A REPORT OF THE CSIS
GLOBAL HEALTH POLICY CENTER

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EGYPT AND U.S. HEALTH ASSISTANCE

Jon B. Alterman[1]

Few countries have been as successful as Egypt in parlaying its strategic position into an economic asset. At the nexus of two continents, astride the Suez Canal, and with one-quarter of the Arab world's entire population, Egypt has made itself an object of interest, and often an object of concern, among the world's great powers for more than a half-century. Since the 1975 disengagement of Egyptian and Israeli forces from the Sinai Peninsula, Egypt has drawn more than $70 billion in U.S. assistance, affecting a wide swath of Egyptian political and economic life. Other assistance has poured in as well, from European countries, from international financial institutions, and in recent years, from other Arab states. Whatever its difficulties at any given time, outsiders have consistently considered Egypt a prize worth winning, and they have contributed funds to make it so.

The U.S. economic assistance program in Egypt—a more than 30-year effort—is unusual in the annals of U.S. development assistance for several reasons. Most importantly, politics successfully insulated the multibillion-dollar effort from challenge for decades. Intimately tied to Arab-Israeli peacemaking, and tied as well to substantial U.S. military assistance to both Egypt and Israel, many in Egypt and the United States came to consider the program as untouchable. Over the years, far smaller U.S. Agency for International Development (USAID) programs were wrapped up or refocused to comport with shifting U.S. global priorities and conditions on the ground, but the USAID program in Egypt continued unabated, almost as if it were an entitlement.

As such, the program is simultaneously representative and unrepresentative of the consequences of USAID efforts. With few resource constraints and liberal timelines, the USAID effort in Egypt can help highlight some of the consequences of U.S. assistance over time, as there are fewer exogenous variables than in most other aid efforts. Yet, at the same time, the unique security of the U.S. funding stream has had its own distorting effect on the program, simultaneously reducing the imperative and capacity of U.S. officials to condition assistance on Egyptian performance. The effects on Egyptians were no less profound, shifting the challenge from winning approval of the aid toward managing the internal politics governing its distribution.

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The health sector is a valuable prism through which to examine these phenomena shaping the overall U.S.-Egypt economic aid relationship. Over more than three decades, the United States invested more than $1 billion in health projects in Egypt, and the period of U.S. assistance corresponded to a period of dramatic improvements in Egyptians' health. Bilharzia was largely eliminated from the rural population, the rate of infant and child death from diarrheal diseases plummeted, and population growth flattened considerably. USAID efforts played a significant role in supporting each of these trends.

Yet, at the same time, three decades of U.S. assistance did not help nurture a powerful Egyptian government apparatus that could address Egypt's twenty-first century epidemiologic shift toward hypertension, diabetes, and heart disease. Oftentimes, U.S. assistance was more successful creating outcomes than institutions, jeopardizing the sustainability of the accomplishments. Equally importantly, even large-scale U.S. assistance was a relatively small factor in Egyptian society given the size of Egypt's population and the scale of its challenges. In many cases, the broader trends underway in Egyptian society—such as what many Egyptians described as the decline of Egyptian higher educational institutions over the last three decades—were far more consequential shaping the Egyptian domestic environment than multimillion-dollar contracts over a far shorter period of time.

This study is based on an extensive literature review, combined with interviews with dozens of Americans and Egyptians in late 2009 who worked on health care projects from 1975 to the present. Virtually all of the interview subjects stressed the importance of anonymity, because they did not want to be seen criticizing their employers, host nation, or donors. What emerged from the interviews was a combination of pride and remorse—a sense that a great deal had been accomplished, but that for all of those accomplishments, the results could have been better, that more lives could have been saved, and perhaps most importantly, that Egypt's domestic health efforts could have had more momentum as the United States phased out its support for health projects in Egypt at the time of the interviews.

