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Debunking the Gendered Health Discourse: A Case Study of Migrant Women of Indian Sundarbans

***Rima Bardhan[1] Jaya Shrivastava[2]**

Abstract: *The present paper through gendered health discourse attempts to understand the underlying nuanced pattern of multiple realities about health that brings out the oppositional and "natural" differences between male and female bodies within the context of an ecologically fragile region i.e. Sundarbans. The domain of medicine for a long period remained 'male-stream ' that eventually led to understand the mechanisms of the body from the man-made world that deliberately ignored the pain, sufferings and experiences of the female bodies. The medicalisation of women bodies design a specific way to control, regulate and monitor the feminine embodiment of women that bereft them off their bodily autonomy. However, the mainstream Sociology remained ignorant about this issue for a long time until 1960s and 1970s period. Therefore, this paper attempts to debunk the gendered health discourses on the basis of everyday lived experiences of the migrant women of Sundarbans as to how they perceive their bodies and form the identities about their 'selves 'as they strive hard*

to manage their lives amidst socio, cultural, economic and ecological adversities.

Keywords: Gendered Health Discourse, Migrant Women, Indian Sundarbans, Medical Gaze.

Introduction

Gendered health discourse basically refers to the patterns and ways of communication that address health issues which further reinforces the structured gender inequalities that is prevalent within the domain of medicine. Gendered health discourse tries to focus how over the time the domain of medicine that has been considered apparently an objective and neutral social institution which precisely identifies, examines and diagnose issues related to human bodies and provides a scientific explanation why and how the body malfunction and ways to treat it to bring it back to normalcy is enmeshed in the wider socio-cultural framework of the society. The biological deterministic approach views medicine as a neutral and universal discipline however, feminists around the world advocates that social situations influence our understanding of the body and it further influence the domain of medicine which syncs with the socially accepted set of values and norms and thereby, treat the bodies in a way that overlaps and coalesce with the pertinent norms of the society that merges with the historically accepted notion of being "healthy" or "normal". Medical science over the years through technological advancements have helped in diagnosing, treating and curing diseases that saved millions of lives but if observed from a social-constructivist paradigm medicine is not just a mere objective, universal, value-neutral social institution rather it is deeply embedded in the socio-cultural context of the society that have an indifferent approach towards treating the male and the female body. The men dominated medical domain perceived women bodies as sexually in-differentiate bodies that

determines their social situatedness and further essentialized motherhood as natural to women. This led medical science inherently link gender identities with biological sex and define the category of 'women' based on their reproductive capability. The dearth of knowledge in medical science in examining the existence of diverse body types essentialized the category of 'women' as the embodiment of femininity that is intrinsically related to their procreative ability. The fact that not all women menstruate, or all people who menstruate are not women was time and again ignored by medical science. The medical myths that mingled with the patriarchal structures have a deep-rooted impact on how women perceive their bodies, how they manage their pain and discomfort in silence by adhering to the gender biased regulations. Any form of physical discomfort was invariably linked to the mysterious uterus and a woman body was reduced to its biological functioning that dismissed the women's true experience with their bodies. They were bereft of the agency to decide about their own bodies.

Historically the medical science remained male stream that focused in examining, diagnosing and treating the male bodies. The birth of modern medicine can be traced back to late eighteenth century in Western Europe while fathoming the process of emergence of western medicine Michele Foucault (1973) described that modern medicine's emergence can be understood in two distinct ways: medicine of species' and 'medicine of spaces'. The former refers to the development of medical gaze with precision where medical practitioners became curious to unfold the mechanisms and functions of the human body. Human body became sites for examination and observation. The latter refers to the means of prevention of diseases by regulating and controlling the everyday conduct of the people for instance, in terms of maintaining hygiene in

public places. This was a collective effort made by both government and the medical practitioners to control, monitor and regulate disease by controlling the conduct of its people. However, women bodies were always kept out of the domain of medicine. As medical science progressed there was a growing inquisitiveness to unravel how human body works but this precisely focused on the male body. As Cleghorn (2021) elucidates that women bodies were always distinguished with the male body and medicine defined it as defective, indifferent and faulty. Since women are biologically placed at a higher order than men due to the presence of their uterus they are socially and culturally burdened with the procreative responsibility. For a long time, knowledge about the female body was restricted to their biological capacity which overshadowed their other bodily discomforts. A woman's body was seen as an enigmatic entity wrapped around the silence of its procreative mechanism about which she can neither share her experiences in public nor is she well-equipped with the knowledge as to how to navigate with her bodily challenges. The androcentric medical science hierarchised the male and the female bodies where the former was always treated as superior, strong and powerful over the latter as defective, fragile and weak. Rather than just being an objective and neutral domain of science that immersed in debunking the mythical, metaphysical narratives that once clouded the knowledge about the functioning of the human body it played a deleterious role in syncing with gender biased socio-cultural norms that linked the image of the women to the patriarchal notions of womanhood and femininity.

