In Brief

Public Health Malaise and the Practices of Ritual Healing: An Analytical Discussion in the Contemporary Societies of Darjeeling Hills

Sapan Tamang*

Abstract

The nature of human life is beyond science. It is perhaps the most precious creation of god on earth. As stated in the Hindu philosophy that life is constituted by the five elements of nature viz; *vayu (air), agni (energy), jal (water), prithvi (earth) and aakash (sky).* It is believed that the perfect equilibrium in all these elements in human body is often considered as a healthy body and mind. Every human being desires to live his life with optimum peace and dignity which infact is possible only through healthy body and mind. So, good health is an urgent need of human life. It is also well evident that the practices of healthcare system and the methods of diagnosing diseases vary across the world in terms of technological advancement, regional variations and cultural orientations. India, being a highly pluralistic and diversified culture, has always been a witness to such kind of divergent nature of health practices and healthcare system in its various parts. Thus the present study attempts to explore an idea about the healthcare practices and its socio-cultural legacy associated with Gorkha Community of Darjeeling Hills in the larger public health terrain of Indian Union.

Key words: *Healthcare, Public Health, Cultural Orientation, Pluralist Society, Codified & Uncodified Healthcare.*

Introduction

Health is an important secondary need of human life after the basic need like food, cloth and shelter. Every human being desires to live his life with optimum peace and dignity which infact is possible only through healthy body and mind. As stated in WHO charter, good health as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity. (Thapa, 2017) It is generally believed that the nature of human life is beyond science, as it is further conceived in the Hindu philosophy that life is constituted by the five elements of nature called "*Panchamahabhutta*" i.e. *earth*, *sky*, *water*, *air* and *fire*. The proper equilibrium in all these five elements in human body is often considered as healthy body and mind. Further, the explanation of these five elements in our body is stated in the *Vedas* as earth is the source of minerals, sky the source of consciousness, water the source of thirst, air the source of respiration and fire the source of energy, and it is believed that the imbalances of any of the element of '*panchamahabhutta*' in human body leads to the causation of sickness in the form of imbalances of three basic elements of human body i.e, *Kaffa*, *batta*, and *pitta* that is blood, pituit, black bile and yellow bile.. It is generally believed that Medicine is the science and practice of the diagnosis, treatment and prevention of disease. Medical system and healthcare practices vary across the world due to the regional differences in culture, knowledge and technology. It is indeed well evident that the global health system is dominated by the Modern medicine (MM), Biomedicine (BM) or Western Medicine (WM) but in the developing countries of Asia, Africa and Latin America still majority of the population rely on Traditional medicine(TM), Alternative Medicine (AM), Folk Medicine (FM) or Complementary Medicine (CM).

* Assistant Professor, Department of Political Science, Dinhata College, Coochbehar, W.B., e-mail: sapanbomzon@gmail.com

Relationship among Panchamabhut and Sense				
State	**English Name**	**Sense**	**Sense Organ**	**Food**
Akasha	Space	Sound	Ear	
Vayu	Wind	move-ment	Skin	Potato
Agni	Fire	Light	Eye	Chilli
Ap/Jala	Water	Taste	Tongue	Cucumber
Prithvi	Earth	Gnadha/ Solid	Nose	

- Diseases occur due to imbalance/vikriti between the states. Eg. Wind- Parkinson, vayu/Agni-ap
- Physiology of Traditional Medicine-Kapha, Vata and Pitta
- Modern Physiology-Hormones, BP, Lipid level, Blood Sugar etc.

