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Food Habits and Health Development on Socio - Cultural Dimension Among the Birhor Tribe (Special reference to the Bilaspur District, Chhattisgarh)

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Abstract: The Birhor tribe, one of the five Particularly Vulnerable Tribal Groups in Chhattisgarh, faces severe nutritional and health challenges as they transition from a nomadic hunting-gathering lifestyle to a settled existence. This paper examines the interplay between their traditional food habits, cultural beliefs, and contemporary health outcomes in the Bilaspur district. Findings reveal a diet heavily reliant on forest products and government-distributed rice, alongside high rates of malnutrition and a persistent reliance on traditional healing practices. From a holistic perspective, health encompasses people's physical, mental, and social well-being, not just the absence of disease. Family members are thought to benefit socially, psychologically, and physically from these spirits. Due to their isolation in pristine natural environments, far from civilisation, and the preservation of their traditional values, customs, beliefs, remoteness, and mythology, primitive tribal groups have extremely poor health. Additionally, the Birhor tribe in Bilaspur, Chhattisgarh, has several genetic anomalies and health issues. Malaria, TB, influenza, diarrhoea, high infant mortality, and malnutrition are constant problems for them. Calcium, vitamin A, vitamin C, riboflavin, protein, and other nutrients are typically severely lacking in tribal diets. The Birhor tribe think that illness is always brought on by evil spirits or ghosts who violate certain taboos. To appease supernatural forces, people turn to magico-religious practices for healing. Lack of access to clean food, safe drinking water, regular diets, and protection from the sun, cold, and rainy season. Inadequate medical facilities and a lack of health knowledge have exacerbated their problems. They use native medicines to treat the illness. because of Birhor's health issues. The rate of maternal and infant mortality has gone up.

Keywords**:** *Food Habits, Food Consumption, Health, Birhor Tribes, Socio-Cultural*

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I. INTRODUCTION

The Birhor are a Particularly Vulnerable Tribal Group who primarily live in the forest-fringe areas of the Bilaspur district in Chhattisgarh. The Mundari terms Bir (forest) and Hor (man) are combined to form the word Birhor, which means "man of the forest". The Birhor tribe is thought to have originated from the Kolarian clan. The Birhor tribes inhabit grass-thatched homes (Tada) outside villages, near hills, mountains, rivers, streams, and caves. The sun god, Budhi Mai, the ancestors, the mountains, and the trees are venerated as the primary deity. Hunting, gathering medicinal plants, manufacturing rope from Moline tree bark, selling wood, and subsisting on kanki-koda and Mahua are their primary sources of income. The Birhor tribes once lived in temporary dwellings made of branches, leaves, and other natural materials. However, as they have transitioned to a more established existence, some of them might now live in more permanent dwellings built of mud, thatch, or other locally accessible materials. However, due to urbanisation and government initiatives, several Birhor tribes have recently established permanent or semi-permanent settlements. A society's value system, philosophical and cultural traditions, and social, economic, and political structure are all closely

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linked to its current state. The tribal group firmly believes that the family's prosperity largely depends on the ancestral spirits. Anthropometric indices, family literacy, cultural feeding practices, and socioeconomic level were used to evaluate the health state. The current disease was analysed, and the morbidity pattern was investigated using a clinical examination and a history of previous illnesses. Historically nomadic, the Birhor are categorised into two groups: the wandering Uthlus and the settled Janghis. In Bilaspur, Chhattisgarh, they reside primarily in forest fringes, where their socio-economic status remains among the lowest in the state. Their health development is deeply influenced by a cultural dimension that perceives disease through a lens of supernatural causes and ancestral spirits.

