

# Food insecurity during COVID-19 in a Canadian academic pediatric hospital: a cross-sectional survey

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## Abstract

**Background:** Hospital-based food insecurity is defined as the inability of caregivers to obtain adequate food during their child's hospital admission. We aimed to measure the prevalence of household and hospital-based food insecurity, and to explore the associations with caregiver distress in an academic pediatric hospital setting.

**Methods:** We conducted a cross-sectional survey of caregivers of children admitted to the general pediatric ward of an academic pediatric hospital in Toronto, Ontario, from April to October 2020. We measured household food insecurity using the 18-item Household Food Security Survey Module, and included 3 adapted questions about hospital-based food insecurity. We measured caregiver distress with the Distress Thermometer for Parents. We used descriptive statistics to assess the proportion of respondents with food insecurity, and linear regression models to explore the relation of household (adult and child) and hospital-based food insecurity with caregiver distress. We used thematic analysis to explore caregivers' feedback.

**Results:** We contacted 851 caregivers, and 775 (91.1%) provided consent to participate. Overall, 430 (50.5%) caregivers completed at least part of the survey. Caregivers described a high prevalence of household (34.2%) and hospital-based (38.1%) food insecurity. Adult ( $\beta = 0.21$ , 95% confidence interval [CI] 0.07–0.36), child ( $\beta = 0.38$ , 95% CI 0.10–0.66) and hospital-based ( $\beta = 0.56$ , 95% CI 0.30–0.83) food insecurity were significantly associated with caregiver distress, independent of covariates. We identified financial burden, emotional and practical barriers, stress obtaining food and advocacy for food as important themes in caregiver feedback.

**Interpretation:** Both household and hospital-based food insecurity were highly prevalent among caregivers. To reduce caregiver distress, hospitals need to consider reducing barriers for caregivers in obtaining food for themselves during their child's admission.

Household food insecurity, defined as unreliable access to sufficient quantities of affordable and nutritious food, affects 1 in 6 children under the age of 18 in Canada.<sup>1</sup> It has been associated with multiple negative health outcomes in children, including behavioural problems, developmental delay and decreased academic performance and school engagement.<sup>2–8</sup> Children who experience food insecurity are likely to be sick more frequently and be hospitalized more often.<sup>9</sup> There are concerns of increased rates of food insecurity during the COVID-19 pandemic,<sup>10,11</sup> but no evidence to date appears to have specifically addressed families with children with acute or chronic illness at this time.

Hospital-based food insecurity is defined as the inability of caregivers to obtain adequate healthy food, or enough to eat, during their child's hospital stay.<sup>12,13</sup> Food insecurity is also associated with poorer health among adults, including caregiver distress.<sup>1</sup> Hospital-based food insecurity may interfere with the caregivers' ability to play an active role in family-centred care as they may be hungry. Caregiver hospital-based food insecurity has not been well studied. In a recent study in the United States before the COVID-19 pandemic, about one-third of caregivers reported hospital-based food insecurity.<sup>12,13</sup> Little is

known about hospital-based food insecurity in the Canadian setting, or in the context of the COVID-19 pandemic. Understanding hospital-based food insecurity is important to inform health system policies to support caregivers optimally during pediatric hospital admissions.

Given the high prevalence of household food insecurity in Canada, potentially exacerbated during the COVID-19 pandemic, we hypothesized a high prevalence of hospital-based food insecurity in Canadian hospitals. This hypothesis is further supported by the fact that parents need to buy their own food when their child is admitted to hospital, and parents of children with a chronic illness already have high financial burdens.<sup>14</sup> Our study objective was to determine the prevalence

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of household and hospital-based food insecurity in our hospital setting. Furthermore, we investigated the association between food insecurity and caregiver distress during a child's hospital admission and overall caregiver experiences about their food situation during their child's hospital stay.

