Healthcare provision from static centres and the issue of self-financing

An Exploratory Study of Selected NGO Health Centers in Bangladesh

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which amounts to around Taka 200,000.00/- annually. Concern is raised about the futility of the subsidy provided, and whether this is the best value-for-money for improving the health of the poor. This study will explore the health intervention experiences of selected NGOs providing healthcare services from static facilities to decide on the feasibility of continuing current services provided through BRAC Health Centres (BHCs).

Objectives of the exploratory study

- To explore the nature, extent and underlying concept of financing (including perception of subsidy) healthcare services from static facilities
- To explore the healthcare package offered, user fees charged, and facilities existing in the static health center of the selected NGOs
- To explore the client/disease profile, and satisfaction with services provided (proxy of service quality)
- To see the sites of the health intervention experiences of selected NGOs providing health care services from static facilities to decide on the feasibility of continuing current services provided through BRAC Health Centers (BHCs)

Methodology

Five NGOs (Non Governmental Organization) with a valid track record of working for improving the health of the poor was purposively selected for this study. These were: Grameen Bank, Gonoshastho Kendra (GK), NGO Service Delivery Programme (NSDP), Marie Stopes Clinics, and Dustha Shastho Kendra (DSK). A team of three persons from BRAC working in the field of Public Health visited the central offices of these NGOs between September 1-15, 2003 and interviewed key informants on issues of interest. A checklist was used for this purpose. This was supplemented by field visits to some static service delivery centres run by these NGOs to cross-check existing facilities and services, and conduct some exit interviews to explore client satisfaction with services. Descriptive analysis of the data was done to compare and contrast with BRAC BHCs on issues of interest.

Findings

Findings based on descriptive analysis of the data are presented in the following paragraphs by study themes.

Underlying concept of healthcare provision from static centres

In majority of cases, health service provision is seen as an integral component of pro-poor development activities by the NGOs. Health for the poor is not considered as a commodity from which profit is to be made or from which 100% cost-recovery is to be achieved. A broad dividing line is drawn between for-profit sector (private) and the NGO sector in this regard. The importance of static centres is emphasized as a primary referral back-up to the community-based health activities of the NGOs and considered essential for assuring some degree of quality healthcare for the poor. The key informants noted that without the back-up of the static centres it would be very difficult to address the growing demand for healthcare arising from the activities of the NGOs, which is not always available from the Government centres for a variety of reasons. These static facilities also act as centres around which the community-based activities can be organized.

Financing and cost-recovery

Financing of the static centres is done from two sources; (1) subsidies from the centre and (2) user-fees. The capital cost and major share of the recurring costs are provided by the centre, sometimes funded by different donors and sometimes by cross-subsidy from other revenue generating operations of the NGOs. All of the studied NGOs are cross-subsidizing their health programme with revenue from their other activities to different degrees. In case of Gonoshastho Kendra (GK), major cost of running the static health centres (40-80%) is subsidized by revenue from its commercial operations e.g., *Gonosasthya* Pharmaceuticals and CIDA/Plan International. The main objective of their health programme is to set a role model in the country to demonstrate how services can be organized by using the paramedics (multi-purpose) in most cases. The service is not profit directed and still revenue is not their aim. The cost recovery of GK static health

centers varies from 20% to 60% excluding the capital cost. They usually calculate recurrent cost. One of the referral centers, Savar hospital, is having cost recovery more than one hundred percent. In all the centers GK provides subsidy for poor class of the people.

Marie Stopes Clinic Society works in the field of reproductive healthcare with safety net for the poor and the vulnerable. The major source of income or revenue generation is from MR (Menstrual Regulation) service. It has been found that sixty percent of the revenue generation is shared by MR. The MR service charge vary Tk. 400/- to Tk. 700/- in different cities. In Chittagong it is Tk. 600/- in Sylhet Tk. 700/- and in Feni Tk. 400/- per patient. The only center that is providing the emergency obstetric care to the client has got provision of caesarian section. They are charging a very nominal fee for caesarian section and it is Taka 3000/- per patient. At present they have 44 mini clinics 10 satellite clinics and 23 referral centers. Out of twenty-three, nine centers have one hundred or more than one hundred percent cost recovery without calculation of depreciation cost. Their aim is to minimize the cost of the program in a cross- subsidized way.

