

# Hunger Is A Health Issue



A Guide  
for Group  
or Personal  
Reflection



*A Passionate Voice for Compassionate Care®*

The Catholic health ministry has a sacred legacy in carrying out the corporal works of mercy. We are blessed to feed people who are hungry, provide drink to people who are thirsty, welcome strangers to a new land and care for people who are sick or wounded. Catholic health care's other legacy — ministering by the principles of social justice — calls us to attend to social determinants of health so we are not only responding to hunger and thirst with one serving of food and one glass of water at a time, but also changing hearts, opening minds, advocating for policies, preserving resources, protecting the environment and honoring God's people with what they need to lead full and rewarding lives.

In the article by a consulting nutritionist at the Connecticut Mental Health Center, Francine Blinten identifies three pillars of food security: food availability, food access and food use. Along with screening tools that allow for assessment of food instability, Blinten believes that her education and training left her with knowledge gaps across areas such as food access, stable employment and safe housing, which can impede nutritional and overall health. Her valuable insights may be helpful to you in how to best encounter those suffering food insecurity.

The pages that follow provide a reflection process to engage leaders around the central questions the article poses. The process is designed to be used flexibly by individuals or groups as a reflection, as part of personal formation and as an exercise between in-person sessions for participants in senior leader formation programs. We hope that it will be useful to executives, managers, clinical and non-clinical associates, board members, sponsors, ethics committee members and others.

### **Suggested Reflection Process**

1. Begin your reflection with prayer – one is provided.
2. Read the Executive Summary of the article.
3. Review the Questions for Reflection, noting their concepts, but not answering them yet.
4. Read the full article.
5. Return to the Questions for Reflection:
  - A. Review the questions after reading the entire article.
  - B. Take time to consider each question, jotting down any responses, considerations or questions that come to you.
  - C. If you are completing this as an individual, you might consider taking time to discuss your responses with a colleague – get her or his thoughts on the questions; see if the person agrees with your thoughts or has different viewpoints to offer. If you are discussing as part of a group, take your written notes with you to the meeting. For group use, it could be helpful to assign the reading and then convene either by phone or in person for group discussion.
6. Close with prayer – a concluding reflection is provided.

As you use this guide, please let CHA know if it is useful in your ongoing formation, as well as any changes, suggestions or insights about it that you would like to share. It is a resource for the ministry, and we want it to best suit your needs. To share comments, please contact Mary Ann Steiner, editor, *Health Progress*, at [masteiner@chausa.org](mailto:masteiner@chausa.org).

## Opening Prayer

Leader: Let us recognize we are in the presence of God.

Reader 1: A reading from the book of Exodus 16:2-3, 12-15

Here in the wilderness the whole Israelite community grumbled against Moses and Aaron. The Israelites said to them, "If only we had died at the Lord's hand in the land of Egypt, as we sat by our kettles of meat and ate our fill of bread! But you have led us into this wilderness to make this whole assembly die of famine!"

The Lord said to Moses: "I have heard the grumbling of the Israelites. Tell them: In the evening twilight you will eat meat, and in the morning you will have your fill of bread, and then you will know that I, the Lord, am your God."

In the evening, quail came up and covered the camp. In the morning there was a layer of dew all about the camp, and when the layer of dew evaporated, fine flakes were on the surface of the wilderness, fine flakes like hoarfrost on the ground.

On seeing it, the Israelites asked one another, "What is this?" for they did not know what it was. But Moses told them, "It is the bread which the Lord has given you to eat."

(Silence)

Leader: The Lord of Israel heard the grumbling of the people and provided for them. Jesus, the bread of life, calls all of us to action.

Reader 2: A reading from the Gospel of Matthew 25:33-35, 37, 40

He will place the sheep on his right and the goats on his left.

Then the king will say to those on his right, "Come, you who are blessed by my Father. Inherit the kingdom prepared for you from the foundation of the world.

For I was hungry and you gave me food, I was thirsty and you gave me drink."

Then the righteous will answer him and say, "Lord, when did we see you hungry and feed you, or thirsty and give you drink?"

And the king will say to them in reply, "Amen, I say to you, whatever you did for one of these least brothers of mine, you did for me."

(Silence)

Leader: The gospel calls us to feed the hungry and give drink to the thirsty, but we know that many will go without today, without access to healthy food and clean water. Let us take a moment to make our petitions known.

Reader 1: For those whose health is affected by limited access to food and water, that we work to create places for them to receive an abundance of life-giving nourishment, we pray to the Lord.