## Methods

### Study design

We used a cross-sectional, survey-based study design and followed the Checklist for Reporting Results of Internet E-Surveys (CHERRIES)<sup>15</sup> and Standards for Reporting Qualitative Research (SRQR).<sup>16</sup>

### Setting and participants

The study setting was the general pediatric inpatient unit of the Hospital for Sick Children in Toronto, Ontario, from April through October 2020. The Hospital for Sick Children is the largest academic pediatric hospital in Canada and serves children aged 0 to 18 years. The research assistant (N.Z.) approached all caregivers with a child admitted to the general pediatric ward by calling the guardian identified in the child's electronic medical record. Participating caregivers had to be able to understand English and have Internet access to participate. There was no minimum length of hospital stay to participate in our study.

### Procedure

Caregivers were given a recruitment letter upon hospital admission that informed them that the study explored food insecurity (Appendix 1, available at [www.cmajopen.ca/content/10/1/E82/suppl/DC1](http://www.cmajopen.ca/content/10/1/E82/suppl/DC1)). The research assistant (N.Z.) contacted the caregiver identified in the electronic medical record by phone 24–48 hours after admission and asked for consent to participate. No telephone messages were left about the study. One caregiver per household consented via a REDCap survey link. We invited this caregiver to complete the survey during admission or after discharge. We sent 3 reminders to complete the survey. No incentives were offered.

### Data sources

Two authors (M.v.d.H., C.S.B.) designed the survey (Appendix 2 and Appendix 3, available at [www.cmajopen.ca/content/10/1/E82/suppl/DC1](http://www.cmajopen.ca/content/10/1/E82/suppl/DC1)), which included validated measures of food insecurity and caregiver stress. One author (N.Z.) reviewed the electronic health records for children whose caregiver participated in the study. If there was any unclarity, another author (M.v.d.H.) also reviewed the electronic health record.

## Measures

### Exposure

We measured household food insecurity with the 18-item US Household Food Security Survey Module (HFSSM).<sup>17</sup> The HFSSM is included in the Canadian Community Health Survey. This module includes 10 adult-specific and 8 child-specific questions. We classified caregivers as food secure (no items affirmed)

or marginally (1 positive response), moderately (2–5 positive responsive) or severely food insecure (> 6 positive responses).<sup>1</sup>

No validated screening tool appeared to be available to measure hospital-based food insecurity. Therefore, we adapted 3 questions from the HFSSM to identify hospital-based food insecurity. For example; if the HFSSM question was “I/we could not afford balanced meals in the last 12 months,” we adapted the question to “I/we could not afford balanced meals during my child's hospital admission.” We chose these specific 3 questions to elucidate the severity of the hospital-based food insecurity (Table 1). Scoring was similar to the scoring of HFSSM.

### Outcome

We measured caregiver distress with the overall distress score and the “Practical Problems” subscale of the Distress Thermometer for Parents (DT-P) developed by Haverman and colleagues<sup>18,19</sup> in 2013. The DT-P is a well-validated questionnaire used in diverse populations of parents with chronically ill children.<sup>18</sup> The DT-P is strongly related to the Hospital Anxiety and Depression scale ( $0.55 \leq r \leq 0.61$ ) and moderately-to-strongly related to the Parenting Stress Index ( $0.38 \leq r \leq 0.43$ ).<sup>18</sup> Numerous studies have used the DT-P to measure caregiver distress in parents of children with different pediatric chronic health conditions.<sup>20,21</sup>

For the overall distress score, caregivers indicated how much distress they perceived in the previous week on a thermometer, where 0 indicated “no distress” and 10 indicated “extreme distress.” Studies have identified a cut-off score of 4 to 5 to detect substantial caregiver distress.<sup>18,19</sup> In our analysis, we measured caregiver distress as a continuous variable.

### Covariates

We asked caregivers 25 general sociodemographic questions that were based on the Canadian Community Health Survey.<sup>22</sup> Caregivers reported on the number of children in their household, their ethnicity, employment status, household income and their own health status. We collected details about the child's chronic condition, duration and month of admission from the electronic health record.