Therefore, this paper debunks the gendered medical discourse that not only objectified the maternal body of woman to control and marginalise their feminine embodiment by medicalising their procreative ability but it focus on the dynamics of power

within medical discourse that plays a pivotal role in shaping the identities and legitimising it through the historically situated social and cultural institutional practices within the existing sets of cultural relations. The present study focuses on the migrant women hailing from an ecologically fragile region i.e. Sundarbans, the world's largest delta 340km wide delta formed by the confluence of Padma, Brahmaputra and Meghna River along the Bay of Bengal is named after its famous Sundari trees local name of the Mangrove. It is spread over an area of 10,000 sq.km in Bangladesh Khulna division extended over 6,0172 sq.km and in West Bengal it extends over 4,260 sq.km across South and North 24 Parganas. approximately there are over 102 islands in West Bengal out of which 54 islands are inhabited by nearly five million people. The Indian Sundarbans rich flora and fauna not only contribute to the economic growth and prosperity of the country but ecologically it also plays an important role in protecting the people of the coastal areas of Bengal from natural calamities especially cyclones. The lifestyle of people is heavily dependent on agriculture and fishing and the socio-economic condition of people in this region is extremely arduous in nature. They struggle hard to strive for their quotidian existence in this disaster-prone delta region. Growing population and several developmental projects taken by the government led destruction of dense mangrove cover which over the years taught the village dwellers to master the art of combating life against arduous climatic conditions and wilderness. Lives become more difficult for the women to dwell in the delta, so they migrate to the closest metropolitan city Kolkata in search of better healthcare services, job opportunities and access to basic sanitation and hygiene facilities. Through the lived experiences of the women who jostle their lives amidst the predicaments of managing a living and tackling their bodies, the study debunks the gendered health discourse that has a pernicious impact in shaping the lives of

these marginalised and deprived section whose perception about their bodies are governed by the authoritative gendered medical knowledge. The paper further illustrates the irony of the modern medical science discourse where it should have enlightened the women hailing from economically deprived section with the knowledge about their bodies instead it advocates an authoritative discourse that deliberately ignores the pain, the sufferings, the anguish and trauma that women from this triply oppressed situation experience. The present paper argues about the social construction of women's bodies that regulate, control and put surveillance on them. The paper highlights the lived experiences of women from the delta weaved through stories of their generational trauma stemming from their socio-economic and cultural foundations coalesced with their region of living. The paper used existential phenomenology as a method through feminist approach to understand the everyday lived experiences of the migrant women of Sundarbans who strive hard to make ends meet.

The paper focuses on two prime objectives which include:

I. To evaluate the existing healthcare system in the delta that enforce women to migrate.

II. To understand how the women perceive the idea about their bodies amidst persistent health issues

Global warming over the years has adversely affected Sundarbans due to the rising sea level and severe cyclonic conditions disrupted the lives and livelihoods of the people of this delta. Amongst all, the health of the women in the delta is in jeopardy due to lack of adequate healthcare support that consequently deny them from their basic right to health. Thus, this paper debunks the gendered health discourse that work as a repertoire to maintain the patriarchal status quo which enforce

the women from the deprived community to remain nescient about their rights and privileges, subsequently making it difficult for them to come out from the vicious web of patriarchy. The present paper critically evaluates how the biological deterministic approach of medical science essentialise the socially accepted roles of women at the cost of their lives. The lives of these women oscillate between the powerful and powerlessness position in terms of fulfilling their ideal role of being a 'woman'. Therefore, it is pertinent to question the discourse that works as a powerful instrument to inflict control and surveillance over women's bodies.