Response: Lord, hear our prayer.

Reader 1: For those who work tirelessly serving those most in need at food pantries and soup kitchens, may they be energized by your Spirit and the holy work they do, we pray to the Lord.

Response: Lord, hear our prayer.

Reader 2: Let us come to recognize our place in working for justice for those whose voices are not heard and needs not addressed in our community, we pray to the Lord.

Response: Lord, hear our prayer.

Reader 2: Let us come to truly appreciate the abundant gifts of the fruits of the earth you have given to us all and work to protect and steward the resources you provide, we pray to the Lord.

Response: Lord, hear our prayer.

Leader:

Lord of all,

All good gifts come from you.

As you provided Israel with manna and quail, you give us food and water,

yet we know people are hungry and thirsty,

give us the grace to be your hands in the world,

to recognize our own abundance and ability to give,

to promote the right to healthy food and clean water,

to act with generosity and in solidarity not just in tragic moments but always.

In your name we pray,

Amen.

## **Executive Summary**

Author Francine Blinten works as a consulting nutritionist at the Connecticut Mental Health Center. She says her education and training left her with knowledge gaps across areas such as food access, stable employment and safe housing that can impede nutritional and overall health. Food security rests on three pillars: food availability, food access and food use.

Hunger is a physical sensation caused by a lack of food. Food insecurity is a household-level condition that is broader than hunger, and it is complicated by coping strategies used to compensate for food inadequacy.

When food is available to those who are not food secure, there is often a shift toward low-cost foods that are high in sugar and saturated fat. There is overconsumption, hoarding and extreme avoidance of wasting food in anticipation of a food shortage. Food insecurity cannot always be identified by a person's appearance; people struggling with food insecurity are almost 2 ½ times more likely to be obese than the general population.

There are screening tools that allow clinicians to assess food insecurity, and screening success hinges on connecting food insecure households to community resources that can meet specific household needs outside of the practice setting.

## Questions for Reflection

Francine Blinten is a clinical nutritionist concerned about the connection between food insecurity and mental health in her roles at the Connecticut Mental Health Center and the Yale University School of Medicine, Department of Psychiatry. She contends that many health care professionals aren't trained to detect for hunger and food insecurity, which leads to patients being misdiagnosed or disregarded.

1. How widespread do you think Blinten's examples of misdiagnoses are due to lack of training and awareness of social determinants? How often do you think patients are deemed non-compliant when they haven't the means or access to carry out directives or suggestions for healthy foods and proper intakes?
2. What screening practices does your ministry have in place to help patients with issues related to food insecurity? Where is the best place/what is the best time to pursue those screenings and fill in that aspect of whole-patient care? How does it fit into the discharge plan? If your ministry doesn't have access to a clinical nutritionist for most patients, who is the right person to make sure food and nutrition issues are pursued for the patient's best health outcomes?
3. Blinten distinguishes hunger from food insecurity: the former is a personal sensation caused by lack of food; the latter is a larger issue that is household based and often ongoing and episodic. Talk about the two situations in terms of justice and how Catholic health care can contribute to both the immediate alleviation of hunger and the long-term goal of having healthy foods accessible to everyone. Does your ministry partner with other area health and social service organizations to alleviate hunger and food insecurity in your community?



# Hunger Is A Health Issue

FRANCINE BLINTEN, MS, MBA, CCN, CNS

**D**r. Laura Gottlieb once diagnosed abdominal pain in a patient when the real problem was hunger. “I confused social issues with medical problems in other patients, too,” she wrote in a well-known 2010 opinion piece published in the *San Francisco Chronicle*.<sup>1</sup>

She mislabeled the hopelessness of long-term unemployment as depression, and the poverty that caused patients to miss pills or appointments as noncompliance.

“My medical training had not prepared me for this ambush of social circumstance. Real-life obstacles had an enormous impact on my patients’ lives, but because I had neither skills nor the resources for treating them, I ignored the social context of disease altogether.”

Gottlieb’s experience resonates with me in my own work as a consulting nutritionist at the Connecticut Mental Health Center. I also was unprepared for the many barriers my patients faced in achieving a healthy diet and lifestyle. My education and training left me with knowledge gaps across areas such as food access, stable employment and safe housing that can impede nutritional and overall health.