We identified potential confounders in the relation between food insecurity and caregiver stress a priori.<sup>21</sup> We included the following covariates in our analysis: child age, child's chronic condition (yes or no), duration of admission, caregiver's own health status, employment status, household income, single-parent household and number of children.<sup>23</sup> The month of admission was relevant given the 1-caregiver

**Table 1: Hospital-based food insecurity questions**

1. I/we could not afford to eat balanced meals during my child's hospital admission
2. Did you or other adults in your household ever cut the size of your meals or skip meals during the hospital admission, because there wasn't enough money for food?
3. During the hospital admission, were you ever hungry, but didn't eat because there wasn't enough money for food?

policy implemented during the COVID-19 pandemic, affecting our study from April to June 2020. This difference could have affected caregiver access to food.

### Qualitative component

To explore caregivers' experiences obtaining food in more detail, we included 1 open-ended question in our survey: "Do you have any other feedback regarding your food situation during your child's hospital admission?"

### Data analysis

We used descriptive statistics to assess the sociodemographic characteristics and the proportions of caregivers with household or hospital-based food insecurity. We compared categorical variables between caregivers who reported household food security and food insecurity. We used linear regression models to explore the association between household (adult and child) food insecurity, hospital-based food insecurity and caregiver distress during admission. In the regression models, we used both household and hospital-based food insecurity as continuous variables. We conducted an unadjusted analysis and a model adjusted for all covariates. We used variance inflation factors to assess multicollinearity. We performed multiple imputation with 15 imputed data sets using the multivariate imputation by chained equations (mice) package in R to overcome bias that may result from missing data, and combined the estimates across the 15 data sets using Rubin's rules. We tested for interactions between food insecurity and caregiver distress and the child's duration of admission or

chronic condition. All *p* values were 2-tailed and statistical significance was set at 0.05. We used R version 4.0.2 for all analyses.

We used a thematic approach to explore the answers to the 1 open-ended question about caregivers' experiences obtaining food during hospital admission. Two authors (M.v.d.H., N.Z.) independently reviewed answers. These 2 authors identified and independently categorized common themes related to hospital-based food insecurity using NVivo software (version 12), which were then reviewed with all other authors.

### Ethics approval

This study was approved by the research ethics board from the Hospital for Sick Children, Toronto.

### Results

From April to October 2020, 1340 children were admitted to our general pediatric ward. We successfully contacted 851 caregivers by telephone. Of these, 775 (91.1%) caregivers gave consent to participate, and 430 (50.5%) completed at least part of the survey. Of the participants who completed part of the survey, 44 (10.2%) did not fully complete the HFSSM (Figure 1).

### Food insecurity

Of the 386 caregivers who completed the HFSSM, household food insecurity was reported by 132 (34.2%) caregivers and for 76 (19.7%) children; 147 (38.1%) caregivers reported hospital-based food insecurity. Table 2 describes the severity of