Human progress depends on health, which is also crucial to human well-being. Several interrelated elements, including social, political, and economic factors, influence a community's health issues. It is widely acknowledged that the primitive tribal groups' health is extremely poor and worse due to their isolation in pristine, natural environments far from civilisation. Their traditional values, customs, beliefs, remoteness, and myths remain intact and largely unaffected by the nation's developmental processes (Ram & Prassad, 2011). The Birhor tribe is one of several that disappear because they are either disregarded by their government or assimilated into other ethnic groups. Their population is estimated to be between 8,000 and 22,000. In a public hearing, the minister of tribal welfare was questioned on the number of Birhor. He stammered back that he thought there were about 1,000 Birhor. There are more than 4,000 in his region alone (Ram & Prasad, 2011). Food is vital to life and is crucial to human development, health, and well-being. Its significance extends beyond basic nutrition, affecting social, cultural, mental, and physical aspects of life. Food provides the body with the energy it needs to carry out all its processes, from simple ones like breathing and blood circulation to more complex ones like physical activity. The macronutrients—fats, proteins, and carbohydrates—found in food provide the energy.

➢ *Food Behaviour*:

The patterns, decisions, and routines associated with how people or groups eat are referred to as food behaviour. Numerous elements, including cultural, social, psychological, biological, and environmental factors, may influence these behaviours. Important facets of eating habits include the relevance of food consumption, ethical food values, luxury food, and food behaviour connected to health awareness, all of which were covered in research on food behaviour (Kokkoris, 2021).

- Cultural Influences: What, when, and how food is consumed are frequently influenced by cultural customs and conventions. In some societies, some foods are symbolic or considered staples.
- Social Influences: Since eating is frequently a social activity, food choices may be influenced by social situations or peer pressure. When dining with others, people typically eat differently than when dining alone.
- Emotional and Psychological Factors: Food behaviour can be significantly impacted by emotions, stress, and mental health. For example, emotional eating is the propensity to eat in reaction to emotions other than hunger, such as stress or melancholy.
- Health and Nutrition Awareness: A person's eating choices can be influenced by their knowledge of nutrition, dietary recommendations, and health hazards. Healthier eating habits can result from a greater understanding of the importance of a balanced diet, particularly for individuals aged 19 to 50.
- Biological Factors: Taste preferences, hunger, and appetite are all influenced by biological processes. Genetics and hormones can affect how much food a person eats or how they react to different flavours.
- Economic and Environmental Factors: Food behaviour is influenced by food availability, pricing, and resource accessibility. Depending on their budget, local food conditions (such as food deserts), or food pricing, people may make different decisions.
- Convenience and Time: Fast food and ready-to-eat meals are becoming more popular due to modern lives' frequent demands for quick and convenient meals, which may affect long-term eating habits.

➢ *Food Frequency:*

The term "food frequency" refers to how often people or groups consume specific meals or food groups over a given period, usually a week or month. It is commonly measured using a Food Frequency Questionnaire (FFQ), which asks participants how frequently they eat different foods. Understanding a person's nutritional intake and capturing eating patterns are the objectives. Food frequency data can be used to determine nutrient intake, eating patterns, and potential risks of diet-related health issues.

- Meal frequency: Meal frequency is the number of meals a person consumes in a day (e.g., breakfast, lunch, dinner, and snacks). Three main meals with snacks in between, or more frequent, smaller meals spaced throughout the day, are common eating habits. The timing of meals can affect energy levels, metabolism, and overall well-being.
- Food Group Frequency: The frequency with which particular food groups, such as fruits, vegetables, grains, dairy, or meats, are ingested. This aids in evaluating the variety and harmony of a diet. For instance, the amount of vital nutrients (such as vitamins and fibre) in a person's diet can be determined by how often they eat fruits and vegetables.
- Portion Size Frequency: The frequency of portion sizes can be used to assess if a person is eating enough food to meet their energy requirements. Large portions, particularly of high-calorie foods, can cause weight gain and other health problems.

Through the perspective of culture and tradition, anthropologist Clark Wissler—known for his work in cultural anthropology—made important contributions to our understanding of human activity, particularly eating behaviour. His theories focused on how human habits, such as how people obtain and use food, are shaped by culture and the environment. This hypothesis holds that the dietary customs of various cultures are strongly influenced by their surroundings. People who live close to the ocean may rely on

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fish and shellfish, whereas those who live in arid regions may adopt a diet centred on foods well-suited to dry conditions (such as grains and dried fruits). This idea demonstrates how food behaviour is adaptive, with civilisations forming eating customs based on what is available in their immediate surroundings.

