



RESEARCH ARTICLE

Health Assessment of Buksa Tribe: Exploring CSR Models for Indigenous Community Empowerment in Ramnagar Block, Nainital District

Mohit Kalra^{1*}, Arpan Nautiyal², Krishnapal Singh³

Abstract

The Buksa tribe, an Indigenous people living in Uttarakhand, India, faces various health and wellness problems. This research examines how long someone from Buksa live, considering the plethora of socio-economic factors that contributed to the situation in which they find themselves. The study employed a mixed-methods design, involving qualitative interviews and quantitative data analysis, to comprehensively analyse key determinants of life expectancy among the people of Buksa. The way their health is affected by limited access to healthcare services and traditional practices is explored in detail.

This study also looks into how these healthcare disparities should be addressed by CSR (Corporate Social Responsibility) programs and sustainable business partnerships. It highlights how social entrepreneurship models could enhance healthcare access while upholding customs and encouraging community empowerment. The findings reflect, there are chances for companies to adopt sustainable development plans that support SDG 3 (Good Health and Well-Being), SDG 8 (Decent Work and Economic Growth), and SDG 10 (Reduced Inequalities). These practices ultimately improve the health outcomes of Indigenous communities while generating value that benefits both businesses and underserved communities.

Keywords: Buksa tribe, Indigenous People, Healthcare, Corporate Social Responsibility, Sustainable Development Goals.

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Introduction

The Buksa tribe, also known as Mehre in Dehradun, is situated in Nainital, Bijnor, and Pauri Garhwal districts of Uttarakhand in the foothills of Dehradun. This vibrant community thrives at the heart of the Himalayas and provides an exciting mix of colors, making it intricately woven into the tapestry of the Himalayan landscape, with some members tracing their lineage back to valiant Rajput kings. One early reference to the tribe can be found in G.R.C. Williams's¹ *Memoirs of Dehradun* (1874), where he calls them 'Mehra', which means 'great eaters of fish and lovers of strong drink'. According to Crooke² (1896), a legend says that they came from Dakhin, while others specifically informed that they migrated from Delhi. Nag & Roy Burman³ (1974) explain that 'Buksa' is derived from a word used to describe them by the cannibals (bhakshi) who inhabited in terai; hence, they were called Bhakshi killers or Buksa. While another school argues that 'ban' means forest in the Hindi language and bonk means forest dwellers, thus using these two words

1 Williams, G. R. C. (1874). *Memoirs of Dehradun*. Dehradun Press.

2 Crooke, William. (1896). "Legend of the Buksa Tribe." *Journal of Indian Folklore Society*, 23(1), 45-56.

3 Nag, S., & Roy Burman, B. (1974). "Origin and Etymology of the Buksa Tribe." *Himalayan Journal of Anthropology*, 12(2), 78-92.

in combination gives rise to nomenclature like 'Buxa or Bhuxa' (Nag & Roy Burman 1974).

Not all Buxas tell the same tale of their beginnings. Some claim descent from royalty, tracing their lineage back to Raja Jagatdeo, a Rajasthan warrior who sought refuge in the foothills after facing defeat by the Mughals. Others swear by Udaijit, a Panwar Rajput, as their forefather. And for many, the pride of a Kushvanshi Rajput heritage rings true.

Cultural profile of the Buxa

Buxa villages in the foothills of the Himalayas are no longer solely their own. Other communities, like Muslims and Kumauni Pahari in 1997, have woven themselves into the fabric of these settlements. Despite these cultural varieties, Buxa houses remain clustered, posing a sense of unity even as their neighbours diversify (Bisht, B. S., 2006). Buxa's in Dehradun proudly claim the identity of "Mehra Rajput" with pride, reflecting a perceived Rajput lineage. Although their original Buxuari dialect is still widely spoken, Hindi has also become a familiar tongue for this community.

Buxa villages at the foot of the Himalayas, which were once isolated havens, are no longer alone in this sense. Since around 1997, other communities like Muslims and Kumauni Pahari have woven themselves into the fabric of these settlements. Nevertheless, even with all these cultural mixes, Buxa houses continue to appear in clusters as their neighbours diversify. Notably in Dehradun, the Buxa regard themselves proudly as "Mehra Rajput", indicating that they are Rajputs by birth. However, their native Buxuari dialect still echoes, but Hindi too has become a common language for these resilient people.

Changes in the Constitutional Status of the Buxa

In 1950, the Buxa was categorised as a Scheduled Caste (SC), and then in 1956, it was removed from the Scheduled Castes to the Backwards Class column of the state. In June 1967, they were declared as Scheduled Tribes (ST), and later in the year 1981, they were put in PVTGs. This provided Special Central Assistance (SCAs) for plain districts during 1983-4 to be extended to hill areas during 1984-5 for Buxas. During the Eighth Five-Year Plan, a special office was established for solving the problems of land alienation and allied problems of PVTGs. Likewise, among other things, primary schools were constructed, handpumps installed, bore holes dug in; biogas plants were erected while iodised salt was distributed, cattle farming was introduced, agricultural subsidies provided, etc., at different times in Uttaranchal State (Naswa, 2001).⁴

Physical Features

Buxa and Pathi have the highest percentage of blood group 'B', 'A' has significantly less, followed by O (Yadav,

Pathi & Purhtra 2003).⁵ According to somato-metric measurements Buxa are predominantly mongoloid group with some features of Rajputs (Yadav and Patni 2004).⁶ The Buxa are approximately five feet and six inches in height, thickest in build with narrow eyes that have the opening of eyelids linear and horizontal descriptively rendering physical features typical to those connote as 'Mongoloid characteristics'.