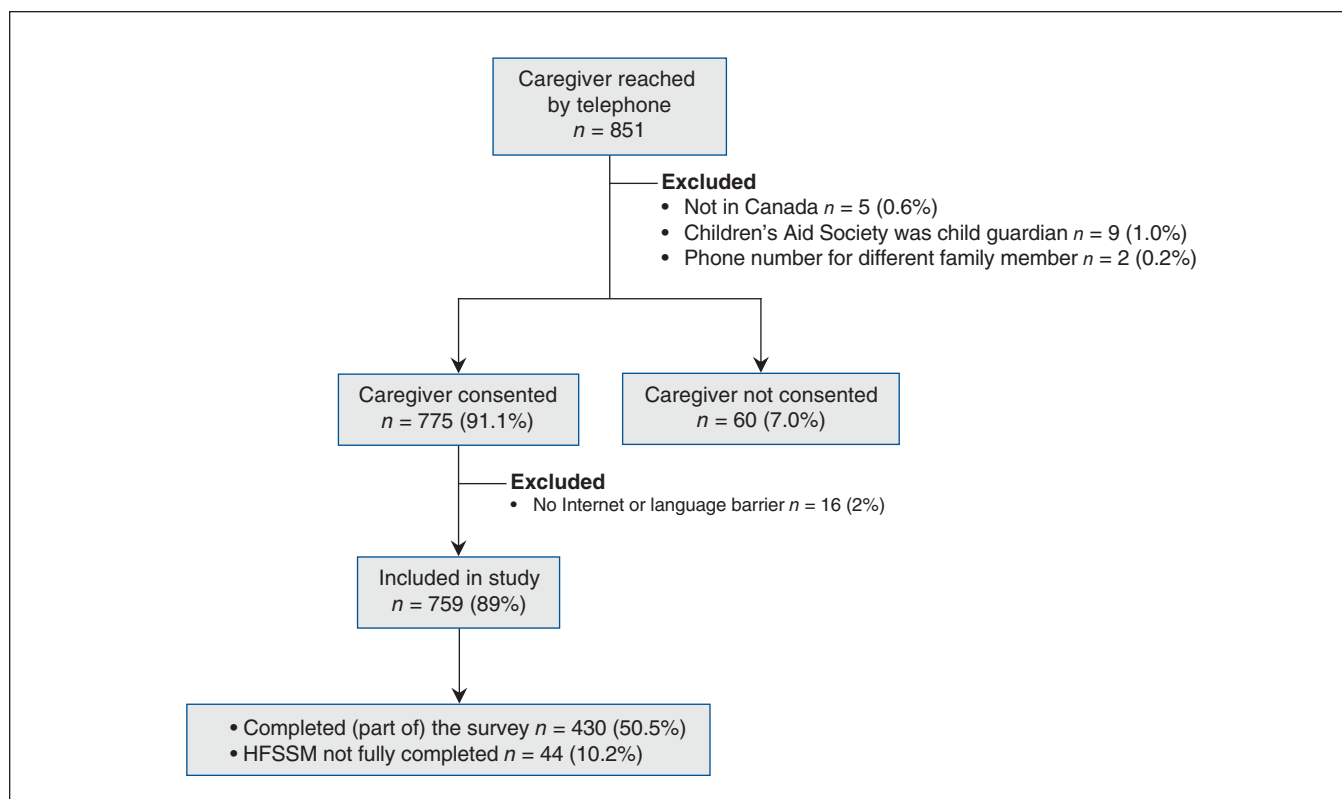


Figure 1: Study flow diagram. Note: HFSSM = Household Food Security Survey Module.

household and hospital-based food insecurity. Both household and hospital-based food insecurity was reported by 96 (24.9%) caregivers. Table 3 describes the sociodemographic characteristics of caregivers reporting food insecurity and those reporting food security.

### Caregiver distress

Both household and hospital-based food insecurity were significantly associated with caregiver distress, independent of covariates. In the adjusted model, each affirmative answer on the 10 adult questions of the HFSSM was associated with a 0.21 (95% confidence interval [CI] 0.07 to 0.36) increase in caregiver distress score. Each affirmative answer on the 8 child questions of the HFSSM was associated with a 0.38 (95% CI 0.10 to 0.66) increase in caregiver distress score. Each affirmative answer on the 3 hospital-based food insecurity questions was associated with a 0.56 (95% CI 0.30 to 0.83) increase in caregiver distress score (Table 4; see Appendix 4, Appendix Tables 1–3, available at [www.cmajopen.ca/content/10/1/E82/suppl/DC1](http://www.cmajopen.ca/content/10/1/E82/suppl/DC1), for full covariate effects).

A stratified analysis, adjusted for all covariates, showed that the association between adult food insecurity and caregiver distress was stronger for households of children without a chronic condition ( $\beta = 0.42$ , 95% CI 0.09 to 0.76) than those of children with a chronic condition ( $\beta = 0.11$ , 95% CI –0.06 to 0.27). Other interactions were nonsignificant (data available upon request).