The interview subjects were part of a long legacy. Foreigners have been helping Egyptians address their endemic health issues for the better part of two centuries. In 1825, the French physician Antoine Barthélémy Clot arrived in Egypt to organize health care for the military and, as the Pasha's physician, helped institute broader public health measures for a general population battling dysentery, smallpox, and periodic outbreaks of cholera.[2] Though he was able to establish a medical school that has reigned for a century and a half as Egypt's elite medical training institution, public health conditions remained persistently dire. A Rockefeller Foundation survey in 1913 found that

[2] Gerard N. Burrow, "Clot-Bey: Founder of Western Medical Practice in Egypt," *Yale Journal of Biology and Medicine* 48, no. 3 (July 1975): 253.

fully 60 percent of Egyptians in Upper and Lower Egypt suffered from hookworm, Bilharzia, nonfalciparum malaria, and other parasitic diseases.[3]

The illnesses sometimes shifted over time, as soldiers and returning pilgrims served as persistent vectors of disease, but the generally poor health of Egyptian peasants endured. Crowding, poor sanitation, and sparse medical facilities meant than an overwhelming percentage of Egypt's poor were also among Egypt's sick, sapping the productivity of the Egyptian economy. Foreign powers came and went, and while each addressed Egypt's health challenges, none was able to solve them.

It was into this environment that the United States embarked on a serious effort to boost the health system in Egypt. In the wake of the 1973 Arab-Israeli war, and amidst signs that Egypt's leaders were willing to make peace with Israel and turn their back on the Soviet Union in exchange for a closer relationship with the United States, U.S. officials began to see aid as a vital strategic asset. Anwar Sadat, Egypt's president at the time, was not the first Egyptian leader to see Egypt's strategic position as a potential economic asset. In the 1950s, Gamal Abdel Nasser alternately took money from the United States and Eastern Bloc countries, persuading the Soviet Union in 1958 to finance the High Dam at Aswan after the World Bank (under U.S. pressure) withdrew funding two years prior. Gulf Arab states, newly flush with the spike in oil prices after the 1973 war, viewed Egypt as a frontline state in the Arab wars with Israel, and gave Egypt billions of dollars in assistance.[4]

But in the mid-1970s, Egypt had emerged as a more pivotal state than it ever had been before. U.S. foreign policy was wholly oriented around the idea of rolling back Soviet influence around the world, and Egypt was a potential game changer. Bringing Egypt solidly into the U.S. camp would not only protect Suez Canal shipping, but it would take a decisive step in the direction of solving the Arab-Israeli conflict, the persistence of which continued to stir anti-American sentiment in the region. A Middle East at peace would be a prosperous one, and one immune from Soviet depredations. No single U.S. action in the region could have had a greater impact than shifting Egypt into the pro-U.S. camp.

In this way, the strategic imperatives of the United States became wed to the stability and durability of the Egyptian government. As one analyst wrote later, "The development and humanitarian ends of American aid are not easily separated from the overriding purpose of aid to insure an Egyptian government stable and secure enough to support American foreign policies aimed at normalizing Egyptian-Israeli relations, and wider geopolitical, anti-Soviet objectives."[5] The Nixon

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[3] Nancy Elizabeth Gallagher, *Egypt's Other Wars: Epidemics and the Politics of Public Health* (Syracuse, NY: Syracuse University Press, 1990), p. 12.

[4] According to a scholar who studied the matter closely, between the 1967 Arab-Israeli war and 1978 Camp David Accords that created peace between Egypt and Israel, oil-rich states in the Middle East gave Egypt $14.26 billion in aid. See Gil Feiler, *Economic Relations between Egypt and the Gulf Oil States, 1967–2000: Petro-wealth and Patterns of Influence* (Brighton, UK: Sussex Academic Press, 2003), p. 29.

[5] Marvin G. Weinbaum, "Dependent Development and U.S. Economic Aid to Egypt," *International Journal of Middle East Studies* 18 (1986): 132.

administration tried to rush aid to Egypt, requesting $250 million in economic assistance in April 1974 to try to aid diplomacy.

