n'weti

Policy **Brief**

13

May | 2023

THE GLOBAL FUND FOR AIDS, TUBERCULOSIS AND MALARIA (GFATM) AND THE MINISTRY OF HEALTH: THE NEED FOR IMPROVED MUTUAL UNDERSTANDING OF EACH OTHER'S CONSTRAINTS AS THE ROOT FOR CONFIDENCE BUILDING

KEY-MESSAGES

- The Government and the Global Fund should increase funding initiatives targeting Non State Actors (NSA) to perform currently neglected activities such as the Breaking Down Barriers, using a human right based (HRB) approach and fighting the stigmatization of HIV and TB infected citizens;
- The Global Fund (GF) should install a country office, considering the fact that its absence affects coordination with other programmes and causes reduced national ownership;
- The GF's current performance-based funding system does not adequately convey to recipients the incentives for performance and the necessary monitoring and information system is fragile and does not easily permit the timely gauging of performance. Therefore, the GF should commission an evaluation to review its performance-based finance model, and incorporate the good practices of other funding mechanisms using a similar framework;
- To bolster motivation and work ethics in the sector, promotions of civil service should be based on merit, and doctors' and health workers' salaries should be increased. Therefore, Government and GF should introduce incentives for the whole chain of the programme, rather than only for project managers. This would reduce the tendency to engage in corrupt practices, including the tendency to inflate costs for training courses and travel as a way to generate additional income via per diems and exaggerated fuel bills;
- Although areas of intervention and expected outcomes are well defined by government and well-negotiated with the programme management in Switzerland, following their procedures and hierarchical decision-making structures, when adjustments and exceptions are necessary the negotiation process is considered cumbersome and costly. Therefore, Government and Global Fund should work together on a Procedure's Manual to be followed by both parts setting the document flux, deadlines, levels of approval and expected dates for funds disbursement according to the national fiscal year and planning cycle;
- Compared to other programmes (PROSAÚDE, GAVI) GF has more frequent changes to its rules, resulting not only in extra work under stress, but also knock-on effects on routine work and other programmes i.e. higher transaction costs. Therefore, the GF should align its set of rules with the life span of the Health National Strategic Plan (PESS) and the National strategic Plan for HIV Response (PEN).

EXECUTIVE SUMMARY

The Global Fund has acquired a certain level of ownership from the side of the Ministry of Health (MoH), including alignment with national priorities and integration into the national PFM system. Nevertheless, the program needs additional adjustments to fit the health sector 'modus operandi', given the challenges with planning, adjustment and (re)negotiation of procedures, which arise from the lack of alignment between the programme's fiscal year and Mozambique's planning cycle. The MoH's fragility in terms of management and accountability needs to improve, especially regarding the cost of frequent external audits and the perception of distrust this creates on the side of Ministry staff, which undermines the relationship between partners and Government in relation to agreed utilisation of national institutions of management and accountability. The lack of a country representation constitutes an additional challenge for effective coordination. Both the MoH and GF agree that it is necessary to build confidence, in order to improve mutual understanding of each other's particular partnership constraints and needs.

INTRODUCTION

The GFATM or Global Fund (GF), with its secretariat in Geneva, Switzerland, is a vertical programme based on the private-public partnership model. Founded in 2002, through an initiative by the then UN Secretary General, Kofi Anan, and with seed money provided by the Gates Foundation, it aims to help countries prevent, diagnose and treat HIV/AIDS, TB and malaria, by strengthening local health systems and providing crucial inputs and finance. It is part of a world-wide group of health systems supporters with similar features, referred to as global health initiatives (GHIs). They use a common approach – or one-size-fits-all strategy – to be implemented across a range of countries to target a specific disease, group of diseases or a global health challenge such as HIV/AIDS or the Covid 19 pandemic.