### Caregivers' experiences obtaining food during hospital admission

In total, 71 (18.4%) of 386 parents answered the open-ended question regarding their food situation in the hospital. We identified multiple themes, presented in Table 5.

#### Financial burden obtaining food

Many caregivers commented on the high expense of food in the hospital. They often felt the need to sacrifice their own

food intake and skip meals, or to purchase inexpensive and unhealthy foods. Caregivers also described having to prioritize other expenses related to hospital admission, such as parking costs, over food.

#### Emotional and practical barriers obtaining food

Caregivers reported that they did not want to leave their child's room and did not want to take up the nurse's time to supervise their child. A subtheme also emerged around caregiver restrictions in the hospital related to COVID-19. Caregivers lacked assistance on how to access food for themselves during their child's admission.

#### Caregiver stress obtaining food

Caregivers described their increased stress in finding affordable food for themselves, in addition to the stress of their child's hospital admission.

#### Advocacy for food for parents

Many caregivers advocated for food to be provided to parents during their child's hospital admission. They articulated that this would recognize that caregivers are an important part of the child's care.

### Interpretation

Our study explored the prevalence of household and hospital-based food insecurity in a large sample of caregivers, and its relationship with distress in caregivers during their child's hospital admission. The results showed both a high prevalence of household (34%) and hospital-based (38%) food insecurity among caregivers; a quarter of the caregivers experienced both types of food insecurity.

The prevalence of food insecurity identified in our study is similar to that reported in a 2018–2019 study from a children's hospital in Texas, where 38% of caregivers reported household food insecurity and 43% reported hospital-based food

Variable*	Household food insecurity†		Hospital-based food insecurity†
	No. (%) of adults <i>n</i> = 386	No. (%) of children <i>n</i> = 386	No. (%) of caregivers <i>n</i> = 386
Food secure	254 (65.8)	310 (80.3)	239 (61.9)
Food insecure	132 (34.2)	76 (19.7)	147 (38.1)
Marginal food insecurity	51 (13.2)	38 (9.8)	67 (17.4)
Moderate food insecurity	57 (14.8)	34 (8.8)	36 (9.3)
Severe food insecurity	24 (6.2)	4 (1.0)	44 (11.4)

\*Based on Food Insecurity Policy Research (PROOF) scoring method,<sup>1</sup> for adult items, 1 positive response considered marginal food insecurity, 2–5 positive responses considered moderate food insecurity and 6 or more positive responses considered severe food insecurity. For child items, 1 positive response considered marginal food insecurity, 2–4 positive responses considered moderate food insecurity and 5 or more positive responses considered severe food insecurity. For hospital-based food insecurity items, 1 positive response considered marginal food insecurity, 2 positive responses considered moderate food insecurity and 3 positive responses considered severe food insecurity.

†Caregivers reported on household food security of adults (10 items) and children (8 items) in the household, and on hospital-based food security of caregivers (3 items).