How such aid should be applied was less clear. A USAID mission that opened its doors in Cairo in 1975 found itself having to invent priorities on the fly. According to one observer,

> The [USAID] mission received little more than a shopping list of possible projects, with no clear development plans or priorities from the Egyptian side. There was little choice but to earmark development funds for expansive war reconstruction projects, and eliminate infrastructural bottlenecks in the economy, programs approved by the Egyptian leadership.[6]

Soon, however, health worked its way into the priority list of Egyptian and U.S. decisionmakers. Rural health care had been an important issue for Egyptian policy for decades, with mixed results. In addition, health was an area where Americans had considerable expertise, from the days of nineteenth-century missionary hospitals to more recent efforts under USAID. Over decades, a consensus had arisen that endemic rural disease was a drag on the entire Egyptian economy. As the two sides planned their partnership, health was an obvious part.

Among all the rural diseases afflicting Egypt, Bilharzia was among the most devastating. Afflicting three in five Egyptians in 1970, the disease (also known as schistosomiasis) was carried by snails that populated Egypt's irrigation canals. Snail-borne parasites passed through the skin and sometimes body cavities of the victims, growing into egg-laying flatworms that ravaged the body. Those suffering from Bilharzia had a range of symptoms, from blood in the urine, cramping, and a distended abdomen in mild cases to an enlarged spleen, cirrhosis of the liver, muscle wasting, cardiac and pulmonary failure, and death in severe cases.

Bilharzia's symptoms were noted in Pharaonic times, and its etiology accurately described in the mid-nineteenth century. And yet, Bilharzia defied easy treatment. Interwar efforts to combine applying molluscicides to the affected waterways and dispensing a weak poison to patients foundered. In part, the expense of spreading molluscicide nationwide was too high to bear, and in part, patients were reluctant to subject themselves to the fevers and nausea that the poison caused. Further, bitter bureaucratic battles broke out over whether it was better to kill snails by dispensing chemicals or drying out canals, and whether it was more important to kill snails or improve the sanitation practices that returned parasites to the water system. After decades of effort, no single area of Egypt was free of the parasites. When the construction of the High Dam at Aswan in the 1960s spread perennial irrigation to much of the Egyptian countryside, the expanded set of irrigation canals provided a welcoming host for the Bilharzia-bearing snails. By the 1970s, Bilharzia had become an even bigger problem than it ever had been before.

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[6] Marvin G. Weinbaum, "Egypt's 'Infitah' and the Politics of US Economic Assistance," *Middle Eastern Studies* 21, no. 2 (April 1985): 213.

It was then that Egypt's political leadership got more serious about fighting Bilharzia. These efforts were part of a broad engagement in rural public health, boosted in part by the improvement in both molluscicides and drugs for patient treatment. Beginning in 1980 and in several tranches since, the African Development Bank and the World Bank offered financing of tens of millions of dollars to help control Bilharzia, both on the causation side and the treatment side. Simultaneously, the development of a new drug, praziquantel, allowed effective single-dose treatment of the infected. Quickly, rates of infection began to creep down.

Seeing a largely successful program underway, in 1988 USAID provided the Egyptian government with a $39.7-million grant to both establish the Schistosomiasis Research Project (SRP), a program to research Bilharzia and to help build Egyptians' capacity to do independent research on the topic. The most important research priority at the outset was the development of a Bilharzia vaccine, but other topics included such themes as diagnostics, chemotherapy, and operations research. As such, the effort was intended to complement rather than compete with ongoing Bilharzia eradication efforts. Bilzharzia eradication was an important goal for Egypt, and helping associate the United States with an important Egyptian national priority was in the interests of the embassy and the USAID mission.