Population

According to the Census of 1881, during the colonial period, the 'Buxa' or 'Buxa' numbered 5,664. Their number was reported to be 7,618 (including 3,558 females), and distribution was shown in the erstwhile districts of Bijnor, Nainital, and Garhwal. J.M. Charles⁷, Deputy Collector of Kumaon Tarai, had appended a report on the Buxa in the Census of India, 1931, vol. XVIII. As per the 1911 census, there were about 6,492 Buxa living in the Kumaun division, with the female population being made up of 3,022 persons. About eight percent lived in Garhwal, while ninety-two percent were in the Kumaun division. In Kumaun division alone, according to the 1921 census, they numbered 6292 persons, out of which 2,842 were women.

According to the 2001 Census, the total population of the Raji Tribe in Uttarakhand, including Uttar Pradesh, is 51,138. It comprises males numbered between (26,554) while females accounted for (24,584). Sex ratio was computed at that time as per the given figure, which makes the female count calculated on a scale of every thousand male registered. Approximately 96.87 per cent of total Buxa are Rural only (as per 2001 census). Buxas live in the Udham Singh Nagar (2,4387), Dehradun (15,330), Nainital (2945) and Haridwar (2890) districts according to census-2001 data. The rest of the migrants are reported as spread in Uttar Pradesh (2,378 persons Bijnor / 806 Farrukhabad) and Uttarakhand's Garhwal, 1,202.

When compared with census figures of 1991, this represents an increase by 1.05 percent in under twenty population and a slight decrease by 0.07 percent in the 70 population, indicating high birth rates and shorter lifespans, respectively. The decadal growth of Buxa was at a 48 percent overall population increase from 1991 to 2001. It is noticed that the overall sex ratio has diminished with a shortfall of 61 and 75 females per thousand males in 1991 and 2001, respectively. In rural areas, the sex ratio among the Buxa was relatively better than in urban areas for those years. Besides, it can be noted that while the sex ratio among the rural population decreased from 948 to 927,

5 Yadav, S., Pathi, S., & Purkait, M. (2003). "Blood Group Distribution among the Buxa Tribe." *Journal of Tribal Genetics*, 10(2), 45-58.

6 Yadav, S., & Patni, R. (2004). "Somatometric Measurements and Physical Features of the Buxa Tribe." *Anthropological Studies*, 17(3), 112-125.

7 Charles, J. M. (1931). "Report on the Buxa Tribe in the Census of India, 1931." *Census of India*, Vol. XVIII.

4 Naswa, S. P. (2001). "Changes in Constitutional Status and Development Initiatives for the Buxa Tribe." *Government of Uttarakhand*.

that for urban Buksa rose marginally from 726 to 875 in the censuses of both years. It could be observed that according to the Census of India (2001) population below the age of twenty constituted 51.47 per cent of the total population, whereas the age cohort between ages twenty and forty-four accounted for about 33.56 percent of the total population, with a slightly higher percentage for males.

When compared with census figures of 1991, this represents an increase by 0.05 percent in the under twenty population and a slight decrease by 0.07 percent above seventy population, indicating high birth rates and shorter lifespans, respectively.

In the case of the Buksa community, no marriages were recorded below the age of 10 years during all censuses conducted from 1991 to 2010. In both the 1991 and 2001 censuses, it was confirmed that the proportion of married males and females aged 10 to 14 years declined sharply. Moreover, only a small percentage of marriages among Buksa females occurred below legal age, with 0.84 percent and 2.13 percent in rural and urban areas, respectively, according to the 2001 census. Therefore, not much of early age marriages are found among the Buksa, but by the 2001 census, most marriages among this tribe are solemnised after the attainment of legal ages for marriage ages.⁸

Social Organisation and Religion

Different clans have divided the Buksa people (Buxa). There are no mythical ancestors connected to most of their various clans. Still, some Buksas in the Kumaon division can trace their lineage to 'Khera', which was a traditional hamlet that used to be a political unit with a headman (pradhan) and shaman (bharare). One of the example, the Buksa of Jogipura Khera, belong to the Jogipura clan. Among the Buksa, it is believed that the Muswani gotra is derived from Mussalman (Muslim) and such Buksa are considered to have been Muslims originally who merged themselves into the Buksa community over time.

The marital alliances between the Buksa of Dehradun region and those from Nainital or Udham Singh Nagar are not practiced. Five utensils made out of bronze (peetal), namely banta, parat, lota, karchi and thali must be given as dowry by the girl's family. This custom is still in practice and known as "panched". Dowry payment was never part of the tradition among Buksas. The dowry practices have gradually emerged under the influence of neighboring communities. In Buksa society, a traditional healer is referred to as a "Sayana".