**Table 3: Sociodemographic characteristics by food security status**

Characteristic	No. (%) missing n = 430	No. (%) of caregivers*		
		Total study population n = 430	Food insecure† n = 143	Food secure‡ n = 243
Child age, mo, mean ± SD	2 (0.5)	78.2 (71.3)	83.7 (73.8)	75.0 (70.0)
Child with a chronic health condition	1 (0.2)	257 (59.9)	91 (63.6)	138 (57.0)
Single-parent household	0 (0)	62 (14.4)	36 (25.2)	18 (7.4)
Maternal ethnicity	0 (0)			
European		147 (34.2)	33 (23.1)	104 (2.8)
East Asian		43 (10.0)	6 (4.2)	34 (14.0)
South and Southeast Asian		94 (21.9)	36 (25.2)	46 (18.9)
Black		32 (7.4)	18 (12.6)	8 (3.3)
Arabic		32 (7.4)	12 (8.4)	15 (6.2)
Latin American		21 (4.9)	11 (7.7)	10 (4.1)
Indigenous		10 (2.3)	4 (2.8)	6 (2.5)
Other		51 (11.9)	23 (16.1)	20 (8.2)
Employment	0 (0.0)			
Both caregivers employed full time		89 (20.7)	8 (5.6)	76 (31.3)
One caregiver employed full time		212 (49.3)	70 (49.0)	124 (51.0)
Both caregivers employed part time		8 (1.9)	4 (2.8)	3 (1.2)
Neither caregiver employed		31 (7.2)	23 (16.1)	6 (2.5)
Other (e.g., parental leave)		90 (20.9)	38 (26.6)	34 (14.0)
Number of children	9 (2.1)	2.2 (1.2)	2.5 (1.4)	2.0 (1.0)
Family income before tax, \$	71 (16.5)			
0 to 39 999		104 (29.0)	64 (49.2)	30 (15.2)
40 000 to 79 999		86 (24.0)	39 (30.0)	38 (19.3)
80 000 to 149 999		101 (28.1)	22 (16.9)	67 (34.0)
≥ 150 000		69 (18.9)	5 (3.8)	62 (31.5)
Trouble making ends meet	10 (2.3)	157 (37.4)	96 (68.6)	42 (17.5)
Trouble paying electricity, heat or telephone bill	7 (1.6)			
Never true		270 (63.8)	47 (33.1)	201 (83.4)
Sometimes true		127 (30.0)	77 (54.2)	36 (14.9)
Often true		26 (6.1)	18 (12.7)	4 (1.7)
Housing	4 (0.9)			
Owned		251 (58.9)	53 (37.6)	183 (75.3)
Paying rent		170 (39.9)	87 (61.7)	57 (23.5)
Other		5 (1.2)	1 (0.7)	3 (1.2)
Caregiver's own health	4 (0.9)			
Fair or poor		64 (15.0)	39 (27.3)	17 (7.1)
Excellent, very good or good		362 (85.0)	104 (72.7)	224 (92.9)
Month of admission	1 (0.2)			
April		50 (11.7)	19 (13.3)	30 (12.4)
May		90 (21.0)	35 (24.5)	46 (19.0)
June		75 (17.5)	30 (21.0)	38 (15.7)
July		61 (14.2)	15 (10.5)	40 (16.5)
August		63 (14.7)	18 (12.6)	36 (14.9)
September		60 (14.0)	14 (9.8)	36 (14.9)
October‡		30 (7.0)	12 (8.4)	16 (6.6)
Duration of admission, d, mean ± SD	5 (1.2)	5.4 (5.7)	5.5 (5.6)	5.4 (6.0)
Minimum, maximum		0, 40	0, 39	0, 40
25th percentile		2	2	2
75th percentile		6	7	6

Note: HFSSM = Household Food Security Survey Module, SD = standard deviation.

\*Unless indicated otherwise.

†Caregivers were identified as household food secure if they did not have any affirmative items on both the adult and child questions of the HFSSM. Forty-four (10.2%) caregivers did not complete the HFSSM and food security status was not calculated.

‡Study finished on Oct. 20, 2020.

**Table 4: Association between household and hospital-based food insecurity and caregiver distress using linear regression\***

Food insecurity	Difference in caregiver distress score (95%CI)	
	Unadjusted	Adjusted†
Adult household score (0–10)	0.19 (0.07 to 0.32)	0.21 (0.07 to 0.36)
Child household score (0–8)	0.33 (0.09 to 0.58)	0.38 (0.10 to 0.66)
Hospital-based score (0–3)	0.57 (0.33 to 0.81)	0.56 (0.30 to 0.83)

Note: CI = confidence interval, HFSSM = Household Food Security Survey Module.  
 \*Models included 386 caregivers who completed HFSSM and measured change in caregiver distress score (0 to 10) for each affirmative answer on the food insecurity measure.  
 †Adjusted for caregiver's own health, employment status, household income, single-parent household, number of children, month of admission, child age, child's chronic condition and duration of admission.