The relationship between eating well and good health is well established. Much of the national conversation around food is about increasing vegetable and fruit consumption and limiting intake of calorie-dense, fatty food. However, lower socioeconomic populations consume less nutrient-rich foods due to their higher cost; they eat more energy-dense, inexpensive foods that are high in salt, saturated fat and refined sugar to

stretch food budgets. And health care professionals often lack training to screen for hunger and to refer patients to resources in their communities.

## WHAT IS FOOD INSECURITY?

According to the World Health Organization, a state of food insecurity occurs when there is uncertainty about future food availability and access, insufficiency in the amount and kind of food required for a healthy diet, or the need to use socially unacceptable means to acquire food because of resource or physical constraint.

Food security rests on three pillars: food availability, food access and food use. Food availability is associated with sufficient quantities of food available on a consistent basis. Food access requires resources to obtain food appropriate for a nutritious diet. “Food deserts” or geographic areas with poor access to affordable healthy foods create community-level social disparities in food access that contribute to health disparities. Food use is based on knowledge of basic nutrition and care.<sup>2</sup>

## VULNERABLE POPULATIONS IN THE U.S.

The United States is an affluent nation with an abundant food supply and yet 12.7 percent of American households struggle with food inse-



Larry Moore

curity. Children, and especially children of single parents, are vulnerable. Summer often presents challenges to feeding children who rely on free school lunch and breakfast during the academic year.

Experiences with hunger have a negative impact on the health of children 10 to 15 years later. Children who are hungry are four times more likely to need professional counseling. Hungry teens are five times more likely to commit suicide.

Hunger is pervasive among college students. A recent Temple University study showed that of 43,000 students at 66 colleges surveyed, 36 percent had trouble getting enough to eat daily.<sup>3</sup>

Food insecurity is linked with depression and anxiety, and poor dietary quality is linked to mental health problems, creating a negative feedback loop. Older adults also are at increased risk for food insecurity, some having to choose between healthy food or medication.

### HEALTH CONSEQUENCES

Diet is one of the central determinants of many health conditions including chronic diseases such as cardiovascular disease, type 2 diabetes and cancer. Individuals from food-insecure households are at increased risk for these and other diseases, difficulty in managing these illnesses when they occur, and poorer clinical outcomes associated with such illnesses.

Episodic food insecurity occurs when food funds are exhausted at certain points in time, usually at the end of the month. In 2014, Dr. Hilary Seligman and her colleagues found that inpatient

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admissions for hypoglycemia in California were more common in low-income populations than in high-income populations. Additionally, risk for hypoglycemia admission increased 27 percent in the last week of the month compared to the first week in the low-income population.<sup>4</sup> This happens because monthly food budgets are depleted at the end of the month, resulting in skipped meals and erratic feeding patterns.

Food insecurity is strongly associated with cost-related medication underuse. A study reported in the *American Journal of Medicine* by Seth Berkowitz and colleagues showed that food insecure patients with chronic illness were more likely to be unable to afford a prescription, to delay a prescription, to skip doses due to cost and to take less medication than prescribed due to cost. The prescriptions they studied were for cardiovascular disease and hypertension, diabetes, asthma, chronic obstructive pulmonary disease, arthritis and cancer.<sup>5</sup>

### COPING STRATEGIES TO AVOID HUNGER

Hunger is a physical sensation caused by a lack of food. Food insecurity is a household-level condition that is broader than hunger; it is complicated by the coping strategies used to compensate for food inadequacy.

Food insecurity is often episodic, such as with end-of-month food budget exhaustion, or seasonal, when children lose access to school lunch programs. When cycles of food adequacy and inadequacy occur, adaptive behaviors are used to cope with these food fluctuations. When food is available, there is a shift toward low-cost food that is low in fruits and vegetables and high in sugar and saturated fat. There is also overconsumption, hoarding, reliance on highly filling food and extreme avoidance of wasting food in anticipation of a food shortage. When food is scarce, eating patterns are erratic and meals are skipped. Parents often feed their children while going hungry themselves.

### CLINICAL SCREENING FOR FOOD INSECURITY

Enrollment in federal food assistance programs, such as the Supplemental Nutrition Assistance Program, commonly called SNAP, and the Special Supplemental Nutrition Program for Women, Infants and Children, known as WIC, is associated with improved outcomes across multiple dimensions, including food security, nutrition, health and health care costs. However, most health professionals lack training to assess food insecurity and most health care systems lack tools for referring food insecure patients to community-based resources such as food banks, congregate meal sites and afterschool meal programs for children.