The directors of the project reported great success in 1998. Using project funds, they had been able to establish scientific facilities, carry out research, adapt drugs and testing protocols, and perform epidemiological studies.[7] The SRP's results were used to prod the Egyptian government to adopt universal treatment in areas with high prevalence of Bilharzia, a move that coincided with—and probably helped propel—infection rates dropping from more than 20 percent at the outset to the low single digits a decade later.[8] By 2002, Bilharzia infection had been reduced sufficiently that the government could shut down its National Schistosomiasis Control Program, having largely won the struggle against this endemic disease after 150 years of effort.

And yet, while the prevalence of Bilharzia in general plummeted, donors remained frustrated with progress in Egyptians' indigenous capacity to implement health-related projects. The African Development Fund, which had been working on Bilharzia in Egypt for more than two decades, issued a scathing report after completing its last tranche of funding. Noting that Egypt had been able to reach targets for the reduction in the incidence of Bilharzia, it argued that the effort took three times as long as anticipated. The reasons were myriad: "bureaucratic inefficiencies, absence of staff specifically assigned to the project, inadequate supervision and follow-up…inadequate reporting and confusing records keeping…[and] a failure to involve beneficiary communities in the

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[7] T. El Khoby, N. Galal, and A. Fenwick, "The USAID/Government of Egypt Schistosomiasis Research Project," *Parasitology Today* 14, no. 3 (1998), *passim*.

[8] Shady Salem et al., "Successful Control of Schistosomiasis and the Changing Epidemiology of Bladder Cancer in Egypt," *British Journal of Urology International* 107 (2010): 208.

formulation and implementation of the project."[9] The report documented a persistent unwillingness to prepare audit reports of project funds and so sloppy and inconsistent a set of survey protocols as to make statistical conclusions about efficacy dubious.[10]

A World Bank evaluation in 2002 judged that the Egyptian Department of Health's capacity to "design, evaluate and adjust the national schistosomiasis control strategy" was only "negligibly achieved" after a decade of work.[11] The evaluators judged a persistent inability to gather statistically robust data that shed light on the efficacy of different efforts, a continual lack of follow-through on ideas for promoting behavioral change, a persistently weak middle management layer, and a constant tendency toward concentrating planning and decisionmaking in Cairo rather than in the field.[12] Overall, the World Bank concluded, the failure of this program to connect research and practice created a tenuous link between evidence and program management, reducing the efficacy of the overall eradication effort.

Judging from the most basic goal of reducing Egyptians' morbidity due to Bilharzia, then, international efforts were a resounding success. Whereas the construction of the High Dam at Aswan spiked infection rates from already high levels, a broad international effort at treatment and prevention brought those levels down to the very low single digits within two decades. Lives were saved, lives were improved, and the economy strengthened. The goal of the projects, however, was not merely that. Donors sought to use the projects for a secondary goal of improving Egypt's indigenous research capacity. In this area, persistent weaknesses in management undermined success. From the Egyptian metric, looking over time, Egypt had worked with others to reduce the incidence of a problem. From an international perspective, even after working for more than two decades with the international community, Egyptian management practices continued to undermine the success of joint programs.

While Bilharzia eradication focused on a relatively small set of interventions, the efforts to improve maternal and child health was more broadly based. In 1975, about one in seven Egyptian children died before his or her first birthday, and one in five died before the fifth birthday.[13] The effects of such high death rates were multiple. Not only was there a tremendous human cost in preventable death, but the perceived likelihood of childhood death made parents more likely to have more children. In addition, a large number of children who survived early childhood illness had lasting

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[9] African Development Fund, "Arab Republic of Egypt: Bilharzia Control Project III: Project Completion Report," February 2000, p. xiii, http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/ADF-BD-IF-2000-32-EN-EGYPT-PCR-BILHARZIA-CONTROL-PROJECT-III.PDF.
[10] Ibid., pp. 8, 10.
[11] World Bank, "Project Performance Assessment Report: Arab Republic of Egypt: National Schistosomiasis Control Project (Credit No. 2403-EGT)," June 25, 2008, p. 17, http://siteresources.worldbank.org/EXTWBASSHEANUTPOP/Resources/egypt_schistosomiasis_ppar.pdf.
[12] Ibid., pp. 18–19.
[13] USAID, *Egypt Health and Population Legacy Review: Volume 1* (Washington, DC: USAID, March 2011), p. 20, http://pdf.usaid.gov/pdf_docs/PDACR591.pdf.

disabilities, creating large economic costs that could persist decades into the future. And yet, early childhood death was a complex phenomenon. Deeply intertwined with overall poverty, endemic disease, poor sanitary conditions, and deficient health care, no obvious point of intervention existed for governments wishing to reverse these trends.

