

Broadening Bioethics: The 2011 Montefiore Center for Bioethics' Annual Reunion Challenges Attendees to "Think Outside the Box"

Often when an individual hears the word "bioethics," she or he pictures doctors, nurses, and other members of the health care team grappling with the effects of innovative technology on individual patients' lives in the acute care setting. But what if bioethics can be applied within other settings, or even across geographical boundaries? If the application of bioethics is broader than we often give it credit for, what might "doing bioethics" in alternative settings look like?

On March 9, 2011, attendees at the Montefiore Center for Bioethics Annual Certificate Reunion had the chance to find out just that as Dr. Tia Powell, director of the Montefiore Center for Bioethics and Director of the Certificate and Masters in Bioethics Programs at Albert Einstein/Cardozo Law Schools introduced the keynote speaker for the event. For about an hour, the audience inside the Price Center auditorium at Albert Einstein School of Medicine heard from Mirai Chatterjee, director of Social Security at the Self Employed Women's Association (SEWA) in India. A native of India herself, Ms. Chatterjee gave a first-hand report of the dilemmas that arise when one attempts to advocate for the public health needs of those living in urban and rural settings of India.

SEWA is a national union that was founded in 1972 by Ela Bhatt, a labor lawyer and organizer, who was inspired by Mahatma Gandhi's passion for Indian independence and the ideal of freeing Indian citizens from poverty and injustice. SEWA's main goals are to provide security of work, income, food, health, housing, insurance, and pension for its members. As an organization, SEWA has pioneered the delivery of services that promote public health and empowerment for Indian women. Today, over one million Indian women from nine states and over 200 trades and occupations are organized into this one national union. SEWA continues to support programs such as micro banking and the barefoot doctor programs, which train individuals to provide basic health care to individuals in underserved areas. As director of Social Security at SEWA, Ms. Chatterjee currently oversees programs related to health care, childcare, and insurance.

During her presentation, Ms. Chatterjee relayed several stories of individuals who have benefited from the bargaining power and collective strength that SEWA offers. She told accounts of women who survive by selling fruit, vegetables, old tins or spices. After joining SEWA, these same women found greater financial security and an abating of police harassment. What was the reason for this change? As Ms. Chatterjee reports, "Whatever gains SEWA members might have made over the years is entirely due to their organizing, taking leadership and building their own movement. Organizing has resulted in their visibility and in voice and representation."

But Ms. Chatterjee was quick to add that grassroots efforts are not enough. The collective efforts of SEWA members are mighty, but they must be combined with policy changes. Only then can the results be life changing—and life saving. One way that policy change can happen is when organizations like SEWA build coalitions with others in the community. When this happens, the government is encouraged to do more for the Indian people. Currently, the women in India that Ms. Chatterjee spoke of need advocates who will fight for asset building on their behalf. These women need access to savings, credit, insurance, pension, and financial literacy services. They also need access to many items that citizens of other countries take for granted—health care coverage, insurance, childcare, shelter, and basic infrastructure. Social determinants of

health often keep Indian women from attaining many of these needs. Finally, Indian women need capacity-building opportunities in order to enhance their own technical capabilities and skills. By having such opportunities, women can take on leadership and managerial roles within their own cooperatives and unions.

One practical step toward policy change that SEWA has taken is to petition the Indian government for help in creating better access to quality health care. The result of SEWA's advocacy was the creation of a government-funded program, called the National Rural Health Mission (NRHM), which improves the availability and access of health care for the poor, those living in rural areas, and women and children. By establishing this program, the Indian government acknowledged the systemic changes that need to happen within the country in order to meet the health care delivery needs of certain citizens. What is perhaps even more heartening is that the Indian government has continued its trend in supporting health care needs for the country. Recently, officials reported a plan to increase overall spending on health from 1% to upwards of 3%.

The work done by Ms. Chatterjee at SEWA has clearly brought much change, but her role in public health does not stop there. She also serves on the boards of several other organizations in India, including Friends of Women's World Banking (FWWB) and the Public Health Foundation of India (PHFI). In addition, she is a member of the National Advisory Council, chaired by Sonia Gandhi, which monitors the implementation of the social programs of the government of India. Lastly, on the international level, she was a Commissioner in the World Health Organization's (WHO) Commission on Social Determinants of Health.

As a person who juggles a number of leadership and advocacy roles, Ms. Chatterjee had one piece of advice for the audience as she closed her presentation: "What we need, if I may say so, after some years of experience in public health, are more 'doers' – people who walk the talk, and act based on people-centered values that we all hold dear. It sounds like a tall order, but it is not really. Such 'doers' are to be found everywhere—in the streets of Ahmedabad [in Gujarat, India] and in the Bronx. In Centers of excellence like this one [Montefiore-Einstein Center for Bioethics] and among each of you here."

At the end of Ms. Chatterjee's speech, several applications for bioethics within India were evident. For instance, SEWA faces ethical issues in health care decision-making for particular populations, as well as social and structural determinants of population health and the value conflicts inherent in population-based programs.¹ These issues, while different in scope, are not unlike the bioethical queries that those within the audience face each day in the acute care setting. As Ms. Chatterjee pointed out, acting ethically is based on people-centered values, and no matter where ethics is implemented—whether in India or in the Bronx-- sorting out such values can be complex. By the end of Ms. Chatterjee's presentation, the audience was enlightened about the commonalities—and differences—between bioethics as routinely practiced in the U.S. and bioethics as implemented in urban and rural India. And at the very least, all attendees were left with one important lesson: Bioethics does extend farther than we often give it credit for.

¹ Betty Wolder Levin & Alan R. Fleischman, "Public Health and Bioethics: The Benefits of Collaboration," *American Journal of Public Health* 92,2 (2002):166.