II. LITERATURE REVIEW

Previous research on the Birhor highlights a critical state of health and nutrition: Studies across Chhattisgarh indicate a high prevalence of undernutrition, with chronic energy deficiency affecting over 40% of adults. Common ailments include malaria, tuberculosis, and skin diseases like scabies, often compounded by unsafe drinking water and poor sanitation. The shift toward settled agriculture has altered traditional diets, leading to a "double burden" of low protein intake and increased consumption of low-quality market foods. Shyness and deep-seated faith in traditional healers (Baigas) often prevent Birhor women from seeking modern maternal and child healthcare. Originally, the Birhor tribe of Chhattisgarh was a part of the Mundari clan. They are classified as "Uthlu" (migratory) and "Janghhis" (settled) based on their lifestyle (Vidyarthi, 1986). The primary occupation of the "Uthlu" is rope production, food gathering, and hunting. They use plant-based basic materials for both personal consumption and financial gain. The second group, referred to as "Janghhi," is comparatively advanced and has begun to settle in forested areas. Because of their custom of consuming and sharing monkeys, the Birhor tribe is also known as Mankidi, Mankria, or Mankar-khia Kol (Adhikari, 1984). The tribal people are either nomadic or semi-nomadic. According to its etymology, Birhor means "dweller of the jungle." This tribe's name comes from two words: "bir," meaning "jungle," and "hor," meaning "man" (Shau, 2011). The Birhor language, which is a member of the Munda language family, is spoken by these tribal people. Birhore rely solely on the forest for their daily needs, as they are essentially nomadic hunters and gatherers. The Birhor have evolved a high degree of coexistence with the forest. Their expertise extends beyond the field of medicine. Information on some underutilised, high-protein plants that can be used as supplements is extremely important. In view of the aforementioned factors, traditional ethno-medical research has been conducted in the current globalised era (Verma & Panday, 1990). The socioeconomic, cultural, and health conditions of the secluded Birhor people are particularly crucial. As a result, they have created a unique method of utilising some underutilised plants for sustenance. These features are similarly noteworthy, and further study of these plants may open up new avenues for health and nutrition (Kumar & Pandey, 1998). The primary causes of their poor physical and mental health are unhygienic surroundings, ignorance, a lack of personal hygiene, and a lack of health education. Birhore has higher rates of maternal, neonatal, and overall death due to health issues. By methodically analysing food availability, dietary patterns, and nutritional levels among the tribes in various Indian regions, comparing the amount of nutrition, the physical requirements of that group, as well as the work efficiency and the impact of diet on children's growth, and analysing samples of domestic beverages for nutrient content (Gupta, 1980). The levels of milk, pus, oil, fat, jaggery, sugar, and other nutrients were shown to be directly correlated with the socioeconomic class of the teenage tribal population across nine Indian states, following an evaluation of their dietary and nutritional status (Rao et al., 2006). Abubakari (2016) showed that mothers who followed a healthy diet were less likely to have low-birth-weight babies, based on a study of feeding habits among women in northern Ghana and their offspring's birth weights. investigated the Pahari Kharia tribe's cooking techniques, attitudes and ideas about food, eating customs, and the custom of making particular foods for important occasions (Maharana & Nayak, 2017). Mahmud and Dalal (2019) investigated how the Bhil tribe's resettlement affected their quality of life during the building of the Sardar Sarovar Dam. They found that resettled families' health was adversely affected by reduced food consumption and deteriorated, leading to higher disease incidence in the modern era despite increased healthcare services. examined how Udaipur's traditional eating habits are changing—Rajasthan and how globalisation has affected it (Dhar, 2016).

III. OBJECTIVE OF THE STUDY:

The present study has the following objectives:

- To study the informants' food habits and behaviours.
- To investigate cooking methods, including the amount of time spent preparing food.

IV. RESEARCH METHODOLOGY:

The current study focuses on the eating habits of Birhor families living in the Bilaspur districts of Chhattisgarh, specifically the Dharam Jaigarh and Kota development blocks. Purposeful sampling was used to choose 56 Birhor families for the study. This study is quantitative and employs an exploratory research methodology, collecting primary data through focus group discussions, non-participant observation, interview schedules, and eating frequency questionnaires. While secondary data has been gathered from books, research papers, and the internet.