In the early 1970s, public health experts began to target two areas of intervention. The first was diarrheal diseases, which were responsible for about half of all child deaths, and the second was immunizations against many of the endemic diseases that swept the countryside. Diarrheal disease turned out to be relatively straightforward to address. Although preventing diarrheal disease required a wide series of interventions in sanitation and food preparation and storage, a simple step could go a long way to preventing death from diarrhea. In the 1970s, public health officials began to see the promise in oral rehydration therapy (ORT), an inexpensive treatment of diarrhea in young children. By combining purified water with a simple mixture of salt, sugar, and other common ingredients, parents had a tool that could save their children's lives. ORT got its start in South Asia in the 1960s, and the government of Egypt sought its adoption in the 1970s, but progress was slow. By 1982, only 10 to 20 percent of diarrhea cases received ORT. Even worse, Egyptian health care providers counseled withholding food and drink for sick children, making dehydration and death more likely outcomes.[14]

Beginning in 1981, USAID funding helped establish Egypt's National Control of Diarrheal Diseases Project, to which USAID contributed $34 million over a decade. Focusing on both the production and distribution of oral rehydration salts, as well as public education efforts to increase demand for the products, the project helped drive down infant mortality due to diarrhea from 33/1,000 in 1982 to 11.8/1,000 in 1989—a 64.5 percent decline.[15]

The easier part of the project was simply manufacturing packets of salts. Slightly more difficult was arranging distribution, both through a far-flung network of Egyptian government health clinics and through pharmacies for the better off. But the most complex part of the project was public education, especially given the fact that more than half of Egyptian women in this period were illiterate.

In order to carry out the project, the Egyptian Ministry of Health embarked on an intensive training of physicians, nurses, pharmacists, social workers, and community leaders. Tens of thousands underwent formal training through 47 rehydration training centers established around the country. Medical and nursing curricula also included training in ORT, ensuring that new medical professionals were sent out with current knowledge.

Equally important was a huge media outreach campaign, which capitalized on the spread of televisions throughout Egypt. Although only 38 percent of Egyptian households had televisions in

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[14] Molly Kinder, "Preventing Diarrheal Deaths in Egypt," Center for Global Development, n.d., p. 4, http://www.cgdev.org/doc/millions/MS_case_8.pdf.

[15] USAID, "Project Assistance Completion Report," National Control of Diarrheal Diseases Project Grant No. 263-0137, p. 7, http://pdf.usaid.gov/pdf_docs/pdabf504.pdf.

1980, 90 percent had them by 1984.[16] A massive campaign that featured 63 different television spots, radio programming, billboards, and magazine advertisements quickly boosted awareness of ORT. A remarkable 99 percent of mothers said they knew about it in 1986.[17]

While the Control of Diarrheal Diseases Project did not eliminate the incidence of diarrheal disease among young people in Egypt, that was never its aim. What it was able to do with high effectiveness was curtail the incidence of death as a consequence of diarrheal disease. In so doing, it was able to strengthen and mobilize a nationwide education and training effort, as well as a distribution system that reached into Egypt's poorest communities. In that, it was successful. Yet, as the project wrapped up, USAID donors worried aloud that the Ministry of Health had seemed to be losing interest in sustaining any effort in the diarrheal diseases field.[18] As the foreign funding diminished, so too did the Egyptian government's attention to the challenges of its citizens.