insecurity.<sup>13</sup> Compared with the general Canadian population, food insecurity was much more common among participants in our study. In the latest annual report from Food Insecurity Policy Research (PROOF) Canada (2017–2018), household food insecurity among households with children was 16.2%.<sup>1</sup> The higher prevalence found in our study may be related to the timing of survey administration during the COVID-19 pandemic. However, our prevalence is still much higher than recent estimates of food insecurity during COVID-19; Statistics Canada found that 19.2% of families living in households with children reported food insecurity during the same period.<sup>11</sup>

Caregivers in our study may have had increased financial costs, as has been previously reported for caregivers with a chronically ill child.<sup>14,24</sup> In contrast to medical costs, rent and utilities, food costs are variable and families may cut down on their food as a way to afford paying additional costs. Hospital admission itself adds to the burden of expenses, as parents in our study endorsed additional hospital-related financial stressors, such as transport and parking.

Our study showed that caregiver distress increased as food insecurity increased. Interestingly, the association between adult food insecurity and caregiver distress was not significant in children with a chronic condition. This may be because these caregivers have access to social work and other funding opportunities. Alternatively, caregivers of children with chronic conditions may already have higher levels of caregiver stress or be used to being food insecure. High caregiver distress is associated with a child's maladjustment to illness and adherence with medical treatment.<sup>18</sup> High caregiver distress may also affect participation in family-centred care. A previous study by Jones and colleagues<sup>23</sup> reported that greater perceived fulfillment of caregiver needs during hospital admission is associated with greater participation in hospital care. Consequently, patients of families with hospital-based food insecurity may experience a lower quality of family-centred care and be at risk for poorer child health outcomes.

Many caregivers provided written feedback about their food situation in the hospital. Although we could not identify any previous Canadian literature with which to compare our identified themes, a previous study from Manchester, England, identified similar themes regarding the expense of buying food and parents' ambiguity; this study also noted that despite the

contribution parents make to the work of caring for their children, they were not entitled to discounted meals.<sup>25</sup> A more recent study in the US reported that parents agreed that the child's needs come first, but parents need to eat to help their children.<sup>13</sup> This parallels what caregivers in our study acknowledged, namely that parents need to eat to be able to take part in the care of their child during hospital admission.

Most caregivers with food insecurity reported both household and hospital-based food insecurity. Clinicians need to be aware of this overlap. When identifying families with social needs, clinicians should also inquire about immediate, hospital-based food insecurity and offer resources (e.g., meal vouchers), when available, to families to alleviate this concern.

### Limitations

Limitations of our study include nonresponse bias. We informed caregivers about the study topic before they gave consent, and families without food insecurity may have been less inclined to participate. However, our results may have also underestimated the incidence of food insecurity, as we excluded non-English speaking families and families who did not have Internet access. Also, we did not collect any information on referrals to social workers who may have been able to provide meal vouchers. In addition, the surveys were filled in per household, and we did not collect any details about the individual caregiver who answered the survey. Our results are reflective of food insecurity during the COVID-19 pandemic, about which there are no previous local data with which to compare rates of food insecurity. Given the cross-sectional nature of our study, we could not determine any causal relation.

### Conclusion

Both household and hospital-based food insecurity were highly prevalent among caregivers with a child admitted to our academic pediatric hospital who participated in our survey. Future research should further explore the relation among food insecurity, family-centred care and child health outcomes. Hospitals need to consider reducing barriers for caregivers in obtaining food for themselves during their child's admission, such as offering nutritious food at a low cost and reducing other costs, such as parking, to reduce caregiver distress during their child's hospital stay.

