

When Development Withdraws: Embeddedness, Responsibility and the Afterlife of Aid in Kenya

Wambui Mumbi

Independent Researcher | Migration, Mobility and International Relations

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Abstract

Development interventions are commonly evaluated according to what happens during their formally defined implementation periods: whether resources were delivered, targets were reached, institutions strengthened and beneficiaries transitioned toward self-reliance. Such approaches can obscure what happens after external financing changes or ends. This paper examines the afterlife of externally financed development in Kenya through three theoretically selected cases: the Wings to Fly secondary-school scholarship programme, tuberculosis (TB) care, and the disruption and subsequent reconfiguration of United States-supported health financing in 2025. Drawing on documentary evidence and a reflexive account of lived experience, the paper develops the concept of *developmental embeddedness* to describe the process through which externally financed interventions become incorporated into individual trajectories, institutional routines, professional networks, material infrastructures and expectations of service provision.

The paper argues that embedded development does not simply disappear when its original financing arrangement changes. Instead, external interventions can become ordinary and therefore increasingly invisible to the people and institutions that depend upon them. A financing disruption can consequently reveal an architecture that was previously experienced only through its outputs: education, clinical care, medicines, laboratories, health workers, data systems and community services. The three cases illustrate different forms of afterlife. In Wings to Fly, responsibility can become increasingly individualised after formal programme completion. In TB care, responsibility is distributed across government institutions, health workers, programmes, facilities and external partners. In the 2025 health-financing disruption, responsibility became an object of active redistribution and negotiation among the Kenyan government, United States agencies, multilateral institutions, implementing organisations and health-system actors.

Rather than treating aid dependence as a simple condition measured by financial volume, the paper proposes examining what external financing becomes embedded within. The more functions, relationships and expectations an intervention becomes incorporated into, the more difficult it may be to identify who should sustain those functions when financing changes. The paper therefore reframes aid withdrawal as a problem of responsibility redistribution and institutional afterlife rather than merely programme closure.

Keywords: development aid; embeddedness; aid withdrawal; responsibility; Kenya; health financing; tuberculosis; education; development afterlives; sustainability.

1. Introduction

International development is frequently organised around a temporal sequence: a problem is identified, resources are mobilised, an intervention is implemented, outputs are measured and, eventually, the intervention is completed or transferred. This temporal structure is useful for budgeting and programme management, but it can obscure what happens after an intervention's formal life.

A scholarship can end while its effects continue through an individual's educational trajectory, professional identity and expectations of opportunity. A health programme can close while clinical routines, referral relationships, trained personnel, procurement systems and expectations of care remain. A financing arrangement can be interrupted while the services that developed under it remain necessary. The question, therefore, is not simply what happens when aid ends; it is what has already happened to the intervention before it ends.

This paper approaches that question through the concept of developmental embeddedness. The concept refers to the process through which externally financed development becomes incorporated into existing and emerging systems of life and practice. Embeddedness may occur at multiple levels: within individuals, households, institutions, professional routines, material infrastructures, social relationships and expectations about what governments and development organisations should provide.

Once an intervention becomes embedded, its external origin may become less visible. A beneficiary may experience a scholarship simply as schooling. A patient may experience a donor-supported health architecture as a relationship with a nurse, doctor or public clinic. A health worker may experience externally financed employment as an ordinary component of the health system rather than as a temporary development intervention. This creates an analytical problem for conventional accounts of exit and sustainability: if the intervention's external financing is withdrawn, responsibility does not necessarily disappear with it. Instead, responsibility has to move somewhere.

The paper examines this process in Kenya through three cases that occupy different analytical levels.

The first is Wings to Fly, a secondary-school scholarship programme implemented by Equity Group Foundation with support from multiple development partners. The programme demonstrates how externally financed education can become embedded in an individual's life beyond the formal period of scholarship support. Equity Group Foundation documents substantial external participation in Wings to Fly, including USAID investment of US\$26.4 million supporting more than 4,116 orphaned and vulnerable children between 2011 and 2017, alongside partnerships involving the Mastercard Foundation, KfW and the former UK Department for International Development (DFID).

The second case examines TB care in Kenya, focusing on how externally supported health resources become embedded within government health institutions, professional practices, nutrition programmes, diagnostic systems and patient pathways.