Part of the distraction, however, was because the United States had embarked on a bold Child Survival Project that was much more ambitious. The $68-million project was the largest such program in the world, and it sought to boost child health by aggressively immunizing Egyptian children against diseases such as polio, tetanus, and hepatitis and by aggressively treating acute respiratory diseases such as pneumonia. Additional aspects of the program concentrated on perinatal care through initiatives to train midwives, encourage child spacing, and improve infant nutrition.

On pure metrics, the project was a huge success. Egypt's infant mortality experienced one of the steepest drops in the world, and the number has continued falling, going from 124 per 1,000 in 1976 to 24.5 per 1,000 in 2008. Child mortality, measuring the number of deaths of children age one to five, experienced an even steeper decline.[19] The immiseration of the Egyptian countryside was clearly in retreat. However, the project did not meet U.S. goals in terms of sustainability. The constant stream of dollars meant it was not necessary for the Egyptian government to appropriate large funds every year, and as the Child Survival Project wrapped up, Egyptians openly wondered where future funds for immunizations would come from.[20] Even more importantly, USAID-funded programs paid a premium in order to recruit the best workers—in some cases one to three times the base salary of a given employee—as well as bonuses to incentivize employees in the governorate and regional offices to cooperate. That is to say, inherent in the system was an admission that the existing salary structure for Egyptian employees was inadequate. While the decline of endemic diseases in the Egyptian countryside suggests that the successes in child health will enjoy some momentum—there is simply less disease around for young people to catch—failure to reestablish a robust immunization and primary care infrastructure would means those rates would creep back

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[16] Kinder, "Preventing Diarrheal Deaths in Egypt," p. 5.
[17] Ibid., p. 7.
[18] USAID, "Project Assistance Completion Report," p. 11.
[19] USAID, *Egypt Health and Population Legacy Review*, p. 20.
[20] Interview with senior Egyptian Ministry of Health employee, October 5, 2009.

up. There are unlikely to return to where they were, but they are also unlikely to stay where they are.

Another area that drew significant U.S. support was population. Foreign visitors often saw Egypt as a teeming swirl of poverty and disease, and by the time of the Great Depression, there was growing concern that Egypt was on the brink of a Malthusian crisis. The Egyptian government had been addressing population growth since the 1940s, but it had never really been seized by it. Although Gamal Abdel Nasser and Anwar Sadat had launched population initiatives, they soon sagged under the weight of conservative clerical opposition that continued to see pregnancy as an expression of God's will rather than a statistic to be managed. Egypt's population growth rate slowed in the 1960s but shot back up in the early 1970s and remained high throughout the decade.

When Gen. Hosni Mubarak acceded to Egypt's presidency after the assassination of Anwar Sadat in 1981, there was no reason to think population was among his highest priorities. A decorated pilot and longtime regime insider, he had made his mark by carefully and reliably executing the tasks he had been given rather than by showing creativity or initiative.

In February 1982, four months after taking office, Mubarak came to Washington. While visiting, his U.S. hosts gave him a RAPID report, an acronym for "Resources for the Awareness of Population Impacts on Development." American consultants, with USAID funding, had been generating such reports for countries all over the world in the late 1970s and early 1980s, but the report Mubarak saw had a profound impact on him.

The most startling numbers were in employment. In 1982, Egypt was struggling to create jobs for the 325,000 people who entered the labor force every year. If fertility continued at its current rate, the report stated, that number would grow to 790,000 by 2010. An aggressive family planning effort, however, could keep the number essentially flat. In addition, family planning alone could boost per capita GNP by 30 percent.

Mubarak returned to Egypt and soon made population one of his signature issues. He directed his aides to hold a major conference linking the issues of population and development, and in 1985, he established the National Population Council, which he headed personally. Equally important, Mubarak himself attended the first three meetings, assigned roles to his ministers, and ensured they followed up.