**Table 5: Caregivers' experiences obtaining food during their child's hospital admission**

Theme	Subtheme	Representative quotes
Financial burden	Food is too expensive	<p>"The food in the hospital is too expensive. To eat even 2 meals a day will cost about \$30. If you're here for a week that's over \$200. It makes it hard." (SN 37)</p> <p>"I think I cut back on what I choose to eat while in hospital just because we don't eat out much and the price to eat out 3 meals a day gets expensive and I don't want to go broke eating out." (SN 155)</p> <p>"Food at the hospital is very expensive I've only been here 2 weeks now and spent over \$200 so far I can only imagine how much more money it would cost me without support it is possible to run quickly into financial issues." (SN 385)</p>
	Caregivers sacrifice their own food	<p>"I didn't eat for the first day, second day only one sandwich and so expensive to buy." (SN 94)</p> <p>"We skip at least one meal or more to afford a long stay." (SN 274)</p> <p>"I am just eating eggs and chocolate bars as my food in the hospital." (SN 122)</p>
	Financial stress	<p>"Hospital food options are expensive and unaffordable during long hospital stays. Between parking and food, it puts a financial strain when your child's medical expenses exceed your household income." (SN 133)</p> <p>"Over the years I definitely went without food during hospital admission because I otherwise wouldn't have had the money to get my car out of the parking lot when my son would be discharged." (SN 147)</p> <p>"My children have complex medical needs however because of my income I do not qualify for any financial support. I have 5 children, 3 with medical needs. I sometimes avoid taking them to hospital because financially I cannot afford it." (SN 28)</p>
Emotional and practical barriers	Difficulty leaving the child	<p>"At times it is very hard to get downstairs during the times it is open (my son has high needs and can't just stay with a volunteer)." (SN 400)</p> <p>"I do not feel comfortable leaving my child without parent's eyes on him and the nurse so as a result I packed food as best I could for 4 days." (SN 30)</p> <p>"It has been a bit challenging because I have to call a nurse to stay with my child while I get something to eat, and do understand they are extremely busy." (SN 131)</p>
	COVID-19 restrictions	<p>"We had an odd situation due to COVID due to lack of available options, inability to leave the hospital and getting care for our daughter to go downstairs and get food. We both skipped meals as they were not as accessible." (SN 24)</p> <p>"Especially with COVID, security measures are high and parents can't freely walk around. A meal program would be great for all families and their physical and mental health." (SN 253)</p> <p>"I couldn't go and get a gift card to order food because we couldn't leave the room. No offers to help with that [were] made. I went 2 days without eating." (SN 126)</p>
	Lack of information	<p>"There is unclear information about having meals sent to the room for the parents, and there are no prices attached to the menus, so ordering from the meal train is impossible." (SN 380)</p> <p>"When my child was admitted there was no guidance given to help me get food for myself." (SN 126)</p> <p>"Only today was she told that an exception is made and as my daughter is under 6 months and can't actually eat the Food Train food, it was offered to my Mrs. She had one meal all of today as she wasn't allowed to go out of the room." (SN 201)</p>
Caregiver stress		<p>"The stress of having a child admitted in the hospital is enough on top of worrying about getting yourself meals throughout the day while trying to care for your child. Especially being one parent for the child, during a pandemic." (SN 53)</p> <p>"In high-stress situations, such as having a child in a hospital, the last thing parents think about is feeding themselves." (SN 253)</p> <p>"It doesn't make sense not to offer or feed the parent that is staying in hospital with the child. If the parent isn't strong or has the energy how can they help their child recover or be of assistance to the doctors and nurses?" (SN 347)</p>
Advocacy for food for caregivers		<p>"I hope this will help other families with regards to obtaining food from the hospital who have been staying there for a longer period of time. Never have I imagined in my life that I will get a food voucher from a stranger. I know how it is to be in need, especially as essential as food. So, if you can help them with this — that will be awesome!" (SN 782)</p> <p>"It doesn't make sense not to offer or feed the parent that is staying in the hospital with the child. If the parent isn't strong or has energy — how can they help their child recover or be of assistance to doctors or nurses?" (SN 347)</p> <p>"A meal program/discount for overnight/extended stay would be so beneficial for families and we are shocked that it is not already in place." (SN 253)</p>

Note: SN = study number

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