Brief History of Medicine and Healthcare Practices

In India, *Atharvaveda*, the sacred test of Hinduism is considered as the first book of knowledge in medicine. The school of health care, *Charaka*, that of medicine and *Sushruta*, that of surgery are the first medical practitioners who formally introduced the health care practices in this globe. These two foundation lead to the birth of *Ayurveda*, the science of life where many branches of medicines are described. ***(Unnikrishnan, 2004).*** If we look back to the history of medicine then it is evident that there are four successive stages of medicine viz. Instinctive stage, theological stage, metaphysical stage and scientific stage. Instinctive stage is a primitive stage or the first stage of human civilization where people save themselves by their instinct or by practising the use of different herbs for different diseases as well as worshipping the different gods. The second stage is theological stage which gives the ample of instances that the primitive people had the practices of faith healing because they believed in the existence of supernatural powers and they also believed that the diseases occurs due to the unhappiness of these powers so they worshipped different natural gods and also made different sacrifices to calm down the wrath of these supernatural powers. Third one is metaphysical which states that the diseases occurs due to the imbalances of humours in human body that is blood, pituit, black bile, and yellow bile. The man associated with this idea is a well known philosopher named Hippocrates. After these stages we enter in the last stage that is present stage or the scientific stage. If we come to the Hindu philosophy of medicine, the most ancient document of the Indo Aryan race is Veda. There are four *Vedas. Rig Veda, Sama Veda, Yajur Veda and Atharva Veda*. But we can find the details of medicine in *Atharva Veda*. Hindu philosophy states that there is direct relation between god and disease. We can find the origin of all recognised traditional medicine in *Atharva Veda*. According to this philosophy the first medical practitioner or the doctor in modern term are *Charaka and Susruta* former is expertise of medicine and the latter is the expertise of surgeries. (Cumston, 1999) But simultaneously in this age also we have ample of instances of the practices of healing, sorcery, black magic and the use of negative forces. Emile Durkheim, the famous sociologist argues that there are two categories of things in the world- sacred and profane. Things which are held in respect are sacred and therefore related to supernatural and things which are items of utility are profane and related to worldly activities. Thus sacred is religious and profane is worldly. From the religious point of view, there are two forms of religion viz. *Oral Religion and Religion of the book*. *Oral religion* is the one whose theory and beliefs about the religion are not written in any language or in any document. Tribes all over the country have oral language .Religion of Book on the other hand is the documented theory like *Gita, Veda, Bible, Quran* etc. Oral religion is characterised by their local relevance, relative lack of dogmas etc. The primitive and tribal groups invariably have an oral language like Bhil tribe of western India. Further there are four theories of religion viz. *Animism, Polytheism, Monotheism and Naturalism. Animism* is the existence of intangible, non material or spiritual being. *Polytheism* is to beliefs of more than one spiritual power or deity. *Monotheism* is to belief in one deity and *Naturalism* deals with nature worshipping. According to People of India, project of

K.S. Singh, 45.9% out of 461 tribal groups still practices animism. According to social anthropologists like Durkheim and Parsons Religion is the belief and rituals are mechanism through which beliefs are fulfilled. They further argued that rituals are the part of religion. It is an ingredient of religion. Therefore rituals are termed as practices of religious actions. All these theories of religion and their practices followed by the ritual healing system are very much prevalent in almost every part of rural India. *(Jain, 2011)*

Public Health Discontentment in India

Public Health is always in a questionable premise in India it has always been neglected in India. It has received low priority in the central and state budgets. There is a considerable urban bias characterising health policies and investment strategies in India. Around 75% of the resources and infrastructure of health are concentrated in the urban India. But the conditions and the facilities of health in the rural India has very chronic and deteriorating day by day. They even lack basic primary health facilities in their region. To cope up the situation Government has initiated several programmes and policies among which the NFHS, NRHM and DNHP gained more impetus in the country. The National Family Health Survey (NFHS) was carried out as a principal activity of a collaborative project to strengthen the research capabilities of the Population Research Centres (PRCs) in India, initiated by the Ministry of Health and Family Welfare (MOHFW), government of India and coordinated by the International Institute of Population Science (IIPS) Bombay. The primary objective of the survey was to collect reliable and up- to -date information on health, family planning, fertility, mortality and maternal and child health. There have been four NFHS conducted by the government in a holistic way viz, NFHS-1, NHFS-2, NHFS -3 and NHFS-4 in the following years 1992-1993, 1998-1999, 2005-2006 and 2015-2016 respectively. On the basis of the reports of the all four NFHS, it is revealed that there are huge differences in the health, nutrition, mortality and fertility among the states of India. Some are performing very well such as Andhra Pradesh, Goa, Karnataka and Kerala but the performances of some states are not very satisfactory like Uttar Pradesh (U.P), Bihar, Madhya Pradesh (M.P), Orissa, West Bengal (W.B) etc. Further, there has been a considerable growth in the awareness level, health facilities, family planning, education etc in every successive survey report. It is also notified that the poor nutrition is less common. Anaemia has also declined but still remains widespread. More than half of children are anaemic in ten of the 15 States/Uts. Similarly, more than half of women are anaemic in eleven States/ Uts. Over nutrition continues to be a health issue for adults. At least 3 in ten women are overweight or obese. (Ministry of Health and family Welfare, 1992-1993, 1998-1999, 2005-2006, 2015-2016). The National Rural Health Mission (NRHM) was introduced by the UPA government in the year 2005. The main objective of this scheme was to "carry out necessary architectural correction in the basic health delivery system...to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor women and children". To attain this objective three tiered public health system was started to provide the proper healthcare facilities to the rural masses in the name of Sub Centres (SCs), Primary Health Centres (PHCs) and Community Health Centre (CHCs) units. However, the outcome of the scheme as envisaged above was not very satisfactorily achieved because it has faced several drawbacks such as deficiencies in physical infrastructure which involves as lack of electricity supply to SCs in some States, scarcity of beds for patients in many PHCs, poor condition of sanitary provision in PHCs and CHCs etc. Shortage of Equipments and Medicine in all three units in several states was another lack of the scheme. Evaluation reports have also highlighted the scarcity of manpower in all three units in many states. Further, the NRHM envisages that every village will have an ASHA (Accredited Social Health Activist) selected by the village panchayat who are entitled to act as the interface between the community and the public health system. As per the norms for recruiting ASHAS, it is stated that they have been selected on the basis of recommendation of ANMs, anganwadi workers and the panchayat head but in many cases they are recruited from the people of influential families, relatives of local leaders or the persons backed by the politicians. Further, in some cases the wives of community health workers were appointed. It is also noteworthy to