With strong leadership from the top, USAID was able to play a supportive role as well—constituting 75 percent of all donor assistance for family planning in Egypt.[21] USAID contracts purchased many of the contraceptive devices deployed in Egypt for more than a decade, and USAID contractors helped create the information campaigns that got messages out to tens of millions of Egyptians. U.S. assistance also supported health worker training, statistical analysis, and over time family clinics to provide services to mothers and their children. By 1994, it was clear that

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[21] Hind A.S. Khattab et al., "Egypt," in *Promoting Reproductive Health*, ed. Shepard Forman and Romita Ghosh (Boulder, CO: Lynne Rienner, 2000), p. 63.

Egypt's efforts had been so exemplary that the country hosted the UN Conference on Population and Development, which brought 15,000 delegates from 180 countries to Cairo for the largest gathering ever held on the topic. When an Egyptian sociologist surveyed Egyptian physicians and mid-level government managers a year after the conference, their awareness of the population issue, and the importance they ascribed to it, had more than doubled.[22]

Yet, as the United States began to phase out support for family planning in Egypt in the early 2000s, the program faced serious questions. The first had to do with how Egypt might wean itself off heavy international subsidies for contraceptives and, the second, how it might transition to market-based pricing of contraceptives for those who could afford them.[23] The questions go to the heart of broader issues in Egypt about the nature of the social safety net and the relationship between the public and private sector. External support did not help resolve these questions; rather, it deferred them. Now that Egypt is going through a governmental transition, resolving such issues will be at the core of a discussion about the future nature of the state.

Conclusion

By many calculations, U.S. assistance to Egypt's health sector has been a terrific success. Millions of lives have been saved, the quality of even more lives has improved, and the productivity of the countryside has risen. As the Egyptian government has labored mightily to deliver services, in case after case, the United States was a strong and often crucial partner.

The greatest accomplishments of the U.S.-Egypt partnership in health were often where the goals were most focused. That is to say, when the two sides worked hand-in-hand to deliver services or train primary care givers, they were successful. Similarly, when the goal of the partnership was to move a discrete indicator to meet an agreed target, the two sides were able to meet that target.

Another area where the U.S.-Egypt partnership shined was in publicity. Working together, Egyptian-American teams crafted successful messages for a wide range of important public health programs, helping ensure that they had broad reach within the Egyptian population. Given the high levels of illiteracy in Egypt, this was not a trivial accomplishment.

And yet, there were persistent weaknesses in what the two parties were able to develop jointly. One was developing a strong cadre of mid-level Egyptian managers who could execute programs without extensive oversight. While program management is not a glamorous skill, it is an essential one, and one that is in short supply in Egypt. Similarly, in many projects, U.S. donors reported persistent dissatisfaction with Egyptians' ability or willingness to meet U.S. financial reporting requirements.

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[22] Saad Eddin Ibrahim and Barbara Lethem Ibrahim, "Egypt's Population Policy: The Long March of State and Civil Society," in *Do Population Policies Matter?* ed. Anrudh Jain (New York: The Population Council, 1998), p. 48.

[23] Warren C. Robinson and Fatma H. El-Zanaty, *The Demographic Revolution in Modern Egypt* (Lanham, MD: Lexington Books, 2006), p. 125.

A second issue in the institutional governance field was the problem of decentralizing programs, which is to say creating systems that could be managed effectively by field operations rather than relying on senior leadership to make even small decisions. Egyptian management practice in general is reluctant to cede authority or reward initiative, and these tendencies manifested themselves in joint projects.

A key goal of many of the USAID projects in Egypt was creating a sustainable Egyptian capacity to carry out programs in the absence of U.S. support. In general, that capacity has proved slow to develop, in part because many of the strategies intended to ensure that projects were successful in the near term—such as providing significant salary bonuses and expensive foreign expertise—made them hard to support in the longer term. As well, parts of the Egyptian bureaucracy that habitually worked closely with U.S. partners had better equipment, better staff, and better training than the rest of their organization, sometimes creating rivalries that undermined broader efforts at institutional resilience.