DSK serves the poor people of the urban slums in six districts. In case of DSK, 2.5% from the total interest of 15% charged from microcredit operation is transferred to finance the health programme. The cost recovery in microcredit sector is 98%. On the other hand, the recurrent cost recovery of the DSK hospital in Mohammadpur is 47%. They do not feel to calculate capital and depreciation costs in their revenue generation because the infrastructure and medical equipment were built and donated by the donors' community. DSK has at least 14 funding agencies to fund their project.

NSDP works through partner NGOs in the rural areas to provide services from fixed centres that are mostly subsidized (around 70% of the recurring costs) by USAID. At present the NGO has to provide 17% cost sharing from its own clinic revenue or resources to minimize the cost of the program. It has been found that maximum 30% of the recurrent cost has been achieved so far in the program.

At present the cost recovery of the Grameen health centers with premium is 80% to 90%. They have introduced health card for the family members of a household and their Grameen beneficiaries in the community. At least six of their family members can enjoy the facilities of the health card. In all of the above calculations of cost recovery, only recurring costs are being calculated.

Another way of financing health programme is health insurance. This is successfully utilized by GK. On an average, about 35% families around the static centre (catchment area) are covered by 5-tier insurance scheme, which provides a solid base for revenue generation. Out of all patients attending the health facilities, 90% are health insurance cardholders. They are paying Tk. 25/- to Tk. 80/- per family for annual premium and Taka 20/- for renewal. The patient who is having the health insurance is paying Tk. 10/- as consultation fee and 33% of medicine bill as co-payment. They are paying less for the pathological test and the price chart is different than others.

The primary stakeholder of the DSK health program is microcredit policyholder and five of his family members. The family is to buy a health card with Taka 200 under health insurance scheme and 2.5% of interest generated from microcredit operation is left for primary health care. The policyholder gets medicine on 50% discount, laboratory charges for pathological tests are subsidized and the charge for delivery is less. They provide an ambulance to enhance the efficiency and mobility of the patients for referral cases.

The health premium of Grameen health insurance system is Taka 150/- per year for Non-Grameen members. The members of the Grameen Bank is paying Taka 120/- per year for their premium. The consultation fee for the Non-Grameen cardholder is Taka 10/- per visit in the clinic and for Grameen member is Taka 5/- only. Those who do not have the health card are paying more than others. The consultation fee for them is Taka 50/- only. At present almost all of the borrowers of Grameen Bank have health cards for their family. It is interesting to see 20% to 25% of the cardholders are Non- Grameen.

Static centers and user fees

The locations of static centres are selected by a variety of indicators. Sometimes local demand for healthcare, and sometimes continuation of the activities following major natural disaster determined the selection of sites for service delivery. Donation of land by the community or individual, urge to provide services to remote areas etc. were also responsible in some instances. In short, the site selection of the static health centres of the NGOs did not always follow strict profit motives.

All the static health centres provide in-patient care in addition to out-patient services. The components of the services are mostly similar to the Government's ESP. Marie Stopes provides specialized care on reproductive health e.g., MR, ultrasonography etc. The facilities are mostly rented except for some big NGOs like GK who have their own facilities. Some have very basic lab facilities. GK also has facilities for blood collection and administration in emergency situation. With the exception of GK, most static centres are staffed by a MBBS physician, in addition to paramedics, laboratory technicians and auxiliary staff. Constant and increased flow of patients is ensured by regular presence of a physician. It was revealed (e.g., by Marie Stopes) that without the presence of a qualified physician, patients are reluctant to come to the centres to get services from the paramedics or FWVs. The awareness regarding the utility of physicians for accessing quality care has increased in the community. The paramedics of GK health centres are stationed in the catchment area, thus ensuring continuity of care from the community to the static facilities. Some of the static centres with improved facilities are treated as referral centres by the NGOs e.g., full fledged hospitals in case of GK and DSK.

User-fee charges vary for different services among different NGOs and is based on geographical location and poverty status of the family. The poor members of the NGOs get preferential treatment in this regard. For the non-poor, different strategies are followed e.g., in GK's health insurance scheme a five-tier categorisation is made of the household economic status of the families.