The third case examines the 2025 disruption to United States-supported health financing in Kenya. This case provides an unusually visible moment of systemic embeddedness. Following the U.S. foreign-assistance pause, UNAIDS reported that PEPFAR-supported health workers had been instructed to stop work, implementing partners had been affected, and commodities and laboratory services faced emerging risks. In March 2025, UNAIDS reported that doctors, clinical officers, nurses, laboratory technologists, pharmacists and community health workers supported by the U.S. government were affected, while some HIV facilities experienced closure or reduced capacity.

The cases therefore provide three different analytical vantage points: individual embeddedness and afterlife; institutional and professional embeddedness; and systemic embeddedness exposed through disruption.

The paper asks:

How does externally financed development become embedded in Kenyan individual, institutional and systemic structures, and what happens to responsibility when the financing that helped sustain those structures changes?

Three subsidiary questions follow:

1. How do externally financed interventions become embedded beyond their formal implementation periods?

2. How does embeddedness make external financing less visible in everyday experience?
3. How is responsibility redistributed when the financing arrangements supporting embedded interventions change?

The paper does not assume that greater embeddedness necessarily produces greater dependency. Instead, it advances a more cautious proposition: greater embeddedness may make responsibility for sustaining development outcomes more distributed, less visible and more difficult to reassign when external financing changes. This proposition is examined rather than presumed to be true.

2. From Aid Dependence to Developmental Embeddedness

The literature on aid has long examined questions of dependency, ownership, governance and institutional capacity. Earlier scholarship demonstrated that external assistance can have contradictory effects. Bräutigam and Botchwey (1999), for example, showed how aid could simultaneously support development capacity and contribute to fiscal and institutional difficulties. Knack (2001) connected aid dependence with questions of governance and institutional incentives, while later work has emphasised that the relationship between aid and domestic taxation is neither uniformly substitutive nor uniformly complementary (Morrissey, 2015).

These debates remain important, but financial dependence alone does not fully capture what happens after an intervention has become embedded. A programme can have a relatively modest financial value while becoming highly consequential because it becomes incorporated into an individual's education, an institution's routines or a professional network. Conversely, a large financial programme may leave relatively shallow institutional traces if it operates as a temporary parallel structure.

The relevant question is therefore not only how much external financing entered a system, but also what the financing became part of.

Development anthropology provides an important foundation for this question. Li (2007) demonstrated how development operates through problematisation, expertise and practices of intervention, while Mosse (2005) showed how development policy is sustained through organisational practices and relationships that cannot be reduced to formal policy documents. Such approaches shift attention from development as a set of financial transfers to development as a social and institutional practice.

More recent work on the afterlives of development makes a related intervention. The AfDevLives project, which includes research in Kenya, Tanzania and Mozambique, explicitly examines the material and intangible legacies of development interventions and how those traces are experienced, used and reappropriated after formal intervention periods.

This paper builds on that literature but asks a somewhat different question: not only what remains after an intervention, but how embeddedness changes the distribution of responsibility. Consider a simplified sequence:

External financing → intervention → embedding → ordinarisation →
reliance →
financing change → visibility → responsibility redistribution →
afterlife

The concept of ordinarisation is particularly important. An intervention may initially be highly visible as a development project; over time, however, its outputs can become normalised.

A scholarship becomes schooling.

A trained health worker becomes “the nurse.”

A donor-supported laboratory becomes part of the diagnostic system.

A community health worker becomes a familiar person delivering services.

A commodity supply becomes an expectation that medicines will be available.

The original financing relationship becomes background knowledge.

This is what makes withdrawal analytically significant. When financing changes, the question is no longer simply whether a donor will continue paying; the question becomes who is now responsible for maintaining the thing that the financing helped create, sustain or normalise.

3. Exit, Transition and the Afterlife of Development

Development agencies have long recognised that exit is not synonymous with sustainability. The literature on donor withdrawal has identified weaknesses in systematic exit planning, institutional capacity, communication and the transfer of responsibilities (Slob & Jerve, 2008; ICAI, 2016).

ICAI's examination of DFID's approach to exit and transition similarly distinguished between an intervention ending and a broader transition in the relationship

between donor and recipient institutions. Such transitions involve questions of institutional capacity, staff continuity, planning and the sustainability of gains.

This distinction is central to the present paper. A programme can have:

- a formal end;
- a financial end;
- an institutional transition;
- a social afterlife; and
- a material afterlife.