A related problem, certainly unintended, was the way in which USAID's use of contractors ended up depleting the Egyptian government's own institutional capacity. The U.S. government sought to hire Egyptians as contractors, and because the Egyptians most familiar with the work to be done were in the relevant ministries, U.S. agencies ended up cherry picking the most skilled Egyptian government workers to work for the U.S. side on health projects. The move provided workers with far higher salaries and better working conditions, but it meant that the Egyptian bureaucracy left behind was weaker. In this way, U.S. efforts intended to strengthen long-term Egyptian capacity crippled the government's ability to be a fully effective partner. Theoretically, the Egyptian government could hire such workers back at private-sector rates and retain their services for the Egyptian side. However, the long-term pattern of U.S. funding in these fields—after 30 years of U.S. health assistance—created a sense among some that such work was the responsibility of international donors and not the Egyptian government.

A final area of continued challenge was creating a culture of innovation in the Egyptian health sector. In part, the absence of such a culture is a consequence of the intellectual environment in Egypt and educational patterns that stress rote memorization over creativity and experimentation. While some may consider it to be too much to ask to overcome such baggage, one might also consider if there is another set of circumstances in which creativity would be more likely to flourish. The ingredients are there: a combination of international experts, sustained training, extensive resources, and dispersed work sites that provide some possibility of autonomy, as well as serious national problems that cry for solutions. All provide potentially fertile ground for policy entrepreneurship. And yet, while health conditions improved markedly in Egypt, there was a widespread sense among Egyptians in the field that Egypt had not developed sufficient momentum of its own. Rather than nurturing a strong and independent capability, long-term funding had created a sense of dependency in the Egyptian bureaucracy, which stunted the development of domestic sources of funding, innovation, and drive that could easily replace U.S. support. The relatively lavish U.S. funding of health projects in Egypt made this problem more difficult.

The principal goal of U.S. health assistance to Egypt was political—to reward Egypt for its turn away from the Eastern Bloc in the early 1970s and for making peace with Israel in 1979. To the extent that Egypt's national orientation did not revert to its previous state, the funding was part of a successful policy.

But if the goal of funding the health sector was to build public gratitude toward the United States, or to create a positive image for the United States in Egypt, it appears to have been less successful. According to a range of polls, U.S. approval ratings consistently rank about 20 percent after 30 years of steady economic and military assistance.[24] One might argue that the numbers would be even lower were it not for U.S. health assistance, and perhaps that is true. Yet, in countries with which the United States has no aid relationship, or where the aid relationship is more skewed in the direction of military support, U.S. approval ratings are higher.[25]

The larger story that Egypt presents is that even large-scale assistance over a sustained period cannot be transformative by itself. While much has changed in the Egyptian health field, and U.S. assistance has played a large role in that change, most of the credit accrues to the Egyptian government itself, rather than to foreign donors. While such aid can be a catalyst for change, the host government itself remains the dominant factor in domestic developments. Long-term aid can create the assurance change-makers seek to promote change in their own societies, but it also creates a complacency that can delay rather than instigate fundamental and self-sustaining change.

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[24] A Pew Research Center poll in the spring of 2011 found 20 percent of Egyptians polled approved of the United States, versus 79 percent who disapproved. The numbers were up from 17 and 82 percent, respectively, the year before. Pew Global Attitudes Project, "Egyptians Embrace Revolt Leaders, Religious Parties and Military, as Well," April 25, 2011, http://pewglobal.org/files/2011/04/Pew-Global-Attitudes-Egypt-Report-FINAL-April-25-2011.pdf.

[25] Only two countries in which Pew polled found consistently low approval ratings of the United States similar to those that prevailed in Egypt: longtime U.S. aid recipients Jordan and Pakistan. See Pew Global Attitudes Project, "Obama More Popular Abroad than at Home, Global Image of U.S. Continues to Benefit," June 17, 2010, http://pewglobal.org/2010/06/17/obama-more-popular-abroad-than-at-home/.

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