Client profile/satisfaction

A majority of the clients were poor, whether or not they were members of an NGO. The factors that determined whether the non-poor used services from these centres are included the presence of an MBBS physician, availability of lab facilities, EmOC etc. Most of the time service providers are not available in GoB health facilities. If available, they are not providing quality care, consultation time is very limited and waiting time is long. The medicines which are supplied for all the diseases are the same and clients are not satisfied with the treatment.

Discussion

Summarizing the above findings, the following points emerge:

- Health is not considered a commodity, neither by the NGOs nor by the community. As such, the profit motive is non-existent among the NGOs. They consider their health programme as an integral part of their pro-poor development activities. However, sustainability is an issue for all NGO.
- In order to provide healthcare for the poor, subsidy is a must because cost recovery cannot be 100% due to a poor client base.
- Cross subsidy from other activities of the NGOs e.g., transferring a certain percentage of interest revenue generated from microcredit to healthcare services etc. is required to ensure services for the poor (*If you want to provide services for the poor, no way to go for 100% cost recovery* - ***Dr. Yasmin, Country Representative, Marie Stopes***)
- Only recurring cost should be considered while calculating cost recovery because capital costs are mostly perceived as a onetime investment by either the NGO or the Donors. Customized health insurance schemes, increased user-fees for higher SES groups etc. can be effective tools for cross-subsidy.
- Static centres are required to back-up community-based health activities and address the demand created by the NGO's preventive and health promotive interventions to ensure a minimal level of quality care for the poor which may not be always available from the Govt. centres for a variety of reasons. Emergency obstetric care and standard lab services add to the sustainability of the centres and

meet the perceived needs of the community. Also, an MBBS physician is required at the health centres to satisfy community's increased demand for quality care and for sustainability of the centre. Paramedics working in the centres should have close linkages with the population of the catchments area.

Comparing the situations in other NGOs with respect to service provision from static centres with BRAC BHCs, some similarities as well as some dissimilarities are observed: **Similarities** exist in the consideration of healthcare provision essential to its pro-poor development activities, cross-subsidy of the static centres and satisfaction with less than 100% cost recovery (recurring costs only), availability of ESP services and EmOC (from upgraded centres), major beneficiaries being the rural poor, presence of a qualified physician and concern for financial sustainability. On the other hand, **differences** are observed in calculation of cost recovery (BRAC adds capital costs and head office costs for calculating cost-recovery), yearning for 100% cost recovery from the BHCs, absence of health insurance schemes, and lack of publicity of Shushasthos in the community.

Recommendations

From the above discussion, some recommendations are made for the future operations of the BHCs:

1. Service provision from static centres will be needed for primary back-up of the community-based health interventions as well as specific activities like control of Tuberculosis (TB), control of Diarrheal Diseases (CDD, Acute Respiratory Infection (ARI), Emergency Obstetric Care (EmOC) and for academic interest. Service provision is also needed for satisfying at least some of the demand for quality care created by preventive and promotive health interventions of BRAC and other NGOs. Sole reliance on Govt. facilities for referral linkage may not always fulfill the expectations of the emerging 'health-empowered' population. Instead of shrinking the number of BHCs, it should be increased gradually to serve at least the 4 million households of the BRAC microcredit programme.
2. Constant presence of a motivated MBBS physician (current incentive structure needs to be reviewed) and a team of health workers sensitive to the needs and

expectations of the poor, and having close linkage with the catchment community, will go a long way in building confidence and reliance on the BHCs while increasing the number of clients. Beside the community health volunteers (*SSs*), the paramedics/service providers at the BHCs can act as marketing promotional staff in the field and disseminate information about the quality and diversity of services available in the centres. Adding community ophthalmology, public health dentistry and a school health programme will increase the client base. At least one BHC in a region may be upgraded to provide secondary-level services for the other BHCs as well as serve as a source of cross-subsidy.

3. Cross-subsidy will be needed for the health programme for quite some time because of poor SES (Socio Economic Status) of the clients accessing services from the BHCs. In calculating cost-recovery, capital costs may be excluded and target should be set at recovering a maximum of 75% of the recurring costs. Attempts can be taken to tap part of the capital costs for setting up a BHC in a form the community as practiced in case of Library programme. Chakaria Community Health Project (PI: Abbas Bhuiya) of ICDDR,B is a good example of this. BRAC's Advocacy Division can also play a part in mobilizing community resources.
4. Possible alternative sources of financing static health centres may be allocating some percentage of the total interest charged by the microcredit operation to BRAC Health Programme/BHCs (this will go a long way in improving the image of BRAC as a lead public health performer in the NGO sector), a health insurance scheme tailored to the economic capability of different strata of the community, higher user fees/medicine prices for clients from higher SES groups, introduction of new packages of services e.g., medical check-up and a different pricing policy in the community.
5. Further study is required to explore the economic and financial sustainability of the BRAC Health Centers in near future.