The American Academy of Pediatrics, the American Diabetes Association and the Centers for Medicare and Medicaid Services recommend



universal food insecurity screening and referral to food resources.<sup>6</sup> Food insecurity can't always be identified by an individual's appearance due to the co-occurrence of obesity and food insecurity. People struggling with food insecurity are 2.45 times more likely to be obese than the general population.

Food insecurity is assessed in clinical settings using a specific screening tool that includes two statements.

The screener asks an individual whether each of the following statements were often true, some-

times true or never true for his or her household.

1. Within the past 12 months we worried whether our food would run out before we got money to buy more.

2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more.

"Often" or "sometimes true" responses to either question indicate a positive screen result. Screening success hinges on connecting food insecure households to community resources specific to household needs and delivered out-

## HELPFUL RESOURCES TO COMBAT FOOD INSECURITY

- The Nutrition and Obesity Network has gathered an interdisciplinary team of researchers, clinicians and food systems leaders committed to raising awareness of food insecurity within health care settings and improving nutrition policies and priorities in the hunger safety net through shared research and evaluation. For information on this "clinical linkages" work, please visit: [https://nopren.org/working\\_groups/food-security/clinical-linkages/](https://nopren.org/working_groups/food-security/clinical-linkages/).
- For referral to federal nutrition programs, call the USDA's National Hunger Hotline at 866-348-6479 or 877-842-6273 for Spanish.
- If ineligible for federal nutrition programs and/or emergency food is needed, call 211 or the Eldercare Locator at 800-677-1116.

## FOOD RESOURCES

### Supplemental Nutrition

#### Assistance Program (SNAP)\*

<https://www.fns.usda.gov/snap>

Money on debit card to purchase food. The average benefit is \$127 per month per person.

### Women, Infants and Children (WIC) Program\*

<https://www.fns.usda.gov/wic>

Money to purchase pre-specified foods for pregnant/post-partum women, infants and children under the age of 5. Nutrition education and breastfeeding support also is provided.

### School, Afterschool and Summer Meals Programs for Children

<https://www.fns.usda.gov>

Free or reduced-price healthy meals or snacks for students. Eligibility criteria for programs during the school year and summer may vary.

### Food Pantries

[www.feedingamerica.org](http://www.feedingamerica.org)

Free food and grocery items for people of all ages. Food must be picked up in person by patient or a proxy.

### Congregate Meal Sites

Meals provided to older adults at specific sites, such as senior centers, churches or housing communities.

### Home-Delivered Meals

Meals delivered to older adults who cannot otherwise prepare or obtain nutritionally adequate meals.

### Medically-Tailored Meals

Home-delivered meals tailored to meet the needs of specific health conditions.

### Soup Kitchens/Free Dining Rooms

Free prepared meals for people of all ages.

\*Eligibility calculators available online.

# What It's Like Living with Hunger

*Serena Spruill, a recovery support specialist at the Connecticut Mental Health Center, gave a talk about her own experience with hunger and food insecurity at a training session for co-workers. Some of her comments are excerpted here, with her permission.*

I have had hunger issues in every phase of my life: throughout childhood and into my teen years, as a young teen mom, all during my married life and especially as a single parent with five children to support. When I really sat down to think about it, hunger (food insecurity), never went away.

I was born in New Haven, Connecticut, in 1954, at St. Raphael's Hospital. My parents had 12 children. I am number 11, the baby girl. My mother died when I was 18 months old. My father vowed to keep us together, and he did. But keeping us all fed was really hard. We, at times, went three days without food. Mostly we would eat one meal per day. We were ecstatic if we got to eat twice in one day.

We ate a lot of the same cheap foods. We ate a lot of sandwiches: bologna and cheese, tuna fish, spam, peanut butter and jelly, or just plain mayonnaise, if that was all we could afford at the time. We would go to the Wonder Bread Bakery on Goffe Street to get our bread. We would buy cans of sardines and eat those. My father made us eat a lot of beans, pinto beans to be exact. Three bags of pinto beans in a large pot with lots and lots of water can feed a crowd. We could have a few bowls of that if we were still hungry after eating the first "helping." We did eat rice with our beans, but not every time. One other family staple was oatmeal. My father would use that big pot to make oatmeal for us. He would treat us by adding raisins or bananas to it. No one could make oatmeal better than my father.