mention that the training of the health activists and the availability of kits is also not very satisfactory. There is very discontinuous and infrequent training of health activists, the quality of training is also varying from state to state. Thus, the theory of NRHM to deliver the proper healthcare facilities to rural masses has fallen far away from its desired ends. (Hussain, Jan 22, 2011) The Draft National Health Policy 2015 was also initiated by the government to provide highest possible level of good health and wellbeing through a preventive and promotive health care orientation in all developmental policies. This policy suggests that the harmony of purpose between the public and private healthcare delivery system to achieve the goal of "universal healthcare" which actually facilitates the unconcerted growth of private intervention in the health delivery system. The policy seeks to deliver a comprehensive set of preventive, promotive, curative and rehabilitative services through the sub centres and PHCs but at the same time it also refers the "package of services". So the idea of comprehensive and the package system is contradicting each other. The DNHP lays emphasis on the holistic approach and cross sectoral convergence in addressing social determinants of health and it can be achieved through planned and adequately financed institutional mechanisms. But except the Swacha Bharat Abhiyan and the Integrated Child Development Services no other initiatives has been made in this regard. Further, the health professionals, academicians, activists and the civil society members vehemently oppose and condemn the pro-business formulation of DNHP (Mohan Rao, April 25, 2015) However, the picture of the urban health in India is also not very satisfactory, over 70 % of urban population is suffering from obesity. It is a chronic medical condition characterised by too much body fat which has rendered 10% of couple in the country infertile. The incidence of obesity in India has been rising very steadily. Women are also at a greater risk of pregnancy complication due to the obesity. Dr. Shobha Gupta, medical director and IVF specialist from Mother Lap IVF centre, said "I see 20 patients coming to me for infertility, of which 4 to 5 % are obese" (Statesman)

Glimpses of Codified and Uncodified Healthcare Practices in India:

There are basically two schematically available treatments for any diseases one is Western Bio-Medicine and another is Indigenous Traditional Medicine. Again, this Indigenous traditional medicine will flow in two distinct streams viz, *'codified traditional medicine'or Classical Codified System and 'uncodified traditional health practices' or Oral Folk System*. In India we have both *codified* and *uncodified* health practices. But the codified traditional medical practices have been recognised by the government in the name of *AYUSH which comprises Ayurveda, Yoga, Unani, Sidha and Homeopathy including Naturopathy*. Whereas the uncodified healthcare practices are very much present in the society but no one is bothering about its preservation and legalisation. There are more than 50,000 herbal formulations documented in Indian medical texts whereas modern medicine has only 4000 odd drugs representing the sum total of world's pharmacopoeia. But after the advent and popularization of so called scientific Western Medicine (WM) or Bio Medicine (BM), both codified and uncodified healthcare system in India started eroding. During the colonial and post colonial period the growth of BM for commercial purpose took a rapid pace. However, there has been an attempt to revitalize the codified system of medicine with the establishment of department/ ministry of AYUSH by the government. The scientific validities, research, efficacy and legitimacy of the above codified system is on, at all level of stakeholders but there is no any organized process to document the oral folk system of medicine commonly called Local Health Tradition (LHT). It is estimated that there exists more than 1, 00,000 herbal healers in India. These folk systems of medical practices are now- a-days considered unscientific. But there exists the cases of scientific validities and knowledge base in the practice of such local Health Tradition LHT. The standardization, regulation and legitimacy of Traditional Medicine (TM) are still questionable in the modern medical sciences. *(Unnikrishnan, 2004)*