In lieu of conclusion

BRAC's health programme (BHP) is currently at a crossroad. BHP needs to be elevated from the stage of merely selling sanitary latrines/health commodities and disseminating health messages to a model of delivering quality public health services, which can have tangible impact on the quality of the lives of the poor. It is disheartening to note that even after a quarter century of BRAC's very successful and productive microcredit operations, the health programme has not yet received a steady flow of funding from BRAC's own coffer and has to depend upon donors. It is high time that BRAC policy makers rethink and redress this, because investment in health (and education) today is a primary factor in alleviating poverty, and the poor have a right to share the prosperity of BRAC in terms of human capital development. The study reveals that it may not be possible to cover the poor group of people for health without subsidy. A certain percentage of subsidies from any sources for the comprehensive health services for the poor are still needed. Now the power structure of BRAC will define the operational strategy of the program to get the maximum social benefit from BRAC Health Centers (Shushasthos) in the community.

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Annexure

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Marie Stopes Clinic Society:

Dr. Yasmin, Country Representative and Mr. Wahiduzzaman, General Manager, Services of Marie Stopes Clinic Society are the key informants who shared their underlying concept of providing healthcare in urban areas. Marie Stopes is working with poor and vulnerable group in the society to address their reproductive health (family planning, RTI/STD) issues and ESP services. The aim of Marie Stopes is to minimize the cost of the program in cross- subsidized way.

At present they are having 44 mini clinics, 10 satellite clinics and 23 referral centers. Out of twenty-three, nine centers are having hundred and more than hundred percent cost recovery without calculation of depreciation cost. Usually recurrent cost is being calculated.

Marie Stopes is intending to provide sustainable quality service to the community with safety net provision for the poor. Their main target is to provide service. They are running 5 referral centers with their own money, 12 centers are funded by DFID and 6 centers are funded by ADB. All the centers are rented houses in urban and peri-urban areas. The space of the centers varies from 750 square feet to 3000 square feet.

Three centers are having ultrasonography facility in their premises and having no significant effect on major income from this facility. The consultation fee for the clients varies from Taka 10/- to Taka 25/- according to the geographical area and location of the center. The number of service providers also varies according to the services they provide. At least one medical officer is working in each center and few centers with satellite clinics are having two. It has been recognized that without medical officer clients and patients are very reluctant to come in the clinic to get services from the paramedics or FWVs. The awareness about the medical doctor has increased in the community to get the quality services from the health facilities.

The major source of income or revenue generation is from MR (Menstrual Regulation) service. It has been found that sixty percent of the revenue generation is shared by MR. The MR service charge vary from Tk. 400/- to Tk. 700/- in different cities. In Chittagong it is Tk. 600/-, in Sylhet Tk. 700/- and in Feni Tk. 400/- per patient. The only one center that is providing the emergency obstetric care to the client has got provision of caesarian section. They are charging very nominal fee for caesarian section and it is Taka 3000/- per patient. The delivery facility has been closed in Feni center due to lack of EmOC services. Marie Stopes also covers the garments factory and fish process workers in their working area. They provide services at the rate of Tk. 10/- to Tk.12/- per client as consultation fee for the workers.

The organization also provides incentive to their service providers and having marketing promotional staff in the field. They are also having provision for referral fees for referral of the clients in their clinics.

Recommendation:

1. Reduce safety net for poor.
2. Reduce manpower but community peoples do not want to visit clinics without doctor.
3. Clinics should be established on the basis of logic and findings and low income generating clinics can be closed.
4. Delivery facility should be provided with EmOC, without emergency obstetric care it does not work.
5. As an experiment, service charge can be increased to increase the income of the center.