These do not necessarily occur at the same time. A scholarship may formally end when the student completes secondary education while its social and professional consequences continue for decades. A donor-supported health project may formally close while trained personnel remain employed, professional networks continue and institutional procedures survive. A financing arrangement may be interrupted suddenly while health services cannot be interrupted without consequences.

This temporal mismatch creates what may be called an afterlife problem. The afterlife is not necessarily a success story; it can include continuation, adaptation, appropriation, decay, abandonment, substitution or conflict. The concept also avoids assuming that an intervention either “worked” or “failed.” A programme may disappear institutionally while continuing to shape people's lives. Conversely, an institution may retain formal structures while losing the capacity that made them functional.

The emerging literature on abandonment and development afterlives reinforces this point. Research on humanitarian and development interventions has shown that projects do not necessarily end through clean closure: their personnel, infrastructures, expectations and relationships can persist or be reconfigured after formal financing ends. The implication is that the end of funding should be treated as an analytical event, not merely an administrative date.

4. Conceptual Framework: Embeddedness and Responsibility

4.1 Developmental embeddedness

This paper defines developmental embeddedness as the process through which externally financed development becomes incorporated into individual trajectories,

institutional routines, professional practices, material infrastructures, social relationships and expectations, such that the intervention's external origin may become less visible while its functions remain consequential.

4.2 Forms of embeddedness

Individual embeddedness

External financing becomes embedded within an individual's life trajectory through education, skills, professional networks, identity, aspirations, employment and social relationships. The Wings to Fly case is primarily located here.

Institutional embeddedness

External resources become incorporated into organisational routines such as clinical protocols, procurement systems, referral pathways, data systems, staffing arrangements, monitoring systems and training structures. The TB case illustrates this form.

Material embeddedness

Development becomes incorporated into physical or technical infrastructure: laboratories, diagnostic equipment, information systems, medicines, schools, buildings and supply chains.

Social embeddedness

Development becomes embedded in relationships among beneficiaries, health workers, mentors, communities, government agencies, NGOs, donors and professional networks.

Expectational embeddedness

Development can become embedded in expectations. Once a service has become normal, its users may cease to perceive it as exceptional, so the disappearance of funding creates a gap not only in resources but in expected provision.

4.3 Responsibility as an analytical variable

The paper distinguishes three forms of responsibility. *Formal responsibility* asks who is legally or institutionally mandated to provide the service. *Financial responsibility* asks who supplies the money. *Effective responsibility* asks who actually has the resources, personnel, authority and operational capacity to keep the function working.

These three can diverge. The central problem arises when formal responsibility remains constant while financial or effective responsibility changes.

5. Methodology

5.1 Research design

The study uses a qualitative explanatory multiple-case-study design. The cases were theoretically selected because they represent different levels and temporal forms of developmental embeddedness, rather than because they constitute statistically representative samples.

The unit of analysis is the process through which an externally financed development intervention becomes embedded in an individual, institutional, material or social system and subsequently undergoes completion, disruption, transition or reconfiguration. The cases are:

- Wings to Fly – individual/formal completion;
- TB care – institutional and professional embeddedness;
- U.S.-supported health financing – systemic disruption and reconfiguration.

The cases therefore allow analytical comparison across different forms of embeddedness.

5.2 Evidence

The study combines institutional documentation, government publications, donor documentation, international organisation reports, academic literature, retrospective participant testimony, and researcher positionality and lived experience. The evidence is deliberately triangulated: documentary evidence establishes institutional arrangements and programme histories, participant testimony provides access to lived experience that institutional documents cannot capture, and the researcher's own experience generates questions and observations but is not treated as representative evidence.

5.3 Researcher positionality

The researcher occupies several overlapping positions: Kenyan, immigration practitioner, independent researcher, former beneficiary of the Wings to Fly programme and former patient within the Kenyan health system.

This positionality presents both an opportunity and a methodological risk. Personal experience offers access to questions that might otherwise remain invisible, and it can reveal the difference between how an intervention is described institutionally and how it is experienced by those who encounter it. However, experience is not automatically evidence of generality. Accordingly, personal memory is used to:

1. generate research questions;
2. identify potentially important processes;
3. reconstruct a case chronology where appropriate;
4. identify documentary evidence requiring verification;
5. inform reflexive analysis.

It is not used to establish the prevalence of a phenomenon.