So, like I said, we only ate one to two times per day. Back at that time, it was before school lunch. It was mandatory

that all students go home for an hour and return for the second half of the school day. I tried to stay on school grounds during the lunch hour and got reprimanded for it. The only reason I didn't go home was because there was no reason for me to go home. There wasn't any food there for me to eat. But, regardless of that fact, I still had to walk all the way home, sit down for 20 minutes, get up, and walk all the way back to school. I did this every day throughout my grammar school years, before hot lunch came to be, and before food stamps came to be.

Things got better in school when I got to middle school. That's where hot lunch was available for all students. I didn't have to go home and come back.

Now we progress to high school. It turns out I was a teen mom, and I, of course, experienced financial challenges in response to that. Granted, this was in 1969, pre-Pampers era, but I still had to buy milk, and it was before WIC. So, I went through all of that. I did it the cheapest way that I knew how, by breast-feeding for three to four months and then using Carnation milk and Karo syrup formula for the duration.

Then I got married and realized how much it cost to feed our growing family. I got the cheap cuts of meats and the cheap everything, and tried to make it taste as good as possible. I would get the protein and the carbohydrates. I couldn't afford the vegetables. I would put the vegetables last. I was a very plain cook. This all changed when I took part in a community garden. I was able to buy everything else that I needed for consumption, and even (began) freezing the excess bounty of the garden's harvest.

By this time, I was a single par-

ent with five children to support. I took advantage of the food banks. It was very hard for me. I had no car. I was on public transportation, and at the time I was in school. I had to rush around to be at these sites at certain days and at certain times. Then I had to lug these heavy bags all the way home after that. I don't mean to sound unappreciative, but, when I would arrive home and empty the bag's contents, it would be bad because, I would get maybe a can of this and a can of that and it wasn't enough of anything that I could make a meal out of that night. I would have needed to have had gotten three more bags just like that to be able to make a meal for my family. I don't know how it is nowadays, but that is how it was back in the '90s. I am sure it is better now.

The food bank was used to supplement what I contributed and what my food stamps didn't cover. The community garden saved my life! That was the missing piece. It improved my health through an increase in exercise and an increase in good nutrition.

What do I want providers to know and take away from what I am sharing?

I deal with clients up front and personal on a daily basis. They speak frankly about being hungry, and especially their frustrations about the red tape they have to go through, for whatever reasons, in regards to food. Repetition matters. You will most probably become weary of repeating the same information to the same client, but that is what that client needs from you. People with mental illness need repetition!

You can never know by looking at a client what a client is going through. You just have to listen and ask. And remember, a cup of coffee goes a long way!"



side of the practice setting.<sup>7</sup> This process requires coordination among clinicians, administrators, policymakers and community providers. (See sidebar, Page 8).

### THE REALITIES OF HUNGER

At the community mental health center where I am a consulting nutritionist, most patients I see live on low or very low incomes.<sup>8</sup> Eighty percent of this patient population is food insecure.

One client, a 43-year-old man, struggles to afford food between pay periods. He does not qualify for SNAP benefits due to his income, which places him just above the threshold of eligibility. He was managing his food budget well until his car broke down, and he had to pay to repair it. This unexpected expense set him back financially. I encourage clients to keep a two-day food diary between nutrition appointments; here is what he recorded:

#### Day 1

Breakfast — Skipped

Lunch — Skipped

Dinner — 2 hot dogs and cole slaw; fruit punch

#### Day 2

Breakfast — Skipped

Lunch — Bag of chips

Dinner — Chicken nuggets and iced tea

He weighs 485 lbs. and is 5' 11" tall.

I referred him to a six-part cooking series we offer to assist clients with basic cooking skills, grocery shopping field trips, label reading and creating a personal pantry. This program was created to address the many challenges faced by patients like this man. They are often poor, mentally ill with comorbidities, food insecure and lack basic cooking skills. The pantry lesson is designed to encourage participants to build their own stock of nutritious, shelf-stable food that will bridge gaps when their food budget is exhausted. We cook a meal from our sample pantry called Indian Dal. It is from a book we distribute to all participants titled *Good and Cheap: Eat Well on \$4 a Day* by Leanne Brown. The book includes cost per serving for each recipe. The Indian Dal costs 65 cents a serving.

Other patients at the mental health center struggle with other basic needs. Many have missing or low functioning teeth. That makes it difficult to eat healthful foods such as nuts and salads

but easy to eat French fries and ramen noodles. Some patients don't own plates or pans.