Backed by the G8 meeting in Genoa, Italy, in 2001, and funded to various degrees by its members, it is considered the world's largest financing mechanism for fighting these diseases, with expenditure of some US$ 4 billion a year. The Global Fund's single largest donor is the US. The budget appropriations for the US contribution to the Global Fund was around US$24.6 billion from Fiscal Year 2001 through Fiscal Year 2021. In collaboration with local partners in recipient countries – both government and Non-State Actors (NSA) – the programme complements other US global health support mechanisms such as PEPFAR, and USAID's TB programme. Health sector strengthening (HSS) is an important part of it (KFF, 2021). According to the GFATM/GF website, millions of lives have been saved through the United States' support to the programme. Thus, in a way, the GF can be considered as an instrument of the US government's foreign and trade policies. The bulk of the funding comes from the public sources of some 80 donor countries[1]. Initially, GF raised and spent funds during a three-year 'replenishment' fund-raising and pledging period. Typically, this started with donors making their pledges and the GF calling for proposals from potential recipients. GF also collaborates with faith-based organizations (FBO), and receives generous financial support from Catholic Relief Services, Caritas, World Vision and the United Methodist Church.

1. At the end of 2020 the list of (cumulative) donations was headed by the United States, France, the United Kingdom, Germany, Japan, Canada, the European Commission, Sweden, Italy and the Netherlands. The list also includes countries such as China, the Russian Federation and Saudi Arabia. https://www.theglobalfund.org/en/government/

The GF was conceived as a vertical mechanism providing funds to governments and local NSA based on demand ('call for proposals') and complementing other funding sources, including the governments of beneficiary countries. As a funding mechanism it is not involved in implementation, the reason why the GF has no country office anywhere in the world. Instead, its interventions are planned, managed and implemented through seven core structures: the Board (where representatives of industry also have a voice), the Office of the Inspector General (OIG), a Technical Review Panel, the Principal Recipient (PR), the Country Coordinating Mechanism (CCM), the Fund Secretariat and the Local Fund Agent (Warren et al., 2017). The Principal Recipient (PR) is responsible for grant implementation and can be part of the public sector e.g. a health ministry, or an NGO (including FBOs) or even a private company. It is under the direct supervision of the Country Coordination Mechanism, which ideally should reflect the Fund's commitment to local ownership and decision-making. The Global Fund Secretariat headquarters in Geneva is responsible for daily operations, primarily grant management. The GF's key features include its emphasis on performance-based finance (PBF). This means that continued financial support for recipients depends on proven results and grant management that considers impact and 'value for money' criteria. In practical terms, it means measuring results by using baselines, indicators and investment in data systems for monitoring. In this process external consultants are often involved in health systems with insufficient capacity of their own. Transparency in financial management is emphasized.

From 2009 onwards evaluations and studies produced insights into possible flaws in the underlying logic of the GF's strategic approach, and came to the conclusion that GF's mode of operation was prone to misappropriations and corruption in receiving countries (Brown & Griekspoor, 2013; Handfield, 2014). The authors also recognized a mismatch between, on the one hand, the scale of the disease-specific programmes and, on the other hand, the structural frailty of health systems in many recipient countries, particularly in Africa, as well as limited absorption capacity. These weaknesses may be due to lack of physical health facilities (health units and hospitals), low salaries and poorly qualified health staff, challenges in the supply chain of medicines and medical items, as well as poor health information systems. A further matter of concern was flagged: a tendency for public health staff to seek employment in GF and other externally-financed projects enticed by better salaries, working conditions and career possibilities, weakening even further the already structurally fragile national health systems.

Taken together, these factors led to the temporary withdrawal of funding by a few GF donors in 2011 and a temporary suspension of activities in a few countries, Mozambique included. They also triggered a restructuring process and changes in the approach to planning, funding, managing and monitoring of the individual programmes covered by the GF. The cumbersome and GF-dominated 'pledging round', based on a model with little predictability and local ownership, was replaced by a new funding mechanism, with three-year indicative allocations in line with locally defined needs and priorities (for details see Warren et al., 2017, Figure 1). This new mechanism has what is considered to be a more effective and inclusive proposal process with enhanced guidance on the required levels and the availability of funds, a simplified grant application, improved audits and accountability for the use of funds to minimize financial irregularities, and greater coordination and harmonisation with other funding agencies (Handfield, 2014). Performance-based financing and the country coordination mechanisms (CCM) with GF key stakeholders, including government actors and NSAs, have been maintained.

THE GLOBAL FUND IN MOZAMBIQUE

The GF started operating in Mozambique in 2004, roughly a year before the adoption of the Paris Declaration on Aid Effectiveness, whose principles of ownership, alignment, improved aid quality and its impact on development were also reflected in the GF approach. At that time the GF was integrated into PROSAÚDE and considered 'a good example' of how global, disease-specific vertical funding mechanisms with a unique business model could be adapted and fitted into Mozambique's country system under harmonisation and alignment arrangements (Dickinson et al., 2007).