5.4 Sampling and interviews

The subsequent empirical phase will use purposive sampling based on analytical role. For *Wings to Fly*, prospective participants include former beneficiaries and programme or mentorship actors. For TB care, prospective participants include health workers, programme personnel and institutional actors involved in diagnosis, treatment, nutrition, laboratory systems or patient follow-up. For the 2025 health-financing case, prospective participants include health workers, implementers, policy/programme actors and development-financing or civil-society actors.

The purpose is not to achieve a predetermined numerical sample but to identify actors occupying different positions in the responsibility chain. Particular attention will be given to disagreement: if a programme manager says responsibility was transferred successfully while a health worker reports that the transferred function could not be sustained, the contradiction is treated as data rather than resolved automatically in favour of one account.

5.5 Data analysis

The analysis follows four stages:

Arrival → Embedding → Formal exit/disruption → Afterlife

Within each stage, evidence is coded around resources, institutions, actors, relationships, routines, expectations, capacity, responsibility, visibility, adaptation, continuity and disruption.

Cross-case analysis then asks: What became embedded? Where did it become embedded? When did the external origin become less visible? What changed when financing changed? Who became responsible? Who was expected to become responsible? Who actually possessed the capacity to assume responsibility?

6. Case I: Wings to Fly – From Scholarship to Afterlife

6.1 Programme background

Wings to Fly is Equity Group Foundation's flagship secondary-school scholarship programme. The programme provides comprehensive secondary-school support, including tuition, boarding, learning materials, transport, mentorship, psychosocial support and leadership development. Current EGF documentation identifies the Mastercard Foundation, KfW, USAID and other partners among its development partners.

The programme therefore represents more than a conventional tuition scholarship. Its intervention included educational financing, material support, mentorship, leadership development and social networks, which makes it particularly useful for studying embeddedness.

6.2 Arrival

The researcher's experience as a Wings beneficiary provides a retrospective entry point into the case. The scholarship was experienced not simply as a financial transfer but as an institutional environment: school fees were one component, while the broader intervention also included mentorship, organised gatherings, leadership activities, material support and relationships with programme personnel and other beneficiaries.

The participant recalls annual mentorship and leadership gatherings that brought together large numbers of scholars and created a distinctive social environment around the programme. The significance of this environment is analytical: the programme did not enter an empty social space, but became part of the participant's educational and social life.

6.3 *Embedding*

The intervention became embedded at several levels.

- *Educational*: It enabled continued secondary education.
- *Material*: It covered expenses that the participant would otherwise have had to secure independently.
- *Social*: It produced relationships with mentors and fellow scholars.
- *Institutional*: It connected the participant to Equity Group Foundation and, later, the wider Equity institutional environment.
- *Identity*: Being a Wings scholar became part of the participant's biography.
- *Professional*: The participant's subsequent interaction with Equity institutions created a potential pathway between scholarship, training and employment.

The last relationship requires particular care. The participant recalls being connected to Equity-related training and subsequently working at Equity Bank. Documentary evidence confirms that Equity has developed post-secondary and professional pathways for scholars, including the Equity Leaders Program and internship opportunities. However, the causal claim that the individual's later employment resulted directly from Wings to Fly cannot be established from the current documentary evidence alone.

6.4 *Formal exit*

At first glance, the programme ends when the scholarship ends: the student completes secondary education, the funding obligation associated with that secondary-school place ends, and the programme can therefore record a successful completion. But the participant's experience suggests a different temporal boundary. The educational intervention continued to exist through accumulated education, social relationships, memories, institutional connections, expectations and subsequent opportunities. The programme's formal life and its lived life were therefore different.

6.5 *Afterlife*

The most important analytical question is whether development ended when the scholarship ended. The evidence suggests that this question cannot be answered simply by looking at the scholarship's funding period. Current EGF documentation describes post-secondary pathways, including university, TVET and leadership opportunities, illustrating

that the institutional ecosystem surrounding Wings to Fly extends beyond the four-year secondary scholarship. The participant's experience similarly indicates that the intervention's meaning extended beyond school.

The afterlife therefore operates at two levels. First, there is the biographical afterlife: the programme remains part of an individual's educational and professional history. Second, there is the institutional afterlife: relationships, pathways and programme structures can continue beyond the original intervention period.

6.6 Responsibility after exit

The Wings case presents a distinctive redistribution of responsibility. During the scholarship period, substantial responsibility is externalised to the programme: the programme pays, organises and mentors, while the beneficiary receives. After formal completion, however, responsibility shifts progressively toward the individual and other institutions. The former beneficiary must navigate further education, employment and adulthood, and the intervention's resources become part of the individual's accumulated capacity.