Methodology:

The study explored the quotidian lives of the migrant women of Sundarbans who juggles back and forth between the delta of Sundarbans and metropolitan city of Kolkata. The women of these regions are victims of triple oppression first, they are marginalised and suppressed because of their status as a woman. Second, their economically fragile condition makes it difficult for them to sustain. Third, the natural catastrophe prone region of Sundarbans put their lives and livelihood at stake. The present paper interrogates the gendered health discourse that construe the bodily experiences of these migrant women that is weaved through the fabric of uncertainty, hidden pain and unexpressed experiences which is studied through existential phenomenological method by using feminist perspective.

Existential phenomenology is well suited to satisfy the lived-experience criterion of a feminist approach to researching women's lives (Garko, 1999, p. 168). Existential phenomenology refers to the process of blending existentialism's focus on concrete existence and phenomenology's quest to unfold a method to develop intersubjective understanding of the everyday lived reality.

Existential phenomenology attempts to understand the day-to-day lived experiences of the people according to Garko (1999) *that pre-reflectively encountered in consciousness i.e., consciousness unaware of itself.* (p.168). Similarly, feminist perspective aids in unfolding the unsaid, unexplored and misinterpreted concealed experiences of women. Women's everyday lived experiences are often ignored and misconstrued that restricts from understanding the real-life experiences of women. Feminist perspective helps to delve deeper into the everyday lived realities of women hailing across class, caste, religion or ethnic minorities. It represents the multiple lived realities of women's world and vociferously question the unquestioned, ignored experiences of their lives. Existential phenomenology studies the phenomena from the perspective of the ones who are part of the research to represent the lived experiences of the people and explore their everyday reality from the existential vantage point. It understands the concealed human experiences that leads to openness of the lifeworld and when understood from the feminist perspective it helps to interpret lived experiences of the women and how they make sense of the world in which they are living. The ontological and the epistemological consideration of existential phenomenology is to perceive the reality or experiences of the subject being studied from their point of view. Unlike the positivists existential phenomenologists refuse to assume the given status of knowledge rather it delves deeper into the life world of its subjects being studied and consider human beings consciously act and make sense of the world in which they live. They construe the reality through their conscious act of living their everyday lives that shape their knowledge about their lived reality. Individuals consciously act through the institutional sets of values and norms based on their assigned gender roles that shape their identity formation, how they construe their everyday

reality, how they feel, act and behave varies on the basis of class, caste, religion, gender and ethnic identities. Existential phenomenology from a feminist lens captures plethora of experiences about health and body of the working-class migrant women hailing from the ecologically fragile delta that encapsulates the wider spectrum of multiple realities of women's lifeworld.

This study explored the gendered health experiences faced in everyday lives of twenty married migrant women from Sundarbans between the age group 25-35 years who are either employed as domestic helper, contractual labourer, or fish and honey seller in local markets of Kolkata. The women of this study primarily belonged from three blocks of Sundarbans that includes Gosaba, Pathar Pratima and Sandeshkhali. Purposive sampling was used for this study and unstructured interviews were conducted in Bengali. Their responses were recorded which are translated and incorporated in this paper by using pseudo names of the respondents to explore the experiences of the women pertaining to their body and bodily experiences as they manoeuvre their lives across two diverse regions. Existential phenomenology from a feminist perspective perfectly syncs to understand the misinterpreted, unheard, unvoiced experiences of these migrant women of the delta as they manage their pain, anguish and trauma in silence while they struggle hard to strive a living. Amidst meeting their day to day needs the lives of these women oscillates between fulfilling their socially constructed feminine role that is invariably linked to their biological capability and the dearth of adequate healthcare facilities to cater to their needs to fulfil the same. Their everyday lived reality reconstructs their perspective of being a 'woman' where they learn to normalise pain and continue to master the art of living amidst adversities. Critically evaluating the

situation of these women reflects the nuanced way of reconstructing the idea of their bodies amidst the health adversities and the socio-cultural structures that reinforces them to adhere to the standard ideal norm of femininity.

Findings of the Study

The data gathered through the accounts of the migrant women of Sundarbans reflects the socially constructed idea of the body and a gendered healthcare facility that asymmetrically distributed the health care services in the delta which perniciously affected the women living in this region. This section consists of two sub-sections that elucidates the two important objectives of this study: the first sub-section includes the dilapidated condition of the health infrastructure of the delta which not only enforce migration but also reflects the persisting gender biases in the era of globalisation and development that invisiblize the basic strategic problems in resolving the issues pertaining to women's health and the second sub-section explains how the women perceive the idea of their bodies through medical gaze.