The community has a rich tradition of folk songs and stories, with women actively participating in singing during special occasions. They also play a variety of traditional musical instruments. Among the Buksa, there have been

some instances of intercommunity marriages with the Rangar and Hindu Gujjar groups, and these unions are accepted and recognized within their society. As per the census of 1991, 99.89 percent of the Buksa people were reported as 'Hindu', while the rest 0.11 percent were following Islam. The British ethnographers and officials had found that the Buksa were one of the most Hinduized tribes in India. The Hindu Buksa worship Shiva, Vishnu, Hanuman, Ganesh, Ram, Krishna, Durga, Parvati, Lakshmi, and other deities. The most revered deities are Shiva and Durga.⁹

Livelihood

The primary traditional occupations of the Buksa are farming and animal rearing. They are also involved in casual labour, service sector jobs both private and public administration and basket making. This is ascertainable from the Census of India figures. According to 1981 census, among Buksa workers, 67.21 per cent were cultivators and 26.14 per cent were agricultural labourers. The household industry only employed 1.65 per cent which shows that their traditional occupation is basketry. According to the Census data, cultivators have been declining amongst the Buksas, while the proportion of agricultural laborers has increased. The others under different occupations showed a rise by 6.05% between 1991 and 2001 censuses, suggesting diversification of livelihood strategies.¹⁰

Hunting, once a common practice among the Buksa, has now become rare due to restrictions imposed by local authorities. Currently, the primary occupation of the community is tilling the land for others or themselves as tenants holding more acres of land. The farmers cultivate two crops annually, namely Kharif (monsoon season) and Rabi (winters season). The main crops grown are wheat (often with mustard), corn, paddy, green pea, and peanuts.

It is informed that nowadays, sericulture is becoming rapidly popular among the Buksa, particularly in and around Dehradun region. One important reason for this is that they easily get financial assistance in the form of loans for the promotion of sericulture. Basket making is a commercial venture now for the Buksa of Udham Singh Nagar and Nainital areas, but not for those inhabiting Dehradun and nearby areas, who do prepare baskets but mainly for their own domestic use. As per community reports, the regulation that permits Buksas to sell land only to fellow tribal members has exacerbated their financial difficulties, with one respondent stating: *"Since the rule that Buksa can only sell their land to tribal people, our problems have increased."*

Health and Diseases

The prevailing ailments among the Buksa community of Garhwal Mandal include fever, stomach disorder, and

8 Census of India. (2001). "Population Distribution and Demographic Characteristics of the Buksa Tribe in and Uttar Pradesh." Ministry of Home Affairs, Government of India.

9 Ethnographic Survey of India. (1991). "Social Organization and Religion of the Buksa Tribe." Ministry of Tribal Affairs, Government of India.

10 Census of India. (1981). "Livelihood and Occupational Structure of the Buksa Tribe." Ministry of Home Affairs, Government of India.

tuberculosis, etc. Additionally, among the Buksa population in the Kumaon Mandal, frequently reported health issues involve abdominal discomfort and general body aches. Other frequently reported illnesses include headaches, ear, nose, and throat (ENT) problems, skin disorders, and lower back pain.

Today, members of the Buksa community today go to a bevin, who will start treating them at home. If the condition does not improve, they then seek help from a *bhagat*, a traditional healer. While non-availability of qualified doctors in the vicinity adds to the suffering of the Buksa patients, it also turns them back to magico-religious healers like the bhagats of the area. However, the facilities for seeking treatment from qualified doctor are poor in those areas where Buksa people live (Table 1)¹¹

Development activities and Schemes

During the fiscal years 2010-11 and 2011-12, as well as in the proposed allocations for 2012-13, the Tribal Sub-Plan (TSP) funds were utilized for the overall development of tribes. This includes efforts like construction of allopathic sub-centres, PHCs & State Allopathic Dispensaries (SAD), and the roll out of Village Health Nutrition Day (VHND) under National Rural Health Mission NRHM. This has also been explicitly stated in the Conservation-cum-Development plan from the Directorate of Tribal Welfare, Dehradun (Uttarakhand), i.e. 77.2% of funds are required for development programme to be brought by department concerned.¹²

Objectives of the study:

- Determine the biggest factors limiting Buksa's longevity.
- Compare the life expectancy in Buksa with the district and national figures.
- Advise on how to bring change in health outcomes and life expectancy in the Buksa tribe by targeted interventions & community-led initiatives.
- Look for the possibilities of utilizing Corporate Social Responsibility (CSR) models for community empowerment.
- Explore ways for companies to adopt sustainable development plans that support Sustainable Development Goals (SDG). Here particular focus is laid on SDG 3 (Good Health and Well-Being), SDG 8 (Decent Work and Economic Growth), and SDG 10 (Reduced Inequalities) in order to improve the health outcomes of Buksa community (United Nations, 2015).

Research Methodology

The research methodology for this project is applied and quantitative in nature (Elwin, V., 1950). The objective of this

Table 1: Medical facilities in Buksa Villages

District	Block	Number of Villages with PHC
Dehradun	Doiwala	9
	Sahaspur	2
	Vikasnagar	1
Nainital	Ramnagar	3

Source: Base Line Surveys by Uttaranchal Bahu-uddesiya Vitta evam Vikas Nigam Ltd., Ministry of Social Welfare, Government of Uttarakhand, 2006.

study is to examine the development and current state of health in Uttarakhand, as well as to identify and propose solutions for existing challenges within the health sector.

Research design

Present study will be based on descriptive and exploratory research design.

Research method

This study will be based on a mixed-methods approach, incorporating both qualitative and quantitative methods.