Between 2004 and 2008 the GF supported the NHS) in its specific area of intervention with grants amounting to US$ 135 awarded to the Ministry of Health (MoH) via the PROSAÚDE Common Fund, using its characteristic on-CUT modality, fully in line with the established Mozambican planning, programming, budgeting, allocation and accounting system, e-sistafe. Up to 2016 the GF disbursed over US$ 972 million (AIDS), US$ 802 million (tuberculosis) and US$ 620 million (malaria). Until that year, 86% of the total disbursements benefitted the MoH, the Principal Recipient (PR). This should have ensured national ownership and adherence to the Mozambican SWAp that had been developed from the late 1990s onwards. The remaining funds benefitted the Community Development Foundation (FDC)[2], the National Council to Combat AIDS (CNCS)[3] and Centre for Collaboration in Health[4] (Warren et al., 2017)[5]. Additional funding initiatives targeting NSA such as the Breaking Down Barriers initiative, using a human right based (HRB) approach fighting the stigmatization of HIV and TB infected citizens, were neglected.

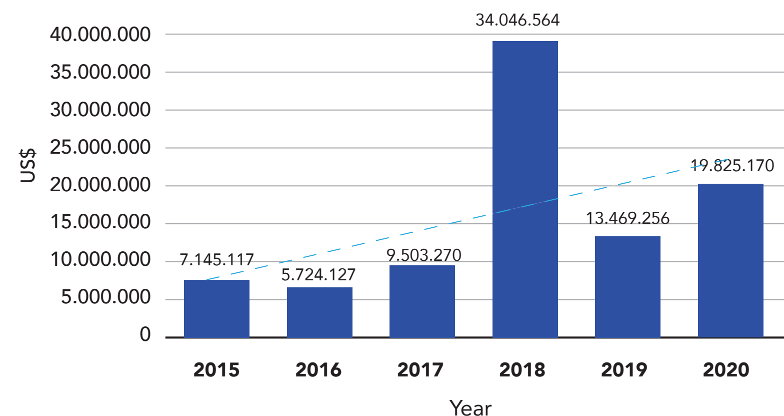
The gradual introduction of the new funding mechanism (NFM) between 2013 and 2016 meant that a recipient country would have access to two funding streams: an indicative funding stream and a competitive incentive funding stream[6].

While the former is larger and more predictable, the second will reward ambitious, high-quality investment cases based on coherent national strategic plans such as PESS. This stream represents the GF's performance-based element where, unlike the GFF, the evaluation criteria are verified at the NHS macro level, not the micro or meso levels.

Both streams are based on the CCM submitting an application to the Secretariat that reflects the applicant's prioritized needs. The total value of funding for a given country is determined by an allocation formula that considers the country's share in the global disease burden, differentiated by the three GF diseases and the country's gross national income (GNI) per capita. Further qualifiers, such as past programme reform, absorptive capacity and fiduciary risks can be used by the Secretariat to make adjustments.

The GF spending pattern from 2015 to 2020 of the GF is shown in Figure 9 below:

Figure 1: GFATM budgets - Updated allocations (dotação actualizada), 2015-2020 (in US$)



Source: Based on e-sistafe data. The conversion MZN to US$ is based on the annual average exchange rate as per https://tradingeconomics.com/mozambique/currency