I asked the client who enrolled in the cooking series why he hasn't cooked the dal recipe he enjoyed for his teenage son. I realized the man doesn't have a kitchen table or a coffee table. It's hard to eat a meal sitting on the floor when your weight is almost 500 lbs.

In another case, a 62-year-old woman presented with pedal edema. When I noticed her swollen legs, I was concerned and referred her to a vascular doctor. She was hospitalized for a week and her edema improved significantly. She told me it was sleeping in a bed that helped more than the diuretic. She didn't own a bed. The primary care provider in our clinic found her a bed, and she continues to improve.

Food security, dental needs, cooking skills, housing status and household dynamics all must be considered when writing my dietary recommendations. Other health care providers can play an important role in asking simple questions such as: "What have you eaten today?" and intervening when food insecurity is identified.

A chaplain at another psychiatric institution tells the story of his work with those in an inpatient setting who have serious mental illness. One woman showed up every week for his voluntary support group. She was often unpleasant and hostile, but she consistently showed up.

One day she said, "Father, I'm having a good day."

The chaplain replied, "Is that right?"

"Yes, a life-changing day," she replied, and continued "the psych meds make my hands shake so I worry when I carry my food tray to a table that the food will spill. Today, another patient said, 'have a seat, I'll carry it for you.' That's why I'm having a good day." This small gesture made for a life-changing moment. The chaplain's message was that we should all do the "next right thing in our own power." It won't fix everything but if we all did the next right thing, we'd be living in a better world.

### CONCLUSION

Managing hunger is stressful and takes up a lot of brain space. It leaves less energy for registering and renewing benefits, applying for and maintaining employment, taking care of health needs, parenting children and managing recovery from substance abuse and addiction.

For every \$1 spent on food, and feeding an indi-

vidual who is food insecure, approximately \$50 is saved in Medicaid expenses. It is less expensive to feed an individual healthy food for one year than to cover the costs of hospitalizations and related medical expenses for one day. From a policy perspective, it would make sense to pay for nutrition support on one end to curtail higher health expenditures on the other end.

**FRANCINE BLINTEN** is a clinical nutritionist in private practice. She is a consulting nutritionist at the Connecticut Mental Health Center in New Haven, a collaborative between the State of Connecticut Department of Mental Health and Addiction Services, and Yale University School of Medicine, Department of Psychiatry.

#### NOTES

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## QUESTIONS FOR DISCUSSION

Francine Blinten is a clinical nutritionist concerned with the connection between food insecurity and mental health in her roles at the Connecticut Mental Health Center and the Yale University School of Medicine, Department of Psychiatry. She contends that many health care professionals aren't trained to identify hunger and food insecurity, which leads to patients being misdiagnosed or disregarded.

1. How widespread do you think Blinten's examples of misdiagnoses are because of lack of training and insufficient awareness of social determinants? What are the consequences if patients are deemed non-compliant when they don't have the means or access to carry out directives or suggestions for healthy foods and proper intakes?
2. What screening practices does your ministry have in place to help patients with issues related to food insecurity? Where is the best place/what is the best time to pursue those screenings and fill in that aspect of whole-patient care? How does it fit into the discharge plan? Who is the right person to make sure food and nutrition issues are pursued for the patient's best health outcomes?
3. Blinten distinguishes hunger from food insecurity: the former is a personal sensation caused by lack of food; the latter is a larger issue that is household based and often ongoing and episodic. Talk about the two situations in terms of justice and how Catholic health care can contribute to both the immediate alleviation of hunger and the long-term goal of having healthy foods accessible to everyone. Does your ministry partner with other area health and social service organizations to alleviate hunger and food insecurity in your community?

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# HEALTH PROGRESS®

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## Closing Prayer

O God, you entrusted to us the fruits of all creation so that we might care for the earth and be nourished with its bounty.

You sent us your Son to share our very flesh and blood and to teach us your Law of Love. Through His death and resurrection, we have been formed into one human family.

Jesus showed great concern for those who had no food – even transforming five loaves and two fish into a banquet that served five thousand and many more.

We come before you, O God, conscious of our faults and failures, but full of hope, to share food with all members in this global family.

Through your wisdom, inspire leaders of government and of business, as well as all the world's citizens, to find just and charitable solutions to end hunger by assuring that all people enjoy the right to food.

Thus we pray, O God, that when we present ourselves for Divine Judgment, we can proclaim ourselves as "One Human Family" with "Food for All". AMEN.

- The prayer is from the ***One Human Family, Food for All*** campaign by Caritas at <https://food.caritas.org/>



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