Area of Study

The Nainital district comprises eight blocks: Okhalkanda, Dhari, Betalghat, Ramnagar, Kotabagh, Bhimtal, Haldwani, and Ramgarh. Among these, Kotabagh, Ramnagar, and Haldwani are located in the plains (Hasan, A., 1979). The district contains a total of 1,141 villages, of which 1,097 are inhabited and 44 remain uninhabited. Additionally, there are 11 towns within the district. The total geographical area of Nainital district is 4,251 square kilometers

Tool used

Lifespan Calculator developed by Northwestern Mutual¹³

Sample size

Table 2: Gender-Based Unit Distribution

Sr. No.	Sex	Units
1.	Male	10
2.	Female	10

Analysis and Calculation

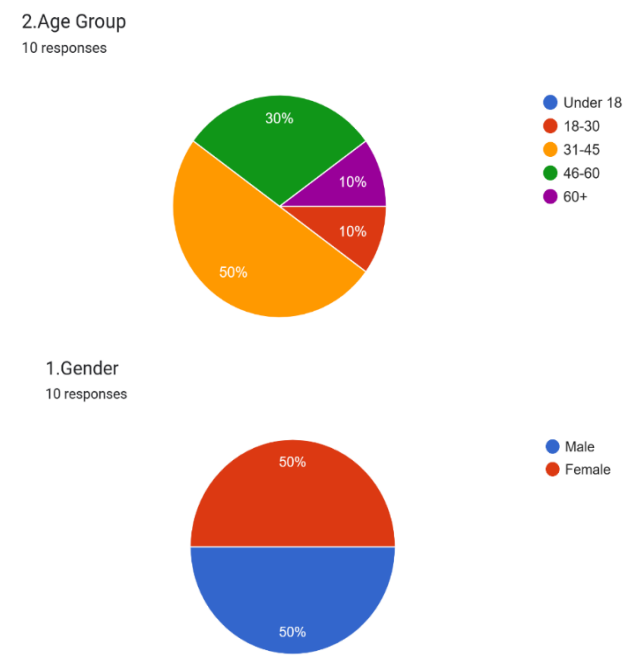
Table 3: Level of Exercise:

Sr. No.	Parameter	Male	Female
1.	Daily Vigorous Exercise	20%	0
2.	Walk a minimum 30 minutes 4 days per week	80%	80%
3.	Somewhat Active	0	20%
4.	Not Active	0	0

The below table shows the level of exercise according to gender and some other values. One-fifth of boys participate

11 Uttaranchal Bahu-uddesiya Vitta evam Vikas Nigam Ltd. (2006). "Baseline Surveys on Health and Medical Facilities in Buksa Villages." Ministry of Social Welfare, Government of Uttarakhand.

12 Directorate of Tribal Welfare, Dehradun, Uttarakhand. (2011). "Conservation-cum-Development Plan for Tribal Communities." Government of Uttarakhand.



in vigorous activity on most days, whereas four fifths walk for 30 minutes or more at least 4 times a week. Of those who neglect daily vigorous exercise, 80 percent of females walk on a regular basis while males do not. Further, 20% of females are minimally active and none not inactive (Fig 1.1). Both men and women (100 percent of them) go to a doctor when sick. But the table hints that men and women alike

Area of Study

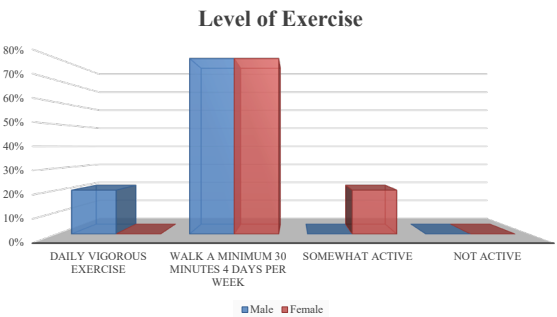
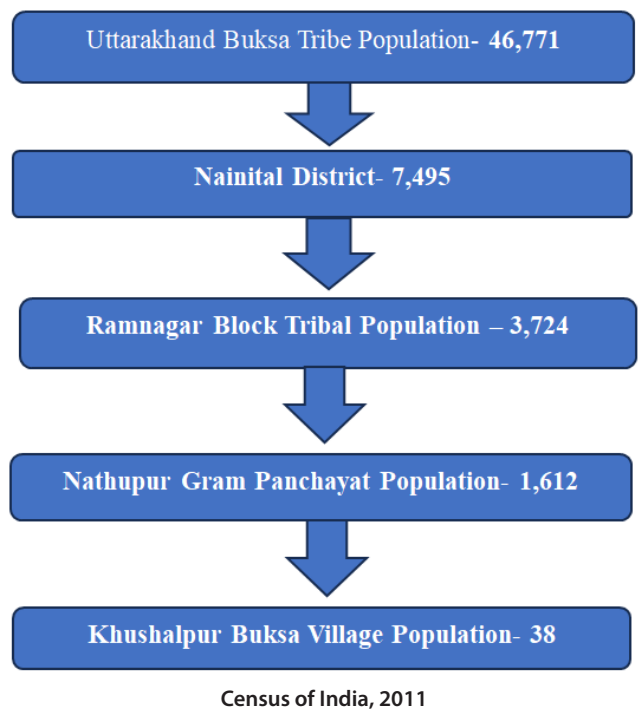


Fig 1.1: Level of Exercise

Table 4: Doctor Visits

S. No.	Parameter	Male	Female
1.	Regularly schedule check-ups	0	0
2.	Visit doctor when feeling ill	100%	100%
3.	Never visit a doctor	0	0

are not fans of routine check-ups or visiting doctors at all. Here, although individuals take action quickly to consult a doctor when symptoms occur, preventive healthcare through medical examinations on a regular basis appears not so utilized across both genders (Fig 1.2).