This study utilises a cross-sectional approach, combining primary and secondary data, Qualitative insights gathered through interview schedules, non-participant observation, and focus group discussions with Birhor families in Bilaspur. Secondary data were obtained by reviewing existing ethnographic reports in published research papers. Dietary variety was assessed using Food Frequency Questionnaires, and health status was analysed using historical morbidity data.

➢ *Traditional Knowledge Among Birhor:*

It is impossible to fully comprehend illnesses and their treatments in isolation, especially in primitive societies. Treatment and health are closely related to the environment, especially forest ecosystems. The foundation of traditional health care systems and treatments is their in-depth knowledge of nature and the environment. Many people have learned about medicinal plants by watching other animals in the wild. Although there are not many ethnobotanical studies

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that mention tribal peoples, those that do show they have a thorough understanding of the therapeutic benefits of many plants they frequently use for healing. The Birhore tribe's knowledge of plants extends beyond their usage and collecting. They are aware of their unique traits and dispersion. Birhore has a great deal of information regarding ethnomedicine. Their expertise extends beyond the field of medicine. Their knowledge of several underutilised, high-protein plants is extremely important as supplemental food (Mairh, Mishra & Kumar, 2009).

- *Food Habits and Health*

They prefer to drink stream water due to custom and habit, except for a few perennial hill streams known as Jharna, which are very poor and highly contaminated with coliform bacteria (Ram & Prassad, 2011). In hilltop and slope communities, where the majority of female household members must walk an additional 4–6 kilometres twice a day to collect stream water, the lack of drinking water is especially severe. Although government authorities have drilled a few wells, most are not working properly; thus, the situation on the plains and hill foot is somewhat improved. In the Chouparan block of Hazaribag district, a 20-year-old Birhor man named Bitu passed away while carrying water from a nearby village five kilometres away (Prabhat Khabar, March 24, 2011). The Telegraph of Calcutta was informed by Ashutosh (2009), a member of the NGO Samvendna, that the Birhors ' lack of knowledge about cleanliness and hygiene makes them vulnerable to illness. They must also be taught the value of clean water. Here, they live a primitive lifestyle. Their basic food, which can be toxic, consists of roots and leaves harvested from the forest. Recently, more than two dozen members of the Birhor tribe perished in two weeks after ingesting poisonous flora. Additionally, these people search the heart of jungles, especially in Koderma, Palamau, and Chatra, seeking tiny animals and birds to eat. "We do not have basic facilities of food, shelter, and clothes, because we do not have any mode of commuting," stated Suva Uthalu, a tribal member of Birhor. Frequently, we are unable to transport our dying loved ones to the hospital. Living here is really difficult. "We do not get any help from the administration, but occasionally they send us clothes and Kadhi Chawal (rice and curry made from curds)," stated Dunga Birhor.

V. RESULT AND DISCUSSION:

The Birhor family's socioeconomic status: 39.28% of the informants are between the ages of 15 and 25, 26.8% are between the ages of 26 and 35, 16.1% are between the ages of 46 and 55, 8.9% are between the ages of 36 and 45, 7.1% are between the ages of 56 and 65, 1.8% are between the ages of 66 and 80, and 60.7% are women. The community has transit routes, of which 23.2% are paved, and 76.8% are unpaved. According to the village's toilet system, 85.7% of informants do not have a toilet in their homes, whereas 14.3% do. Regarding the dwellings' drainage systems, 12.5% of the informants have these, whereas 87.5% do not. drainage system. 8.9% of the informants have petrol facilities in their homes, compared to 91.1% who do not.

Table 1

S.N	Frequency of Pulses	Frequency	Percentage
1	No	2	3.6
2	1-3 Times in a Month	23	41
3	Once A Week	12	21.4
4	2-3 Times A Week	14	25
5	Once Every Day	5	9
	Total Sum	56	100

Source: field survey

Table 1 highlights pulse consumption patterns among 56 participants, revealing that although most include pulses in their diet, the frequency of consumption is generally low. The largest segment of the group (41%) consumes pulses only 1–3 times per month, followed by 25% who eat them 2–3 times a week. While approximately 46.4% of respondents consume pulses at least once a week, only 9% make them a daily staple. Conversely, a negligible 3.6% of participants do not eat pulses at all, indicating that pulses are a recognised but non-dominant component of the group's overall diet.