<u>Comments</u>: **If you want to provide services to poor no way to go for 100% cost recovery (Dr. Yasmin, Country Representative, Marie Stopes).**

Ganoshastho Kendra:

Dr. Manzur Kadir Ahmed, Director, Health Program, Dr. Shajahan, Director, Savar Ganoshasthaya Kendra Hospital and Dr. Reza are the key informants from GK elaborately who shared their vision, mission and present activities of the health program. The health services had been introduced due to local demand of the community, deficiency of the health facilities in the area, GoB service barriers, natural calamities, disasters or the person donated land to serve the rural people. At present GK covers 10 lac population in health services. The main objective of the health program is to show a roll model in the country and to demonstrate nationally how services can be utilized for health. The service was not profit directed and still revenue is not their aim.

At present GK is having 11 health facilities throughout the country. They are having 8 static centers with basic curative care including delivery and MR (Menstrual Regulation) facilities. Centers are located in the rural areas. They are all own-constructed infrastructures. Three referral centers are situated in urban and periurban areas. One is the Nagar Hospital in Dhaka, another is Savar GK hospital and the other is situated in Sreepur, Dhaka.

The health insurance scheme for the community people is one of the major activities of the health program. On an average about thirty five percent of families are having health insurance around the health center and its catchment area. Out of all patients who are attending the health facilities, 90% are health insurance cardholders. They are paying Tk. 25/- to Tk. 80/- per family for premium and Taka 20/- for renewal. The patient who is having the health insurance is paying Tk. 10/- as consultation fee and 33% of medicine bills as co-payment. They are paying less for the pathological test and the price chart is different than others.

In Sreepur, average outdoor patients are 3000 per month. Most of the referral centers are providing comprehensive services for the clients. The consultant from outside is doing the major operations and they are paid accordingly. The cost recovery of GK static health centers varies from 20% to 60% excluding the capital cost. They usually calculate recurrent cost. One of the referral centers, Savar hospital is having cost recovery more than hundred percent. The health sector is getting the subsidy from training activities in Savar, Gonoshastho Trust and also from donor agencies like Canadian CIDA and Plan International.

In each center, one paramedic is deployed for 4000 population. Few centers are having MBBS doctors and a few of them are providing services only with paramedics. The paramedics are skilled and they are multipurpose worker. All the paramedics are working in static facility as well as in the field. The linkage between the person and the field is well established in the community. The community people feel the need of the paramedics in their health problem particularly in cases of pregnancy and delivery. The aim of the health services in Nagar hospital is on no loss no profit basis. In all the centers GK provides subsidy for poor class of the people.

Comments: GoB is having infrastructure and manpower but services are not adequate. NGOs are supplementing the government health services in the community. It has been found that back up support is required for primary health care and static health centers are equally important in the field of health for all.

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Dustho Shastho Kendra (DSK):

Dr. Dibalok Singha, Executive Director, Health DSK and Dr. Shahina Sultana, Coordinator, DSK are the key informants who elaborately discussed the program through power point presentation. The aim of the program is to serve the poor and the people living in slums of Dhaka. About three million people are living in slums of Dhaka, who are willing to pay for services. The slum dwellers often do not have legal access to basic services. DSK is providing primary health care services to around twenty thousand poor people in Dhaka city. DSK is having geographical coverage in six districts. They are working in thirty-one upazillas. DSK has been working in other fields of social development like revolving credit program, water and sanitation, non-formal education project, small project training cell and palli bio center from mid eighties.

In health sector, DSK is providing antenatal care for pregnant women, postnatal care supply of essential drugs, immunization, home visit by community health workers (CHW), safe water supply and sanitation on credit. The primary stakeholder of the health program is microcredit policyholder and five of his family members. At present about 40,000 families are in microcredit. 2.5% health fund is generated from 15% flat interest rate of the credit. They provide service to 1200 members with one medical assistant and three community health workers. The family is to buy a health card with Taka 200 under the health insurance scheme and 2.5% of generated interest is left for primary health care. The policyholder gets medicine on 50% discount, laboratory charges for pathological test is subsidized and the charge for delivery is less. They provide ambulance to enhance the efficiency and mobility of the patients for referral cases. The cost recovery in microcredit sector is 98%. On the other hand, the recurrent cost recovery of the DSK hospital in Mohammadpur is 47%. They do not calculate capital and depreciation costs in their revenue generation because the infrastructure and medical equipment were built and donated by the donors' community. DSK is having at least 14 funding agencies to fund their project.