The table shows the distribution of smoking status by gender. It indicates that more females (80%) claim to have never smoked than males (60%). If part-time and other non-smokers are excluded, only 40 percent of the males consume less than two packs daily while not a single female falls in this category. Furthermore, 20% of females report two or more packs per day also compares with zero males reaching this elevated usage tier. These results underscore a marked gender disparity in smoking behaviors, as more females abstained from ever having smoked than males (Fig 1.3). This Table 6 gender-based patterns of alcohol consumption. All females participants (100%) reported complete

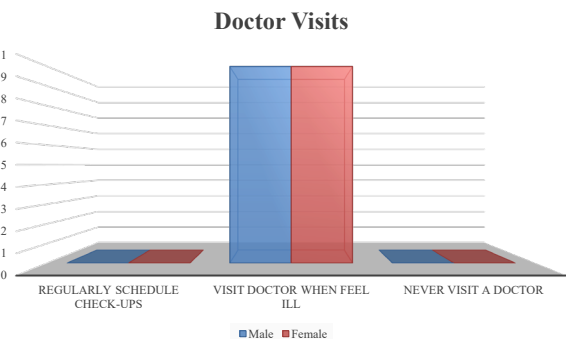


Fig 1.2: Doctor Visits

Table 5: Smoke intake

Sr. No.	Parameter	Male	Female
1.	Never Smoked	60%	80%
2.	Smokes Less than 2 packs per day	40%	0
3.	Smokes 2 or more packs per day	0	20%

abstinence from drinking, 80% males noted the same. 20 percent of males reported consuming 3–4 drinks ≥ 2 times/week, whereas no females reached this level. Also, there were no men or women who reported consumption five drinks per occasion. Our findings emphasize the substantial gender gap in alcohol consumption, with more abstemious females than males, whereas few of the male participants drank moderately (Fig 1.4).

The Table 7 detailed information on how males and females eat. This means that none of the males (0%) reported consuming more than five portions of fruits and vegetables, while all the females (100%) had an average intake of fruits and vegetables. Similarly, 80% of males and 100% of females indicated that they were average consumers of fruits and vegetables. Consequently, only 20% of males said they usually ate perishable foodstuffs with minimum salad compared to no single girl in the study. These findings suggest that women tend to adopt healthier eating habits than men, as evidenced by their greater adherence to fruit and vegetable intake and their lower consumption of processed foods. (Fig 1.5).

The information in the Table 8 shows knowledge and control of blood pressure. The findings indicate that as compared to males (60%), 100% females don't know their blood pressure status. Among men, this category contained 20 % male with normal readings regular check ups for his blood pressure while no woman fell into this class. Additionally, 20% of males reported having high blood pressure that is controlled with medication, while none of the females reported this condition. These findings suggest that there may be a lack of blood pressure awareness among

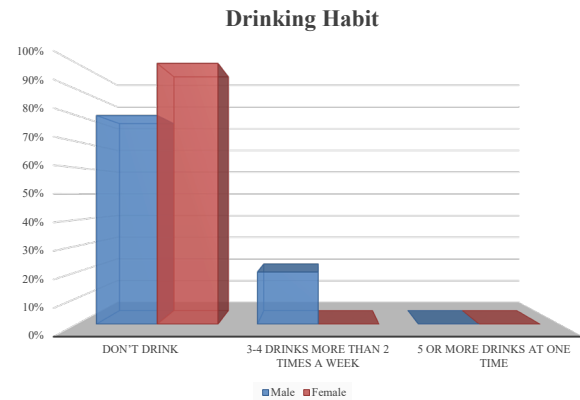


Fig 1.4: Drinking Habit

Table 7: Eating Habit

Sr. No.	Parameter	Male	Female
1.	Eats more than 5 portions of fruits and vegetables	0	0
2.	Average amount of fruits and vegetables	80%	100%
3.	Eat processed foods regularly, and minimal vegetables	20%	0

females compared to males, and highlight disparities in blood pressure monitoring and management between the genders (Fig 1.6).

The Table 9 describes how stress perception is divided by gender. It indicates that 60% of males and 40% of females

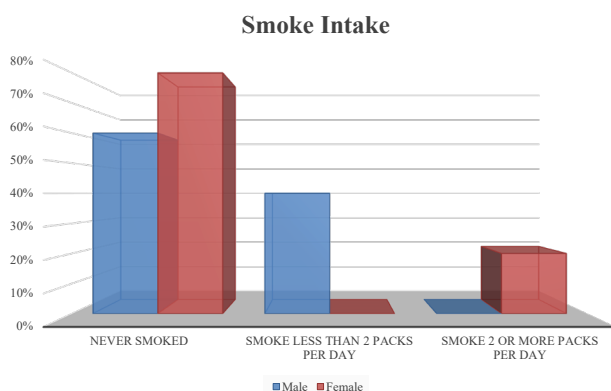


Fig 1.3: Smoke Intake

Table 6: Drinking Habit

S. No.	Parameter	Male	Female
1.	Don't drink	80%	100%
2.	3-4 drinks more than 2 times a week	20%	0
3.	5 or more drinks at one time	0	0

