How many patients would you like to feed?

    Daily Weekly Monthly

27. How do you serve the food to patients?
    (eg; lineups, sit down meals, during your programs, etc)

28. How do you think DTES food providers could work together more efficiently to *purchase* food more effectively and efficiently?

29. How do you think DTES food providers could better work together to *distribute* food more effectively and efficiently?

Community Capacity Building

30. As a health care provider, have you ever received Nutritional Standards Training?
    Yes No

31. Would you welcome professional expertise in Nutrition?:

32. Do you educate your patients regarding nutrition?
    (please circle or mark with X) Yes or No

    If yes, how do you go about this?

33. How could you better educate your patients on nutrition?

34. If there was a system established for the delivery of high quality, wholesale food ingredients to your organization, would you be willing to accept and prepare or distribute it to your members on a daily basis? (eg, fruits, vegetables, meat, bread)
    (please circle or mark with X)

    Yes No Unsure (please explain)

35. If there was a system established for the delivery of high quality, ready-to-eat food/meals to your organization, would you be willing to accept and distribute it to your patients on a daily basis? (eg smoothies, sandwiches, healthy snacks)

    Yes No Unsure (please explain)

36. Would you welcome the creation of a mechanism that allows DTES food providers to collaborate on the procurement, preparation and distribution of food?
    (please circle or mark with X) Yes or No

Open Questions

37. What do you think is the biggest challenge for your patients to access nutritional food?

38. What is your biggest frustration about food provision in the DTES?

39. What do you think is the biggest misconception about food in the DTES?

40. If you had a magic wand what would you list as your top three priorities for food in the DTES?

Thank you for your feedback.

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DTES Kitchen Tables

DTES Kitchen Tables Survey November 2009
GROWERS AND SUPPLIERS

Organization Name:

Survey Respondent Name:

Survey Respondent Role:

Phone: **Email:**

Time & Resources

1. What time and resource saving measures can you suggest for general food procurement for DTES food providers?

Duplication and Redundancy

2. In what ways do you think DTES food providers could work together more efficiently to reduce redundancy and maximize cost savings and other advantages?
(please mark with an X)

Purchasing Food	Growing Food	Transporting Food
Transport of Meals	Cold Food Storage	Dry Food Storage
Food Program Staffing	Food Safety Education	Funding/Fundraising
Food Program Delivery	Menu Development	Bulk Buying
Forward Food Purchasing		
Other:		

Nutritional Food Standards & Education

3. Of the food you sell in the DTES, what % of this food includes the following?

Protein	%	eg; meat, milk, cheese, tofu
Starch/Carbohydrates	%	eg; rice, potatoes, bread
Fruits	%	eg; bananas, apples
Vegetables	%	eg; carrots, broccoli
Desserts	%	eg; muffins, pastries, donuts, cakes, cookies

Other		%	(please describe)
Total	100	%	

4. Of the food you donate, what % of this food includes the following?

		(Please Describe)
Protein	%	
Starch/Carbohydrates	%	
Fruits	%	
Vegetables	%	
Desserts	%	
Other	%	
Total	%	

5. Are you satisfied with the food donations you receive and pass onto DTES organizations? (please circle or mark with X)

In terms of its *Nutritional Quality* to meet community needs	Yes	or	No
In terms of its *Volume* to meet community needs	Yes	or	No
In terms of its *Frequency* to meet community needs	Yes	or	No

6. Do you think there is a need for food donors to be educated on nutritional standards for the benefit of DTES residents? (please circle or mark with X) Yes or No

Food Distribution/Purchasing Methods

7. Approximately, how much food do you currently *sell* to organizations in the DTES annually?

   $

   Volume

8. Approximately, how much food do you currently *donate* to organizations in the DTES annually?

   $

   Volume

9. How do you think DTES food providers could work together more efficiently to *purchase* food more effectively and efficiently?

10. Would you welcome the creation of a mechanism that allows DTES food providers to collaborate on the procurement of food? (please circle or mark with X) Yes or No

11. What suggestions do you have create and run this mechanism?

Community Capacity Building

12. Would supplying more food to DTES community organizations be beneficial to you in terms of local economic development?

Open Questions

13. If you had a magic wand, what would supplying food to the DTES look like?

14. What is your biggest frustration regarding food in the DTES?

15. What do you think is the biggest misconception about food in the DTES?

16. If you had a magic wand, what would you list as your top three priorities for food in the DTES?

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DTES Kitchen Tables Survey November 2009
CAFES AND RESTAURANTS

Organization Name:

Survey Respondent Name:

Survey Respondent Role:

Phone: **Email:**

Time & Resources

1. What efficiencies can you share from your experiences running a café or restaurant that are transferrable to the providers of free or low cost food and meals in the DTES?

2. What are some of the biggest time saving measures you know of in volume food preparation and distribution?

3. What are some of the biggest resource saving measures you know of in volume food preparation and distribution? eg; Money, Staffing

Duplication and Redundancy

4. In what ways do you think DTES food providers could work together more efficiently to reduce redundancy and maximize cost savings and other advantages?
(please mark with an X all that apply)

Purchasing Food	Growing Food	Transporting Food
Transport of Meals	Cold Food Storage	Dry Food Storage
Food Program Staffing	Food Safety Education	Funding/Fundraising
Food Program Delivery	Menu Development	
Other:		

5. Of these things above that could be made more efficient, how do you suggest DTES food providers create systems for this?

Nutritional Food Standards & Education

6. What kind of role can the development of recipes and menus play to ensure quality, nutritional food standards?

7. How important do you think it is for all individuals preparing food to have their Safety/Sanitation Certification, even if that food is distributed for free to DTES residents by volunteers? Do you think this should be made mandatory?

Food Distribution/Purchasing Methods

8. What have you done in the past running a café or restaurant to alleviate the tedium of line-ups? Be creative…

9. What are some practical suggestions to allow community food providers to purchase food collectively in order to be save money and be more efficient?

Community Capacity Building

10. Would you be interested in spending time in the DTES to share your food industry knowledge and expertise. If so in what capacity?

Open Questions

11. What are some of the fixable challenges that you can see in food provision in the DTES?

12. How can “food specialists” such as restaurateurs provide meaningful guidance for food preparation and distribution in the DTES?

13. What is your biggest frustration regarding food in the DTES?

14. What do you think is the biggest misconception about food in the DTES?

15. If you had a magic wand, what would you list as your top three priorities for food in the DTES?

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