Bangladesh desperately needs a quality primary health care service that is accessible to the disadvantaged and the poor. People cannot depend and trust on our health system.
NGOs should take a common position in national health strategy and private sector should have commitment to serve the people.

Recommendation:

- Private sector should work in health service with aim not for profit
- Private Sector should follow standard system

Comments:

We have to save our people by ourselves as with the government system it is not possible.

NGO Service Delivery Program (NSDP)

A group of people from NSDP took part in the discussion and explained their views and ideas regarding the USAID funded program in health sector. At present 41 NGOs are working in NSDP. They are having 278 static health centers all over the country both in urban and rural areas. They are working in three-tier system for rural areas. The DepotHolder (DH) is at the grassroot level than the community service promoter (CSP) in the community and the paramedics in the static health facility.. In rural area the government has allocated the catchment area for NGOs to work. Twelve static health centers are providing safe delivery services in the community. The service charge for deliveries varies from Tk. 250 to Tk. 450 according to the geographical area. Clinic manager decides with the community people and service providers about the user fee and service charge. Forty upgraded centers are providing NSV and Norplant services in the community. The doctors working at the central level of NGO offices provide the specialized family planning services in the community.

In urban, there is no catchment area like rural areas. In urban area there is no depotholder and the doctor is deployed in the center for quality services they want to provide.

At present the NGO has to provide 17% cost sharing from its own clinic revenue or resources to minimize the cost of the program. On discussion it has been found that only 30 % of the recurrent cost has been achieved at this stage of the program. NSDP is also thinking about the cost recovery and sustainability of the program.

Recommendation:

- National level campaign and standard Behavior Change Communication (BCC) should be advocated in the community.
- Local level BCC activities should be strengthened.

Comments:

You have to sustain. In preventable side like immunization donors' money should be there but rest of the money should be from your own resources (Dr. Mizan, NSDP).

Grameen Bank

Dr. Baki, Program Coordinator and Mr. Daiyan , General Manager, Grameen Kallayan are the key informants and shared their underlying concept of providing healthcare in rural areas. There main objective is to help the poor to get the health services in the rural community. There are twenty health centers all over the country. There are 6 health centers in Tangail, 3 in Comilla, 3 in Sreenagar of Munshigonj, 3 in Rajshahi division and 5 in Singair region. Grameen has constructed one center and rest nineteen are rented houses in the rural community.

They have introduced health insurance system and health card for the family members of a household and the Grameen beneficiaries in the community. At least six of the family members can enjoy the facilities of the health card. Head of the family is entitled for annual checkup and if the family members got admission in the hospital they get subsidy on the medical bill. They buy the medicine at discount rate and the pathological test fee is also less. Pregnant women and the children are vaccinated free of charge.

The health premium of Grameen health insurance scheme is Taka 150/- per year for Non-Grameen members. The members of the Grameen Bank is paying Taka 120/- per year for their premium. The consultation fee for the Non-Grameen cardholder is Taka 10/- per visit in the clinic and for Grameen member is Taka 5/- only. Those who are not having the health card are paying more than others. The consultation fee for them is Taka 50/- only. At present almost all of the borrowers of Grameen Bank are having health cards for their family. It is interesting to see that 20% to 25% of the cardholders are Non-Grameen.

They are having one center (called Kendra) for forty group members. One HA (Health Assistant) supervises fifteen centers per month. She used to visit the households of the members and providing health information and education and referring the cases to the static Grameen health center. One manager has been deployed for 400 group members or 10 centers (Kendra).

One health center is having one medical officer, 4 or 5 health assistants, 1 laboratory technician, 1 paramedic and 1 office manager. The local office and the central office monitor the performance of the centers. The regional manager and the program coordinator of the health program conduct regular meetings with the staff. At least 5 to 6 centers are supervised by a senior person of Grameen Kallan and is known as Regional Manager.

At present the cost recovery of the centers with premium is 80% to 90% and only the operational cost has been calculated.

Recommendation:

1. Increase the number of patients
2. Publicity about the center
3. Put the right man at the center for betterment of the services
4. Management of the center should abide by the objectives.

Comments: For any help you are welcome; let us work together to achieve something for the poor. Nobody will take care of the poor unless we do something for them. Those who are sitting in the health sector at the top will not do anything and will also not allow you to do something (Mr. Daiyan . GM, Grameen Kallayan).