Table 2

S.N	Frequency of Dairy Product	Frequency	Percentage
1	1-3 Times in a Month	27	48.2
2	Once A Week	18	32.2
3	2-3 Times A Week	11	19.6
	Total Sum	56	100

Source: field survey

Table 2 indicates that while all 56 participants consume dairy products, the frequency of consumption is relatively low. Nearly half of the group (48.2%) consumes dairy only 1–3 times a month, making this the most common consumption pattern. Approximately 32.2% of respondents include dairy in their diet once a week, while the remaining 19.6% consume it 2–3 times a week. Notably, none of the participants reported consuming dairy products daily or completely excluding them from their diet, suggesting that dairy is an occasional rather than a staple component of their diet.

Table 3

S.N	Frequency of Oil	Frequency	Percentage
1	1-3 Times in a Month	29	51.8
2	Once A Week	16	28.6
3	2-3 Times A Week	9	16.1
4	Once every day	6	10.7
5	2-3 times a day	6	10.7
	Total sum	56	100

Source: field survey

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The data in Table 3, which show oil consumption patterns among the 56 participants, exhibit wide variation, though infrequent use remains the most common trend. Over half of the group (51.8%) reported using oil only 1–3 times a month, while approximately 28.6% consume it once a week. Interestingly, while 16.1% use oil 2–3 times a week, a combined 21.4% of respondents include oil in their diet daily—split equally between those who use it once every day and those who use it 2–3 times a day. This indicates that while the majority uses oil sparingly, a distinct subgroup has integrated it as a constant staple in their daily meal preparation. (Table 3)

Table 4

S. N	Frequency of egg/fish/meat	Frequency	Percentage
1	1-3 Times in a Month	28	50
2	Once A Week	19	33.9
3	2-3 Times A Week	6	10.7
4	Once every day	3	5.4
	Total sum	56	100

Source: field survey

Table 4 reveals that animal protein consumption (eggs, fish, and meat) among the 56 participants is predominantly occasional rather than daily. Exactly half of the group (50%) consumes these proteins only 1–3 times a month, making it the most common frequency reported. Roughly 33.9% include them in their diet once a week, while a much smaller group, 10.7%, eats them 2–3 times a week. Only a very small minority (5.4%) consumes eggs, fish, or meat daily, suggesting that for the vast majority of this group, animal proteins are a supplement rather than a primary dietary staple. (Table 4)

Table 5

S. N	Frequency of fruits	Frequency	Percentage
1	1-3 Times in a Month	31	55.4
2	Once A Week	18	32.1
3	2-3 Times A Week	5	8.9
4	Once every day	2	3.6
	Total sum	56	100

Source: field survey

Table 5 indicates that fruit consumption among the 56 participants is relatively infrequent, with most consuming it as an occasional snack rather than a daily staple. Over half of the group (55.4%) consumes fruits only 1–3 times a month, while 32.1% include them in their diet once a week. Only a small fraction (8.9%) eat fruit 2–3 times a week, and a very minimal 3.6% of participants consume fruit daily. These findings suggest a significant gap in regular fruit intake within this surveyed group. (Table 5)

Table 6

S. N	Frequency of Tea/coffee	Frequency	Percentage
1	1-3 Times in a Month	3	5.4
2	Once A Week	4	7.1
3	2-3 Times A Week	6	10.7
4	Once every day	29	51.8
5	2-3 times a day	14	25
	Total sum	56	100

Source: field survey

In contrast to other dietary items, tea and coffee consumption among the 56 participants is a highly regular and daily habit. A significant majority of the group (76.8%) consumes these beverages every day, with 51.8% drinking them once every day and 25% consuming them 2–3 times a day. Occasional consumption is much less common, with only 10.7% drinking tea or coffee 2–3 times a week and a small minority (12.5% combined) having them once a week or less. These findings indicate that tea and coffee are deeply integrated into the daily routine of most respondents.

