Loans dominated COVID-19 funding: it's time to adjust

As the US foreign assistance architecture faces unprecedented dismantling, lessons from past crises take on urgent significance. Our new analysis of COVID-19 donor funding[1] reveals a profound disconnect between the rhetoric of global solidarity and the reality: most official development assistance was issued as loans, and direct support to partner governments was minimal.

When WHO declared COVID-19 a global pandemic on March 11, 2020, it triggered a wave of aid commitments. However, no unified system existed to track pledges made by governments and philanthropic foundations. Publicly available estimates of COVID-19 funding varied widely, from US$136·5 billion to $21·7 trillion.[2–4]

This uncertainty had serious consequences for the world's poorest countries. Ministers of finance and health often lacked basic information about funding, undermining national responses.

To address this gap, JS and AG conducted an analysis; to our knowledge, our report—Tracking donor funding toward the global COVID-19 response[1]—offers the most detailed quantitative picture of COVID-19 donor funding to date. Between 2020 and 2022, $207·9 billion was pledged globally.[1] Of this, $170·9 billion was disbursed: $148 billion (86·6%) by the World Bank, $19·7 billion (11·5%) by donor governments, and $3·2 billion (1·9%) by other multilaterals.[1] For comparison, the total for all official development assistance during the same period amounted to $885·5 billion.[4]

Although billions were pledged, 60% of COVID-19 funding took the form of loans; just 8·9% was partner government grants. Even concessional loans burden already strained government budgets, particularly during emergencies. In low-income countries, in which only 6·7% of workers are employed in civil service, loan requirements often overwhelm government systems, diverting scarce capacity from national priorities.[5]

Among bilateral donors, direct government support was scarce. Of $19·7 billion disbursed, only 7·6% went as grants to public sectors.[1] Over half (52·5%) was channelled through multilateral institutions. The USA, the largest bilateral donor, allocated just 0·1% of its portfolio as grants to partner governments; 60% went to American and international non-governmental organisations or US agencies.[1]

Compounding these gaps, official development assistance data were delayed, incomplete, or inconsistently reported. The World Bank did not provide comprehensive data through public platforms, requiring direct engagement with our counterparts at the World Bank. The absence of timely reporting underscores a major accountability gap, undermining aid effectiveness commitments such as the Paris Declaration (2005) and the Busan Partnership for Effective Development Co-operation (2011).

The COVID-19 response presents a moment for reform. Improved systems to track official development assistance are urgently needed so that aid can be transparent, predictable, and aligned with national priorities—allowing governments to respond with clarity and confidence.

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*Jehane Sedky, Abbey Gardner, Louise C Ivers
jsedky@hsph.harvard.edu

FXB Center for Health and Human Rights, Harvard University, Boston, MA 02115, USA (JS); Science of Implementation Initiative, New York, NY, USA (AG); Harvard Medical School, Harvard Global Health Institute, Cambridge, MA, USA (LCI)

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Plant-based diets for coronary artery disease prevention

We read with interest the *Lancet* Commission[1] on rethinking coronary artery disease, which shifts focus from ischaemia to atherosclerosis. The prominence of diet as a risk factor for atherosclerotic coronary artery disease (ACAD) is rightfully highlighted in the Commission. However, we believe greater emphasis could have been placed on the importance of plant-based diets given their great potential in atherosclerosis prevention.

Evidence shows that plant-based dietary patterns can influence atherogenesis through multiple pathways. The EVADE-CAD trial showed that an 8-week plant-based diet significantly reduced high-sensitivity C-reactive protein,[2] a marker of inflammation central to atherosclerosis pathogenesis, as indicated by the Commission. Meta-analyses have confirmed that plant-predominant diets consistently reduce LDL cholesterol concentrations, blood pressure, and inflammatory markers compared with omnivorous diets.[3,4]

Beyond risk factor modification, interventional studies with the use of