Dilapidated healthcare facility in the delta that enforced migration

Sundarbans that houses the famous Sundari trees and home to Royal Bengal tiger, was enlisted under UNESCO World Heritage Site and it was also recognised as the wetland of international importance under the Ramsar Convention of 2019, and it is enlisted as 27th Ramsar site. Over the years efforts from the government have improved tourism and development in Sundarbans as each year during monsoon and winter there is huge pull of tourists in the delta. The idea of 'development' in this context can be specifically referred to the development that is seen in terms of attracting tourists and seasonally boosting the

economy of the residents dwelling in the delta. However, if closely observed the notion of 'development' in this context is not an all-pervading phenomenon. The state of health care facilities is the delta is almost defunct. The primary healthcare centre not only lacks adequate equipment to treat and diagnose disease but also the number of healthcare staffs required to run a primary health care centre, or the government hospital is scarce. Most of the patient's health concerns go unrecognised and untreated. The condition becomes severe for women residing in the delta, as some of the respondents narrated:

"On a rainy day I was out with my husband to catch prawns and I was on the third month of my pregnancy and I was unable to bear the sudden excruciating pain that I was facing. After a while I sat down and started bleeding profusely. The primary healthcare centre was 5 kms away from my home. By the time we reached the primary health centre I lost my strength to speak but the unavailability of staff referred my case to the government main hospital where I was left unattended for almost two hours before a male doctor attended me" - Asifa, 32 years

"I often face itching and rashes in my vaginal area however I never wanted to visit the hospital or the primary healthcare centre because the medicines prescribed are not available in our local medicine shop for which we have to go to the town or to Kolkata. Moreover, the hospitals lack female doctors that make it more difficult for me to visit" - Kamala, 29 years.

"It's been two years that I shifted to Kolkata for the purpose of my treatment I was anaemic and my periods were irregular I often faced the issue of vaginal discharge. But getting hold of a doctor in our village was a task in itself. So, in search of job and better healthcare facilities in government hospitals I shifted to Kolkata" - Ritu, 25 years.

All these statements are testimony to the fact that there is a basic problem in catering to the needs of the women who are still perceived as the 'second class citizens'. The narratives indicate the inadequate healthcare facilities that became one of the potential factors for the women to migrate from Sundarbans in search of better healthcare facilities but it is also important to throw light on the fact that how the issues pertaining to women's health are wrapped in silence and normalised as pain that is common and bearable for them. These socially deprived women who migrate in search of better job and healthcare facilities to the city they lacked the knowledge, awareness and the courage to boldly standup for their rights. Often these women faced ignorance, delay, denial and negligence from the medical practitioners, family members and for that matter the state in itself but in this process of being neglected, unheard and unseen they didn't forget to prioritise to fulfil the socially accepted feminine roles. As a part of their everyday struggle, they do not have the 'luxury' to negotiate with their life choices. Most of the women who migrated from the delta were more concerned whether they will be able to fulfil their maternal role rather than prioritising their overall health per se. Many women in their early twenties suffered from urinary tract infection because of the high salinity of the water, prolonged period of exposure in the salty water in paddy fields or while fishing that made them prone to vaginal infections, skin diseases and even respiratory tract infections and other types of health issues. However, the existing healthcare infrastructure shows negligence on their part to accept any other health problems apart from their biological issues that these women might be facing. Moreover, the women's experience with their bodies are invariably linked to the patriarchal idea of feminine embodiment where the women learn to neglect their health issues and endure pain in silence. Although, the societal anguish does not allow them to neglect

problems pertaining to their procreative activity as that would make them less feminine. This becomes another reason that enforce the women to seek better healthcare facilities as their homeland lacks in providing the adequate services that they require.

Therefore, the reason for migration of these women from the delta majorly takes place because: first, the lack of female staffs in the hospital deters the women from paying a visit as the female health issues are invariably considered as 'biological' hence, it is enveloped under the label of 'privacy' and 'shame'. This makes them hesitant and uncomfortable to open up about their health issues to male medical practitioners. Moreover, many expressed the male doctors shows less interest for a detail discussion about their health issues. Second, inexperienced medical practitioners often end up with misleading diagnoses and expensive medical tests that makes life more difficult for them. Third, the extreme rush in the government main hospitals especially during weekends or when free medical camps are organised although, which are rare events according to these women that makes accessing health services almost impossible. Thus, there is an urgent need to raise the voice for a section whose basic rights are neglected but they remain a puppet dwindling their lives between societal choices and power that governs their mind and bodies.