Table 7

S. N	Using the same appliance for everyday use	Frequency	Percentage
1	Stove	3	5.4
2	Gas	33	59
3	Firewood	20	36
	Total sum	56	100

Source: field survey

Table 7 shows data on daily appliance usage among the 56 participants, indicating a clear preference for gas as the primary cooking fuel. A significant majority (59%) uses gas for their everyday cooking needs, making it the most common appliance in the group. Firewood remains a substantial secondary energy source, utilised by 36% of respondents, while only a small minority (5.4%) relies on a stove. These results indicate that while modern gas appliances are the leading choice, more traditional methods, such as firewood, still play a major role in the daily lives of over one-third of the surveyed population.

Table 8

S. N	Time taken to prepare food	Frequency	Percentage
1	One hour	36	64.3
2	Two hours	13	32.2
3	More than two hours	7	12.5
	Total sum	56	100

Source: field survey

Table 8 shows that among the 56 participants, most spend relatively little time on meal preparation. A significant majority (64.3%) reported spending 1 hour cooking, making it the most common duration. About 32.2% of the group spends 2 hours on food preparation, while only a small minority (12.5%) spends more than 2 hours on this task. These findings suggest that for nearly two-thirds of the

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surveyed population, daily meal preparation is relatively quick, possibly reflecting a preference for simpler meals or the use of more efficient cooking methods.

Table 9

S. N	Utensils for cooking food	Frequency	Percentage
1	Aluminum	52	92.8
2	Iron	2	3.5
3	Steel	2	3.5
	Total sum	56	100

Source: field survey

Table 9 reveals a near-universal preference for Aluminium cookware among the 56 participants. A vast majority, 92.8% (52 individuals), use aluminium utensils for cooking, making it the dominant material in the surveyed kitchens. In contrast, both Iron and Steel are used by only a very small minority, with each material accounting for just 3.5% (2 individuals) of the total. These findings suggest that aluminium is the primary choice for food preparation in this group, likely due to its accessibility, heat conductivity, or cost-effectiveness compared to other metals.

Table 10

S. N	Time taken to prepare The food	Morning		Evening	
		Frequency	Percentage	Frequency	Percentage
1	One hours	36	64.3	36	64.3
2	Two hours	13	32.2	13	32.2
3	More than two hours	17	12.5	7	12.5
		56	100	56	100

Table 10 reveals a highly consistent pattern in the time spent preparing meals during both the morning and evening sessions among the 56 participants. In both timeframes, a significant majority of 64.3% completes food preparation within one hour, making it the most common duration. This suggests that for nearly two-thirds of the group, meal preparation is a relatively quick and standardised process regardless of the time of day. A further 32.2% of respondents dedicate two hours to cooking in both the morning and evening. Interestingly, while the percentage for those taking more than two hours remains constant at 12.5% for both sessions, there is a slight discrepancy in the frequency count for the morning (17) compared to the evening (7). However, both are calculated against the same percentage. Overall, the findings indicate that the time demand for cooking remains stable for most households throughout the day. (Table 10)

Food is prepared on stoves in 91.1% of the informants' homes, while both gas and stoves are utilised in 8.9% of the informants' homes. There is a source of smoke emission in 69.6% of the informants' homes when food is cooked on a stove or sigri, while there is no such source in 30.4% of the informants' homes. 33.9% of informants' families make less than 1033 per month, 30.4% make between 1034 and 3071 per month, 17.9% make between 1034 and 3071 per month, and 16.1% make between 5120 and 7680 per month. The informants' eating habits and patterns of food consumption: Meal frequency: the number of times a person consumes meals in a day, which has a substantial influence on health. It speaks to the frequency, amount, and timing of meals. While some people prefer to eat three meals a day—breakfast, lunch, and dinner—others prefer to eat five or six meals spread out over short periods. Eating at the proper frequency promotes healthy digestion, regulates energy levels, and aids in weight management. Additionally, it can help avoid issues like diabetes and manage blood sugar levels. A person must accurately track their meal intervals and avoid overeating or excessive hunger to maintain a balanced diet. to choose the appropriate lunch. Therefore, one should always have breakfast, stay hydrated throughout the day, and adjust their food to fit their daily level of physical activity. Rice consumption frequency: per informant eats rice twice or more per day.