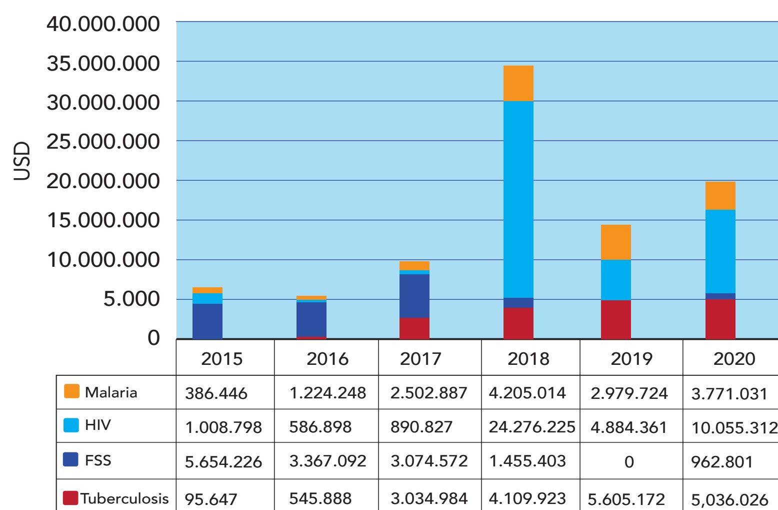
2. Fundação para o Desenvolvimento da Comunidade (FDC). One of FDC's several intervention areas is community health aimed at 'reducing the incidence and impact of endemic diseases such as HIV/AIDS, tuberculosis and malaria among vulnerable groups' (https://fdc.org.mz/pt/portfolio-items/saude/).
3. Conselho Nacional de Combate ao SIDA (CNCS)
4. Centro de Colaboração em Saúde (CCS). The CCS was established in 2010 as a local partner of the Ministry of Health (MoH) through support from ICAP (International Centre for Aids Program) and PEPFAR. for details, see https://ccsaude.org.mz/
5. Today, the NSA World Vision International also receives GF funding.
6. For details see GFATM (2012).

According to these figures, total GF allocations to the health budget over the period 2015 to 2020 amounted to some US$ 90 million (equivalent to MZN 5.5 billion), an average annual budget contribution of approximately US$ 18 million, with a growing trend. The spending pattern by category of support over this period is given in Figure 2.

The dramatic increase in spending in 2018, particularly on AIDS prevention and treatment, was the result of both updated targets and a rise in the number of patients being treated, reflected in the CCM application. The minimal spending on TB in 2015 and 2016 is explained by the fact that, during that period, the pledging round approach transited to the NFM. The necessary adjustments to the planning and budgeting process i.e. the 'transitional' NFM, for which no extra funding was available, was financed through recourse to the TB budget line.

Regarding the period 2021 to 2023, at the beginning of 2021 the Government of Mozambique and its health partners[7] began implementing six new grants to fight HIV, TB and malaria and build resilient and sustainable health systems. The new grants aim to expand access to HIV, tuberculosis, and malaria prevention services, particularly for key and vulnerable populations. According to the press release, the new grants, worth US$ 773.9 million, represent a 49% increase over the previous allocation cycle and are the result of a rigorous and inclusive country dialogue and grant-making process[8].

Figure 2: GTATM annual budget - Updated allocation (dotação actualizada) by type of disease, 2015-2020 (in US$)



	2015	2016	2017	2018	2019	2020
Malaria	386.446	1.224.248	2.502.887	4.205.014	2.979.724	3.771.031
HIV	1.008.798	586.898	890.827	24.276.225	4.884.361	10.055.312
FSS	5.654.226	3.367.092	3.074.572	1.455.403	0	962.801
Tuberculosis	95.647	545.888	3.034.984	4.109.923	5.605.172	5,036.026

Source: Author, based on e-sistafe data. The conversion MZN to US$ is based on the annual average exchange rate as per https://tradingeconomics.com/mozambique/currency

In response to calls for greater accountability, the Officer of the Inspector-General (OIG) conducted audits of Global Fund grants to the Ministry of Health in 2008, 2009, and 2010 in parallel with an audit of PROSAÚDE by the KPMG audit company. The audits revealed weak financial management in the MoH resulting in poor financial accountability for the resources used, as well as difficulty tracking PROSAÚDE funds, often resulting from what in Mozambique is termed desvio de aplicação (misuse of funds). Some US$ 3.32 million were said to be inadequately accounted for. The audits also concluded that there were insufficient control mechanisms, resulting in a lack of accountability. The OIG recommended that the Ministry of Health should repay PROSAÚDE. Together with major challenges in the effective and transparent management of medicines by the Central Stores for Medicines and Medical Items (CMAM)[9], and a strike by doctors and health staff for better salaries, this had a damaging impact on the NHS and damaged confidence in the relationship between health donors and the Mozambican government (Weimer, 2012).

An independent study conducted in 2013 entitled 'Global Fund's paradigm of oversight, monitoring, and results in Mozambique' revealed additional concerns, expressed as 'perceptions', by both the funders and the MoH (Warren et al., 2017)[10]. Among others, the study highlighted three main failings: a) the performance-based financing (PBF) mechanism11, b) not having a country office affected coordination with other programmes12 and c) little national ownership13(Warren et al., 2017: 6, Table 2).