Darjeeling at a Glance

Darjeeling, the *Queen Hills,* situated in the lap of *Kanchanjunga*, prosperous with scenic beauty and mesmerising climate has also been witnesses these kind of uncodified healthcare system from time immemorial. Darjeeling, one of an important district

of West Bengal filled with Nepali speaking population is distinct in their language, culture and food habits from the rest of Bengal. The Darjeeling district, with a small geographical area of 3149 square kilometres (census 2011) has a heterogeneous population. It is a medley of racial and linguistic groups but, remarkably dominated by the Gorkha community. There is still some controversy regarding the nomenclature of this dominant community i.e. the Gorkhas. Some argue that Gorkhas include the hill ethnic groups living in the Darjeeling district like the Nepalis, Lepchas, Bhutias, etc. Others opine that the name is roughly derived from a district of Nepal from where martial races were chosen for fighting the war in the name of Gorkha platoon which later on became the world famous Gorkha army during the World War I and II. Again, the former group argue that Nepali is the only language spoken as vernacular in this region and the same should not be confused with race. Anthropologically similar figure is obtained in the nearby state of Sikkim. Without getting into these controversies, 'Nepali' and 'Gorkha' are used to mention the above dominant community of the hills for the present communication.

Brief History of Darjeeling

Darjeeling in the early years of the 19th century was a part of the dominions of the Rajah of Sikkim. Captain Llyod and Mr. J.W.Grant on an expedition against Nepal chanced upon Darjeeling where they stayed for about a week. They were mesmerized by the cool and bracing climate of the hills and the sight of the magnificent Kanchenjunga. They felt the hills would be ideal for a sanatorium for which they opened negotiations with the Rajah of Sikkim for the cession of Darjeeling. So in February 1835, a strip of hill territory, 24 miles long and about 5 to 6 miles wide, was successfully transferred from the Rajah of Sikkim over to the British by a deed of grant. This strip of land known as the British Sikkim then included the villages of Darjeeling and Kurseong, and it formed the nucleus of Darjeeling District. The relation between Sikkim and the British Government having turned sour due to the infirm Rajah's corrupt Prime Minister, the British Government sent a punitive expedition against Sikkim in 1850. This led to the annexation of the Terai and a portion of the Sikkim hills, bounded on the north by the Rammam and the great Rangit rivers and by the Tista River on the east and by the Nepal frontier on the west. In 1866, to keep away the Bhutanese from marauding into Darjeeling, a hilly tract of 486 square miles east of the Tista was annexed from Bhutan. This hilly tract was amalgamated in Darjeeling District which subsequently formed Kalimpong sub-division. The hills of Darjeeling have faced various ups and downs of delimitations from the kimgdom of Sikkim, kingdom of Nepal, British East India Company, British India, annexation of Kalimpong from Bhutan and finally to Indian Union in the state of West Bengal. First acquired, this hilly strip of land was under forest and sparsely populated. Under the administration of Dr. A. Campbell who was appointed the Superintendent of the new hill station, it developed rapidly. The opening up of tea gardens resulted in the immigration of plantation labourers. There was an influx of settlers to cultivate the wastelands and clear the forest areas. *(O' Mallay, 1907)* This led to a major increase in population. With the construction of roads and railway, communication improved which in turn led to employment opportunities and hence the rise in population. All those who immigrated to Darjeeling during that time were carriers, porters or cultivators. The once practically uninhabited strip of land steadily came alive. During his botanical exploration of the Indian sub-continent in mid 19th century Sir J.D. Hooker has mentioned the names of Lepchas and some sub-communities of the Gorkhas like the Magars, Limboos as aborigines to the region. *(Hooker, 1854)*

Healthcare System in Darjeeling

Before the advent of Britishers in Darjeeling Hills the total healthcare system was dominated by uncodified healthcare practices known as Ritual Healing System or locally known as Jhankri System. This ritual healing system occupies an important place in the society, particularly in the rural society. Darjeeling Hills is the conglomeration of various ethnic communities viz. Magar, Tamang, Gurung, Rai, Limbu, Lepcha etc and each community has its own healer who perform various ritual ceremonies on behalf of his community at the time of need. These healers include *Bijuwa for Rai Community, Fetangma for Limbu, Bungthing for lepcha and lama for Tamang* etc. Among all these local ritual-healers, *Dhami* and *Jhankri* are the common term in