VI. SOCIO-CULTURAL DIMENSIONS OF FOOD HABITS

The Birhor consume various wild tubers (Kanda, such as Nakoua and Pithas), forest fruits, and mushrooms. Historically, they were known to consume monkey meat, though this practice has declined due to wildlife regulations. Meals are typically prepared twice daily using traditional wood stoves, often resulting in high indoor smoke exposure. A notable cultural practice involves a specific order of eating—often serving children or men first —which may negatively affect maternal nutrition. Health in the Birhor community is perceived as the ability to perform daily work; serious attention is only given when a person is physically dysfunctional. Approximately 40% of the tribe relies solely on exorcism (Baiga treatments), while many use a combination of herbal home remedies and hospital visits. Only about 17% of Birhor women receive assistance from a physician during childbirth, with a strong preference for home deliveries conducted by elders. Most households lack proper toilets or drainage systems, leading to high rates of waterborne diseases such as gastroenteritis and typhoid. An analysis of traditional medical practices could lead to the discovery of novel approaches to treating different illnesses with specific adjustments. In reality, some ethnobotanical

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investigations have contributed to the discovery of novel, modified treatments for a variety of illnesses. Numerous ethnobotanical studies have helped identify medicinal plants that tribal people utilise to treat various illnesses. Many of them have the potential to be quite helpful in treating illnesses, so they must be documented and tested through appropriate scientific research. The limited research on tribal medicine has shown this, particularly regarding efficacy, which is really encouraging. Low consumption of pulses, dairy, and animal protein leads to high rates of anaemia (up to 100% in some tribal children). Tobacco and local liquors (Mahua) are widely consumed from a young age, further draining meagre household incomes and impacting long-term health. Their small, isolated population often leads to neglect of government infrastructure development in Bilaspur's remote blocks.

VII. CONCLUSION

There are still individuals living in isolation in pristine, natural environments far from civilisation, with their traditional values, customs, beliefs, and myths intact, despite tremendous global advancements in diagnosis, treatment, and preventive health (Shukla, 2008). Due to a lack of access to clean water, hygienic food, daily diets, protection from the cold, sun, and rainy season, inadequate government-provided medical facilities, and a lack of awareness about health, which has led to an increase in malnutrition, mental illness, and mortality rates, Jharkhand's primitive tribal group faces numerous health issues. At various phases of social, cultural, economic, and health development, primitive tribal societies face challenges.

VIII. RECOMMENDATIONS

The health of the Birhor tribe in Bilaspur is intrinsically tied to their forest-dwelling culture and subsistence economy. While government interventions such as the Janani Suraksha Yojana exist, awareness remains low.

- Implement mobile health clinics that respect cultural boundaries and work alongside traditional healers to bridge the gap to modern medicine.
- Promote the cultivation of nutritious local millets (Kodo, Kutki) to diversify their rice-heavy diet.
- Targeted nutritional programs for pregnant women and children are urgent to address high neonatal and under-five mortality rates.

IX. SUGGESTION:

To achieve sustainable development, the government must prioritise eliminating illiteracy as a foundational step. By doing so, the state can simultaneously bolster its workforce with skilled workers and elevate the general standard of living for its citizens. This educational transformation should also include integrating vocational studies into the curriculum to ensure that youth are equipped with practical, market-ready skills. In tandem with educational reform, there is a critical need to strengthen the healthcare sector, particularly by concentrating on primary health services. Since many state health initiatives are centrally sponsored, implementing rigorous monitoring and evaluation strategies is essential to ensure these programs actually reach the people they are intended to serve. Furthermore, adhering to the principle that prevention is better than cure, the state should focus on improving sanitary conditions, promoting personal hygiene, and utilising health education as a primary tool to curb the spread of fatal diseases. Finally, addressing social and regional disparities is vital for holistic progress.

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