Constructing the idea of the body through clinical gaze

The medical science discourse essentialized and validated the socially constructed gender divisions that reiterate the women to behave in a certain way, feel in a certain way, desire things which are 'feminine' in nature; to be precise it further dictates the patriarchal ideas by substantiating it with women's biological capability as to what should they do with their bodies. Women bodies carry the generational ignorance and negligence

that affected them both psychologically and physically. The domain of medicine and health is as much cultural, social and political as much as it is scientific. Over the years research in the domain of medical science was androcentric that marginalised, oppressed and denied the women of their bodily rights and bereft them of the autonomy over their bodies. Since 1960s feminists vehemently raised their voices against the man-made mystification of the medical science that suppressed the side effects of drugs on women's bodies, racially discriminated the women hailing from marginalised communities and denounced the dogmatic approach of the medical science in empowering the women to narrate their experiences with their bodies. Cleghorn (2021) explained that it was in the 1970s that medical feminism empowered the women to speak about their bodily experiences, demystify the man-made ideas that differentiated and discriminated the women's bodies as repository of "natural" pain and suffering.

"Yes, it hurts a lot during my periods. I often face unusual cramps and body aches and abnormal bleeding. But how can I say this to my in-laws. After the death of my husband last year I have to accompany my brother-in law and my fifteen year old son to the paddy field and also sometimes to fetch wild honey" - Pratibha, 26 years.

"We women are strong and resilient. Period pain, pain during birthing and other womanly diseases are part and parcel of our lives. We learn to grow up amidst all these. As women, we are first taught to manage our feminine self and the body so that we do not slip from our prime role of growing the family large"- Fatima, 35 years.

"The other day I was facing a breathing trouble while I was working in the field. For days my body felt feverish and extremely weak. I blamed my strenuous travel routine from Kolkata to my village in Pathar Pratima . But as the women of the house we do not have the luxury to rest"- Sobha, 32 years.

"Most of my health issues are resolved through homemade remedies like cough and cold or digestion issues are curable at home. However, I have to visit hospital only when issues pertaining to gynecological condition aggravate. I have to then rush to Kolkata for better treatment" - Maya, 28 years.

The above statements show how the women imbibed the idea of bearing pain in silence. The male- dominated medical discourse and the patriarchal society reminds the women about the biological clock that is ticking fast. In the course of meeting up with the ideal feminine image the women idealise pain as part of their living. This dehumanises the status of women in the society and reflects the double standards of the medical science that substantiate the patriarchal ideals rather encouraging the women to debunk the status quo. Gilman (1911) observed that the androcentric world is so engrossed with the phenomenon of distinguishing the masculine and feminine attributes that it escaped what is meant to be humane. Women were identified because of their sex, "the sex" who are set apart to perform their feminine duty. Women are not even half the race, but a subspecies told off for reproduction only. (As cited in Gilman, 1911, p.19). This subsequently reduce women bodies as mere 'sex ornaments' that overshadows other bodily dysfunctions. Thus, Women across class, race, religion or ethnic minorities are denied from sharing their bodily experiences or receive adequate medical attention that aids them swift diagnosis of the issue. It was through long drawn battles from 1970s that women raised their vociferous voices to debunk the man-made socially constructed domain of medicine that deliberately ignored women's experiences with their bodies.

Thus, the medicalisation of the women's body bereft the women of their agency as the power trickles down through a structured patriarchal order that monopolise the medical knowledge and takes upper hand in controlling and monitoring women subjecting them to maternal roles. Foucault (1973) states how modern medicine emerged to debunk the mythical, irrational reasons that explained the bodily dysfunctions, however, modern medicine was not absolutely objective and neutral rather it turned into one of the most powerful institutions to govern and control how people should perceive their bodies. The accessibility of medical knowledge trained, legitimised and inculcated the clinical gaze. The gaze that permits the medical practitioners to observe the body, touch it and examine the body without any interference from the individual who is under medical supervision.

The human body was entering a machinery of power that explores it, breaks it down and rearranges it … it defines how one may have hold obey other bodies, not only so that they may do what one wishes, but so that they may operate one wishes with the techniques, the speed and the efficiency that one determines. Thus, discipline produces subjected and practised bodies." (Foucault, 1979, p. 138).