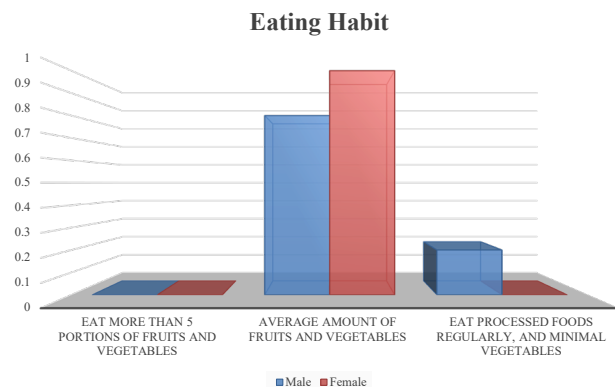


Fig 1.5: Eating Habit

Table 8: Blood Pressure

Sr. No.	Parameter	Male	Female
1.	Do not know my blood pressure	60%	100%
2.	Blood pressure checked regularly with normal reading	20%	0
3.	High blood pressure, on medication under control	20%	0

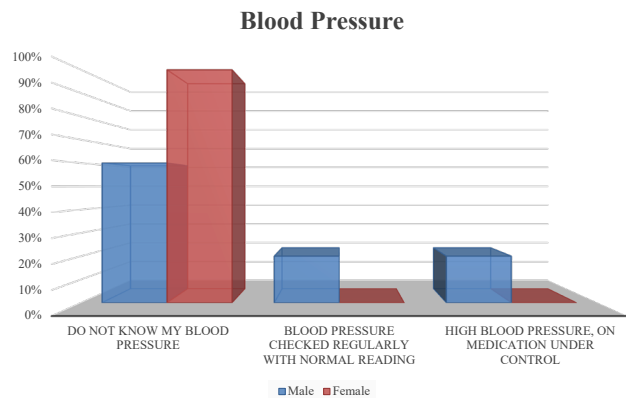


Fig 1.6: Blood Pressure

Table 9: Stress			
Sr. No.	Parameter	Male	Female
1.	Stress is a positive influence	60%	40%
2.	I have my share of ups-downs	40%	60%
3.	Stress often overwhelms me	0	0

consider stress to be a positive force. Conversely, there are more females (60%) than males (40%) who assert they have their share of highs and lows in terms of stress. Importantly, no participant in either sex felt extremely stressed out. From these results, it can be concluded that although both male and female respondents perceive stress differently, they have different opinions as regards its implications on themselves (Fig1.7).

This Table 10 presents gender-wise analysis of family history related to cardiovascular health. The results show that 100% of male respondents reported having a family member who lived to the age of 70 without any history of heart disease, whereas only 80% of female respondents reported the same. Conversely, 20% of female participants confirmed that a family member had experienced cardiovascular issues before the age of 55, while none of the male respondents reported such a case. It is worth noting that none of the respondents across genders claimed to have had two or more relatives who developed cardiovascular problems prior to age 55. These findings indicate that female participants have a higher rate of early onset cardiovascular problems as compared to males in their families (Fig 1.8).

Life Expectancy Calculation

For given sample

- Buksa Tribe Male: 80.8
- Buksa Tribe Female: 81.4

These findings illustrate the varying life expectancy outcomes across populations and regions. The life expectancy for males of the Buksa Tribe is 80.8 years, while for females, it is slightly higher at 81.4 years. (Fig 2.1). The life expectancy of the Buksa community in the Ramnagar block is higher than that of both Nainital district

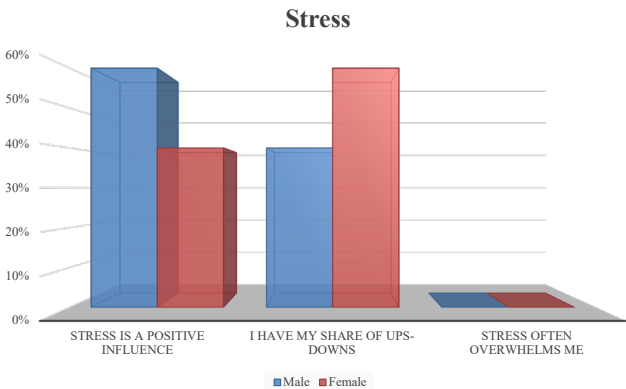


Fig 1.7: Stress

Table 10: Family History			
Sr. No.	Parameter	Male	Female
1.	Family member lived to age 70 with no cardiovascular problems	100%	80%
2.	Cardiovascular problems of a family member before age 55	0	20%
3.	2 or more family members with cardiovascular problems before age 55	0	0

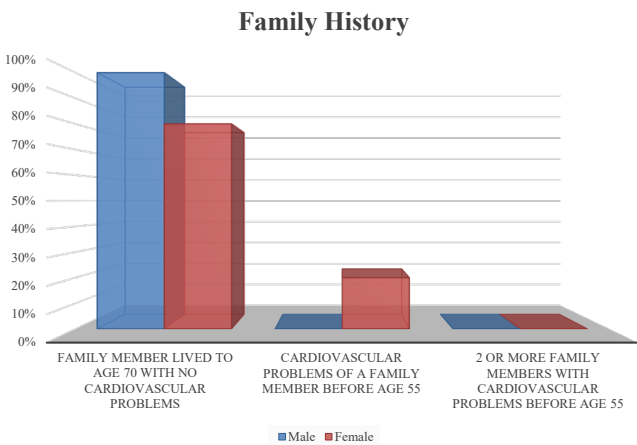


Fig 1.8: Family History

and the state of Uttarakhand overall. Among the Buksa, females exhibit a slightly higher life expectancy than males, primarily due to the prevalence of alcohol consumption among males.