the hill-tribes and *Vaidha* and *Ojha* in the lower hills. In Darjeeling, among the Gorkha and Nepali community, *Jhankri* is a common term of social status. He may be an ordinary person of any caste having spiritual power who acts as a trance between man and supernatural powers. Still in modern age, people of Darjeeling especially in the rural areas, have the legacy of ritual-healers (Jhankris) among all communities. The people of Darjeeling still prefer to visit the local healer (Jhankri) first for their medical urgency than to a doctor. Basically there are two types of healers (Jhankris) in Darjeeling, one type of healers are trained by their guru i.e. a normal human being having good knowledge of healing system but there are another type of healers who are trained by *ban jhankri. Ban Jhankri* is the one who is a deity of specialised *jhankris.* It is indeed a fascinating reality of the region that in the age of global village and universal healthcare system the people of Darjeeling still rely on all these uncodified healthcare system for their basic health facilities. (Thapa S. T., 2017) Further, it is also noteworthy to mention here is that starting from birth till the death, in every occasion whether good or bad these healers are needed to perform the concern rituals and pujas. It is evident that the people of Darjeeling irrespective of caste and creed believed in the existence of supernatural entities both in the form of benevolent and malevolent nature. There is a kind of belief system present in the hill society that if they fails to appease the different deities in different times then they have to face the various difficulties in life. These deities include both natural deities and ancestral worshipping. So, to protect the life from the wrath and anger of these deities the people of Darjeeling basically indulge in all these ritual healing system and these healers plays a crucial role for negotiating with the deities on behalf of the concern parties by offering different rites. They are often acting as liaison between the supernatural deities and the human beings. In many occasions we have also seen that the hills politicians are also encouraging and endorsing this ritual healing system. Whether they have any political motive or they simply wanted to preserve the traditional cultural heritage of ritual healing system that is still a big mystery. Further, it is believed that hill people are basically nature worshippers who believe in nature worshipping. There are many instances where this nature worshipping was being organised in Darjeeling by the then Chairman of Darjeeling Gorkha Hill Council late Subash Ghising in the name of "*dhunga ko puja* i.e. stone worshipping", "*khola ko puja* i.e. river worshipping", "*jungle ko puja*" etc. Jhankri dance (healer dance) was also being organised in different parts of Darjeeling in the name of nature worshipping. Thus, it is revealed that the healthcare system in Darjeeling Hills is associated with culturally rooted belief system and practices such as Ritual Healing System

Local Healer (Bijuwa) appeasing the natural deity

Performing death rituals and rites

Healer from Limbu Community (Fetangma) performing death rituals and rites

It is well evident from the above pictures that the concept of healthcare system in Darjeeling Hills are still associated with the oldest form religion in human civilization i.e. naturalism and animism.

Epilogue

It is revealed from the above study that there are divergent healthcare practices in India which is often culture and community specific. These healthcare practices as I mentioned above are classified into codified and uncodified system and most of the tribal populations healthcare practices are uncodified one. It is also well evident from the present study that the healthcare practices of Darjeeling Hills i.e. Jhankri culture is also an eminent example of an uncodified healthcare system in India. Further, it is indeed interesting to note that the same kind of healthcare system is also practised in Kerala from very inception and the man associated with this system is known as vaidya. But, interestingly the government and the concerned stakeholders of the region took the initiative to revitalise these uncodified system by mixing it with the codified one and named it as Ashthavaidya System of Kerala. Thus, this system is the combination of both codified and uncodified healthcare practices. (Menon 2010) Now, the important issue regarding the existence of these kinds of entire uncodified health regimes in an Indian society is its legality and validity. Every states of India have witnessed these kinds of healthcare practices in different forms. A large number of rural as well as urban populations depend on these kinds of systems for their general healthcare but the legality of such a system in India has always been at stake. Therefore, it is imperative to have an intense study regarding the efficacy and validity of these uncodified healthcare knowledge system and verify its authenticity that whether it is due to the lack proper public health facilities, health expenses or it is really efficacious that these kinds of systems do practices in every Indian society. Further, it is indeed a need to initiate an integrative approach combining both the Codified, Un-codified and bio medical System of Medicines. It has been observed that integration of TM with that of BM in Korea as Traditional Korean Medicine (TKM) could be treated as a lesson in this regard. But in the Indian context, due to diversified cultural practices and unorganised profile of traditional practitioners, there is every possibility of this folk system of medicine being eroded while integrating the medical systems. Thus, to safeguard this knowledge base uncodified healthcare regime, it is needed that a suitable contemporary approach should be made to strengthen the medical pluralism in India where the interest of local health tradition should be taken into consideration.

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