Shainwald (2016) explains that this male-dominated mechanism of medicine not only medicalised the normal bodily functions of women's bodies but pathologized it. Historically medicine merged with the patriarchal power structures that controls and govern female bodies. Riessman (1983) emphasised that the inherent political dimension within the domain of medicine that disproportionately address the issues of people hailing from marginalised communities like racial minorities, women, children, old people or lower-class people etc.

The medicalisation framework provides useful analytic categories for examining the medicalisation of women's problems as a function of (i) the interest and beliefs of physicians, (ii) the class-specific needs of women and (iii) the "fit" between these, resulting in a consensus that redefines a human experience as a medical problem. (p. 50)

Conclusion

This study debunks the medicalisation of the body of women hailing from marginalised section of the society where every aspect of their bodies is put under control and surveillance of the medical practitioners. The marginalisation of the women's body both within the domain of medical science and the institutional set of values, norms and ideas bereft them of their choices. The initiative taken by the women of Sundarbans who migrate from the ecologically fragile delta to the city in hope of adequate facilities got entangled in vicious trap of patriarchy that constructed the gendered medical discourse which reduced the bodies of the women as biological machines who are culturally and socially obligated to perform the task of motherhood. The medical science is used as an instrument to control and govern the population where women are among those marginalised sections who are constantly in the quest of freeing themselves from the shackles of patriarchy. The migrant women of the delta who are triply oppressed are unaware of the power dynamics that is embedded in layers of institutional framework that governs and control their lives. These women are reservoirs of generational trauma who have learned to adjust their living amidst pain, denial and negligence. The inadequate health conditions enforced migration because the drastic climatic condition on one hand is affecting their fertility and on the other hand the dilapidated healthcare facilities has a deleterious impact on their reproductive health as the maternal health

infrastructure is ill-equipped to cater quality services that risk the lives of both mother and children and their overall healthcare system is at stake. The burden of carrying forward the progeny is put on the women through the process of socialisation that is further legitimised by the medical discourse which disempowers the women to realise the rights pertaining to their body. It is important to dismantle the painful legacy of the woman's body and recognise who we are and what we are. They have the full right to make choices about their bodies, express their pain, discomfort, agony that goes unrecognised over the years. This paper through the case study of the migrant women of Sundarbans debunks the authoritative double standard of a gendered medical discourse as how the medicalisation of the women bodies across class, caste, region bereft them from perceiving their body just as a human body where each story of bodily experience, pain and suffering got tangled within the subjugating and oppressing discipline of medicine that reduce the stories of unwell women as unattended file of notes or a case study lurking in archive. It is important to raise the long due unquestioned questions that overlooked the legacy of pain and agony of a section of the population that refused to understand where they are and how they are struggling to sustain.

Henceforth, this paper is an attempt to un-gender the domain of medicine and hear the voices of women, their narratives of bodily experiences pain and suffering that bothers their mental and physical health rather than homogenising issues pertaining to women's health either as gynaecological issue and thereby, normalising it as mundane and 'natural' to them. It is important for medicine to believe in the testimonies of women about their bodies and the histories of the bodies that shapes their experiences and identity about what it takes and how it feels to be a 'woman' that eclipses their right to share their side of the story and access a quality life.

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Critical Realism as the Philosophy of Social Inquiry with a Cross-Cultural Resonance from Indian Philosophical Traditions

Adbhut Pratap Singh

Abstract: *This paper presents Critical Realism (CR) as a coherent and transformative philosophical foundation for the social sciences. It begins by tracing the history of the philosophy of science, examining paradigms from classical realism to positivism, interpretivism, postmodernism, and pragmatism. The paper critiques the limitations of these prevailing approaches, arguing they struggle to capture the complex, layered, and dynamic nature of social reality. The paper then introduces CR, developed by Roy Bhaskar, as a robust alternative. CR offers a framework that connects social structure with individual agency, allows for multiple ways of knowing (epistemic plurality), and maintains a commitment to a deep, structured reality (ontological depth). In a novel cross-cultural analysis, this work explores the connections between CR and classical Indian philosophies. It highlights shared commitments to causality, a multi-layered reality, and the pursuit of emancipatory knowledge found in traditions like Sāṃkhya, Nyāya-Vaiśeṣika and Vedānta. Finally, the paper discusses the advantages of CR, addresses*