7. I.e., Ministry of Health, Community Development Foundation (FDC), Centre for Collaboration in Health (CCS) and World Vision International.

8. https://www.theglobalfund.org/en/news/2021-02-05-mozambique-and-global-fund-launch-new-grants/

9. Centro de Medicamentos e Artigos Médicos (CMAM)

10. The qualitative study was based on 38 interviews with key informants representing GF stakeholders based in Switzerland and Mozambique.

11. 'Recipients focus on disbursement rather than results', 'burdensome administrative requirements'; 'duplication of reporting efforts from the ground all the way to central level';

12. 'Ineffective country-level coordination', 'frequent deadlines and time stress', 'over-worked staff, communication challenges', 'out-of-touch with realities on the ground'

13. 'Reliance on external consultants to develop proposals', 'undefined roles and concerns about accountability', unused potential for agenda alignment and coordination with partners.'

Some of the issues raised above have been addressed as a consequence of the earlier experience, the introduction of the new funding mechanism (NFM) and the review of the management approach emphasising improved accountability, including regular independent external audits. Under the NFM regime, the Programme Management Unit (PMU) is now fully embedded in the DPC, with a team of local staff on the MoH's payroll, and the position of the coordinator funded by GF. This manager has a highly valued professional profile and experience. Topping-up of salaries determined by the programme management is not permitted, except in duly justified cases where it serves training and the human resource qualifications required to improved service delivery.

As regards the GF's use of PBF, a study on HIV and maternal/ child health services published in 2017 suggested a positive correlation between this approach and 'driving down the HIV epidemic and progress in MCH case service delivery as compared with input financing alone' (Rajkotia et al., 2017: abstract). However, other authors have suggested that the GF's current performance-based funding system does not adequately convey to recipients the incentives for performance (Fan et al. 2013). As one key informant suggested, the necessary monitoring and information system is fragile and does not easily permit the timely gauging of performance.

Today, seven years after the study was conducted, several of the issues that once plagued GF operations in Mozambique have been resolved, according to its manager in Mozambique. According to some observers, GF's unfortunate experience of being part of PROSAÚDE II up to 2011, with its expenditure bias towards central government and salary subsidies for senior civil servants, has been addressed through GF's own internal reform and its recognition as a vertical, fully aligned and integrated stand-alone programme. It is 'fully owned' by government (MoH) to the extent that its programmatic priorities within the overall GF framework are set by the MoH, which takes the initiative to submit a proposal to the GF. Its specific areas of intervention as a vertical programme are thus 'perfectly aligned' with the MoH's PESS. Planning, budgeting, disbursement and reporting processes are fully integrated into the national PFM system and e-sistafe. The same is true for implementation based on collaboration with national institutions and their rules (e.g. CMAM, national procurement rules and procurement units). In other words, the way GF is designed, managed and implemented reflects full ownership by government and the MoH, which recognizes that 'what is outside the agreed key features' of the GF and its core areas of intervention in public health 'remains outside' (e.g. support for medical assistance). This does not mean, however, that there is no possibility to negotiate exceptions. In order to maximise 'exceptional' benefits outside the core GF business, the MoH might want to be better able to demonstrate 'intelligent and informed initiatives and negotiate strategies for succeeding'.

There is an understanding that there has been little improvement in PBF: partners want to see the results of the interventions, but they are difficult to gauge and deliver. This affects the reporting and monitoring systems necessary for PBF. While technical solutions for establishing an efficient health information system may lead to some improvements, they are unable to address the core problem. The main cause for this failing is the structural fragility of the NHS itself. Promotion in the civil service is not based on merit, and generally poorly paid doctors and health workers do not necessarily demonstrate professional motivation and work ethics and may be inclined to engage in corrupt practices in the workplace to increase their income. Inflated costs for training courses and travel are ways to generate additional income via per diems and exaggerated fuel bills. This is one of the reasons why GF has a 'no tolerance' approach to the misappropriation of funds. If such cases are detected and confirmed by an independent audit, the culprit must repay the loss. GF also retains the prerogative for paying subsidies to civil servants. These may be justified under certain conditions, such as qualitative human resource development and training that will have an impact on the quality of services.

In addition, the hierarchical superior of a health worker does not necessarily insist on correct quality control and accountability procedures. Plans sometimes lack quality and realism.