The data given has Table 11 shown the variations in life expectancy among different regions. In Nainital, the life expectancy is reported to be 71 years, which is a little lower than the average of 71.3 years for Uttarakhand as a whole. On the other hand, Buksa tribe enjoys a remarkable average life span of 81.1 years. The above findings indicate that within the state of Uttarakhand, there are significant disparities in life expectancy between different regions. These differences may be attributed to variations in lifestyle,

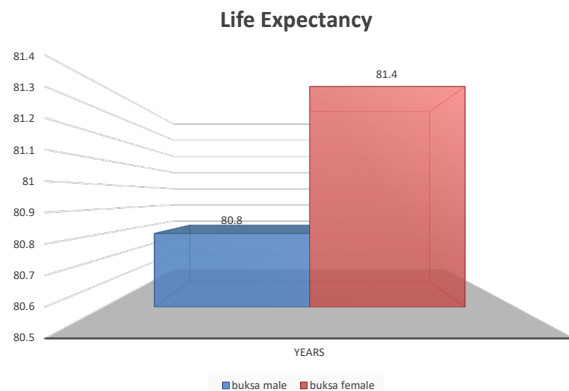
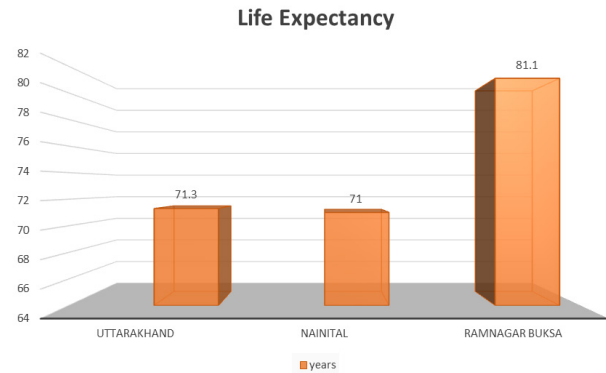


Fig 2.1: Life Expectancy



Source: HDR Survey, 2017 and SRS data, GOI (Fig 2.2)

Fig 2.2: Life Expectancy

Table 11: Life Expectancy: Table 2.2

Sr. No.	Life expectancy	Years
1.	Uttarakhand	71.3
2.	Nainital	71
3.	Buksa Tribe (Ramnagar Block)	81.1

access to healthcare, and genetic factors associated with longevity. (Fig 2.2).

Corporate Social Responsibility and CSR Models for Indigenous Community Empowerment

Corporate Social Responsibility (CSR) is the commitment of businesses and companies to help local communities, employees, their families, and society to raise their quality of life while promoting sustainable economic development (European Commission, 2011). Among indigenous people like the Buksa, CSR has developed from basic charitable acts to strategic alliances honouring traditional knowledge systems and advancing community ownership. According to the European Commission (2011), the modern concept of CSR stresses voluntary initiatives addressing social and environmental issues outside legal compliance.¹⁴

A number of CSR methods have been created, especially to empower indigenous communities. Carroll (1991) defines CSR as a hierarchy where “the economic responsibility forms the base, followed by legal, ethical, and philanthropic responsibilities” (p. 40).¹⁵ However, for indigenous communities, Porter and Kramer (2011) advocate for “creating shared value” (p. 64), a model that ties corporate success to societal progress.¹⁶ Supported by the United Nations Declaration on the Rights of Indigenous

Peoples (2007), the Free, Prior and Informed Consent (FPIC) framework has evolved into essential guide for corporate interaction with indigenous people (UNDRIP, 2007).¹⁷

Models of community-based participatory research (CBPR) let Indigenous people spearhead development projects instead of being obliging recipients. This method guarantees cultural appropriateness and respects indigenous peoples as knowledge holders. The “Two-Eyed Seeing technique”, originating from Mi’kmaq tribes, blends indigenous and Western knowledge systems successfully (Bartlett et al., 2012).¹⁸ Companies like Patagonia have created supply chain agreements with indigenous people, assuring fair trade standards while honouring traditional heritage.

For groups like the Buksa, who struggle with land alienation and debt, CSR models have to address economic empowerment via sustainable livelihood initiatives. Successful models stress capacity growth, leadership development, and institutional strengthening (Patnaik, N., et al., 1984). The effectiveness of these approaches depends on long-term commitments, cultural competency, and awareness that indigenous populations own inherent rights and significant knowledge systems necessary for sustainable development.

Sustainable Development Goals and Corporate Opportunities for SDG Implementation

The United Nations Sustainable Development Goals (SDGs), approved in 2015, provide a comprehensive framework for solving global concerns via coordinated efforts (United Nations, 2015). These 17 interconnected goals aim to end poverty, protect the planet, and promote prosperity for all by 2030. For indigenous populations suffering healthcare disparities, three SDGs are particularly significant- SDG 3 (Good Health and Well-Being), SDG 8 (Decent Work and Economic Growth), and SDG 10 (Reduced Inequalities) as these are critically aligned with the health and socio-economic needs of indigenous communities like the Buksa

¹⁴ European Commission. (2011). A renewed EU strategy 2011-14 for Corporate Social Responsibility (COM(2011) 681 final). Brussels: European Commission.