Curbing the effects of this structural frailty produces additional costs (e.g. for consultancies and external audits). But, worse, the perception of systemic misuse and lack of accountability may undermine confidence in the national partner institutions of externally financed programmes.

From the perspective of the MoH, the GF, with the new funding mechanism, is well established, pretty much aligned with national procedures and does not lack national ownership. For the MoH representatives there is no problem, as long as the programme's priorities, areas of intervention and expected outcomes are well defined by government and well-negotiated with the programme management in Switzerland, and follow their procedures and hierarchical decision-making structures. However, in cases of necessary adjustments and exceptions, the negotiation process is considered cumbersome and costly. Proposals submitted by government may be returned for time-consuming adjustments and renegotiation.

One point highly appreciated by all stakeholders is the fact that the GF works with NGOs, in addition to the Principal Recipient. This is considered necessary in order to deepen and broaden health interventions and include other voices in matters of health policy, programme and financing. However, the inclusion of secondary beneficiaries may not always be appreciated by government (MoH), which, as the Principal Recipient, may want to claim exclusive decision-making and implementing power.

From a planning, programming and budgeting perspective, the main obstacle to alignment is the fact that MoH and GF follow different planning cycles and fiscal years. From the MoH perspective, the different planning cycles produce a lack of predictability and an extra burden on human resource and transaction costs when plans must be adjusted to fit GF finance into the national PFM system which it uses. The complete change in the GF's 'rules of the game' i.e. introduction of the new funding mechanism between 2013 and 2016 and reflected in the spending pattern, meant considerable, unpaid extra work for MoH staff on top of their routine work. The case of 'overworked staff' is also mentioned in the study cited above (Warren et al., 2018). Compared to other programmes (PROSAÚDE, GAVI) GF is said to have more frequent changes to its rules, resulting not only in extra work under stress, but also knock-on effects on routine work and other programmes i.e. higher transaction costs.

Additionally, the frequent audits - which are considered 'policing' - reflect a lack of trust between the partners and the national PFM system, being the main and general problem (not just restricted to GF). This could be considered an 'echo' of the above-mentioned leadership crises between the MoH and GF around 2011. The discovery, in 2016, of the odious debts shattered confidence in the Mozambican government's effective and transparent financial management and accountability procedures even further. Such lack of trust may have reenforced existing prejudice rather than a factual matter arising from health sector practises. In this opinion, 'confidence building measures' are called for e.g. improved familiarization with the current PFM system.

Finally, the GF's 'monopolization' of ownership of outcomes and achievements on its website and publications is a matter of concern. This position does not reflect Mozambique's contribution to the joint effort and a change of attitude is called for. The victory in the fight against a given disease is not solely and exclusively about the external financing mechanism but, rather, in the final instance the Mozambican citizen burdened with sickness.

CONCLUSION

Following the introduction of the NFM approach the GF is perceived to have gained a higher degree of national ownership, alignment with national priorities and integration into the national PFM system. Nevertheless, it is still considered a cause of headaches in the health sector, given the often-cumbersome planning, adjustment and (re) negotiation procedures, arising from the lack of alignment between the programme's fiscal year and the Mozambique's planning cycle. It is probably not impossible to resolve this matter, as budget cycles resulting from specific historical circumstances and contexts are not defined or adjusted by health ministries and support programmes. The early and well documented fragility in management and accountability seems to have been overcome, at least partially, although the cost of frequent external audits is high and regarded by the MoH staff as an expression of distrust that undermines the agreed principle of using national institutions for financial management and accountability. Overall, however, alignment with and integration into the national PFM system have moved forward. The lack of a country representation continues to be a major challenge to effective coordination.

Both the MoH and GF agree that it is necessary to build confidence, in order to improve mutual understanding of each other's particular partnership constraints and needs. There is also agreement on the mutual benefits of making better use of the tools available in the e-sistafe IT platform for programme budgeting (e.g. via the planning and budgeting subsystem and the use of programmatic classifiers). Further efforts are required to improve coordination with other programmes and a coordination office in Mozambique outside the MoH might be useful for this purpose.

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TECHNICAL DETAILS:

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Date: May 2023

Policy brief adapted by Andes Chivangue from one sections of a report commissioned by N'weti and titled **"Global External Financing Mechanisms of Health Sector in Mozambique. Case Studies and Institutional, Financial and Political-Economic Issues"**, written by Bernhard Weimer, with support of Andes Chivangue.

2023