¹⁵ Carroll, A. B. (1991). The pyramid of corporate social responsibility: Toward the moral management of organizational stakeholders. *Business Horizons*, 34(4), 39-48.

¹⁶ Porter, M. E., & Kramer, M. R. (2011). Creating shared value. *Harvard Business Review*, 89(1/2), 62-77.

(United Nations, 2015).¹⁹

SDG 3 aims to “ensure healthy lives and promote well-being for all at all ages” (United Nations, 2015, p. 14). For the Buksa population, whose prominent diseases include fever, stomach disorders and tuberculosis, this aim emphasizes achieving universal health coverage and availability to vital medicines. SDG 8 fosters sustained inclusive economic growth and decent work for all, addressing unemployment and informal economy concerns. Given that cultivators among Buksas have been dropping and agricultural laborers have been increasing, this goal becomes vital for economic stability. SDG 10 aspires to minimise inequality within and across countries, tackling income disparity and social exclusion that particularly impacts indigenous populations.

Companies enjoy considerable opportunity to build sustainable development plans that promote these SDGs simultaneously. Healthcare-focused efforts can fulfill SDG 3 through telemedicine programs and mobile health clinics that transcend geographical limitations. Pharmaceutical corporations have established access-to-medicine programs targeting impoverished people, demonstrating scalable strategies for remote healthcare delivery. Economic empowerment efforts supporting SDG 8 include supply chain integration, where firms source materials from indigenous groups like the Buksa's traditional basket making, producing sustainable employment while maintaining cultural skills.

Addressing SDG 10 demands inclusive business models through impact investing and blended financing systems. Companies can build innovation laboratories designing items exclusively for Indigenous people, guaranteeing cultural appropriateness. These integrated approaches illustrate that financial success and sustainable development may be accomplished simultaneously, notably benefiting indigenous groups through culturally sensitive, community-led projects that encourage self-determination.

Conclusion

The Buksa tribe, situated in the varied social fabric of India is an interesting area to examine this theory from and its correlation with life expectancy. Even against tough socioeconomic and environmental odds, the Buksa demonstrate an impressive ability to adapt and a well of resourcefulness that partakes in this tangled web of life-shortening circumstances. On the Buksa, this research has expertly knit together data about healthcare access for their family-oriented lifestyles and socioeconomic conditions. It highlights the nuanced interplay between cultural factors such as strong community bonds, heavy reliance on natural resources and reduced access to modern healthcare that contribute their life expectancy.

Their close bond with nature enables them to benefit from the power of medicinal plants and live a life rich in physical activity. This also adds to one's feeling of being in balance with life and may ultimately assist people living longer lives. Yet poor access to contemporary healthcare facilities and low levels of health awareness are formidable stumbling blocks. Life expectancy is reduced by nutritional deficiencies, lack of sanitation, and susceptibility to infectious diseases.

Corporate social responsibility strategies and collaborations based on the SDGs can change the way this process works. Companies may make a real difference in increasing life expectancy while respecting cultural identity and encouraging inclusive development by including the Buksa community in ethical supply chains, supporting traditional ways of making a living, and putting money into mobile healthcare and education programs.

Hence, a combination of strategies is needed to overcome these obstacles. Such implementation of interventions that are culturally sensitive (incorporating traditional knowledge with modern healthcare practices) would positively bridge the gap and lead to better health outcomes.

Recommendation

The Buksa tribe's narrative brings out a crisp picture of resilience amidst obstacles. To ensure their welfare and improve life expectancy, a comprehensive approach is necessary. Here are some key recommendations:

- **Enhance access to primary healthcare:** This will involve the construction of infrastructure and transportation facilities that link remote settlements inhabited by Buksa people with primary care centers. Emphasize on preventive measures such as regular check-ups, immunization programs and disease screening initiatives.
- **Hygiene promotion and sanitation:** Disseminate information on hygiene practices, water purification methods, safe disposal of human waste so as to reduce infectious diseases' rate of transmission.
- **Nutrition Education and support:** Implementing nutrition education programs with emphasis on dietary diversity and locally available nutrient rich foods will help address malnutrition through targeted food supplementation programs particularly for pregnant women and young children.
- **Community Empowerment:** Improve literacy levels within the Buksa community while at the same time providing health education. Communicate about disease prevention methods, choosing healthy lifestyles as well as timely seeking medical attention. Educate women in society and provide them with leadership opportunities within their families to achieve better health outcomes.

19 United Nations. (2015). *Transforming our world: The 2030 Agenda for Sustainable Development* (A/RES/70/1). United Nations General Assembly. <https://sdgs.un.org/2030agenda>

- Leverage Corporate Social Responsibility and SDG Partnerships: Encourage engagement with socially responsible enterprises to undertake culturally respectful livelihood programs, telemedicine efforts, and infrastructure development in accordance with Sustainable Development Goals (SDGs) 3, 8, and 10. These alliances can give long-term economic support while conserving the Buksa community's traditional knowledge and identity.

Through these recommendations we can bridge the gap between current challenges facing Buksa tribe towards brighter future with improved life expectancy. Remember, success lies in acknowledging their strengths, respecting their cultural identity, and empowering them to weave a tapestry of well-being for generations to come.

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