This can be described as individualisation of responsibility. Development does not simply disappear; instead, part of what was previously provided collectively becomes an individual capability. The critical question is whether this represents empowerment, responsibility transfer, or both, and the answer cannot be assumed in advance.

7. Case II: TB Care – Institutional Embeddedness and Distributed Responsibility

7.1 From intervention to health system

The TB case presents a different form of embeddedness. The patient does not necessarily encounter “aid.” The patient encounters a doctor, a nurse, a laboratory, a medicine, a clinic, a referral, a monitoring system and a nutrition intervention. This is analytically important because the external financing architecture can disappear from everyday visibility.

Kenya's NTLD-P describes TB care as an integrated programme involving case finding, patient-centred care, treatment, technical assistance, capacity building and nutrition monitoring. The Ministry of Health's nutrition programme similarly recognises

food and nutritional support as part of TB care, linking nutrition to treatment adherence and outcomes. A national study using programme data from 362,685 drug-susceptible TB patients diagnosed between 2012 and 2015 found that nutritional support was associated with reduced risk of loss to follow-up.

The significance is not that every component of the participant's care can now be attributed to a particular donor; it cannot. The significance is that the patient's experience occurred within a multi-layered institutional architecture in which government programmes, facilities, professionals, commodities, diagnostic systems and external support could become difficult to distinguish from one another at the point of care.

7.2 Patient experience

The researcher's retrospective account covers TB episodes in 2016, 2017 and 2018. The initial diagnosis followed a prolonged period of respiratory illness and repeated treatment for what had reportedly been interpreted as pneumonia. During a post-secondary training event, an acute episode of breathing difficulty led to assistance from a programme chaperone and subsequent hospital assessment. The participant recalls receiving a TB diagnosis and beginning treatment.

The significance of the episode for this study is not the diagnosis itself, but the transition from crisis to an organised treatment system. The participant subsequently recalls attending a public facility while working in Kerugoya, collecting medication regularly, being monitored by health workers and receiving nutritional support. She also recalls later treatment and referral across Nairobi facilities, including Kenyatta National Hospital and Rhodes Chest Clinic.

These recollections require documentary and interview triangulation before they can be generalised, but as a lived account, they reveal something important about institutional embeddedness: the system was experienced as a network.

7.3 The networked character of responsibility

The participant's experience suggests that no single actor can easily be identified as responsible for the entire episode. Diagnosis may occur at one institution, medication may be collected at another, a specialist may become involved elsewhere, and laboratory systems may sit within another organisational structure. Nutrition support may involve another programme, and external financing may support particular commodities, personnel

or technical functions. Government institutions may carry formal responsibility while external organisations contribute resources, and clinicians may exercise practical responsibility in individual cases.

This produces a distinction between formal, financial and effective responsibility. The question is therefore not who paid for TB care, but who made the different functions of TB care possible, and who would have been expected to sustain each function if external financing changed.

7.4 Nutrition as an example of invisible embeddedness

Nutrition provides a particularly useful example. The participant remembers receiving nutritional support during treatment. Current Kenyan health guidance identifies nutrition as an important part of TB treatment, including nutritional assessment, food support and adherence-related interventions, and research using national programme data has also demonstrated the relevance of nutritional support to treatment retention.

The patient's experience therefore sits within a broader programme architecture. But the patient does not necessarily encounter that architecture as a donor-funded intervention; she encounters flour, or a nurse, or a clinic, or a reminder to return. The external origin becomes invisible. This is a key mechanism of embeddedness: the more completely an externally supported function becomes incorporated into ordinary service delivery, the less likely the user is to experience it as external.

7.5 Professional embeddedness

The case also raises the possibility of professional embeddedness. The participant recalls a clinician taking an unusual interest in repeated TB relapse, discussing the case with colleagues and considering whether the clinical pathway was missing something. Whether that interaction was formally connected to a referral protocol or represented individual clinical initiative remains a question for further interviews.

This distinction matters because development can become embedded not only in institutions but in professional habits. Training, technical assistance, clinical guidelines, peer relationships and referral networks can survive beyond the financing arrangement that helped establish them. Professional embeddedness can therefore constitute one form of institutional afterlife.

7.6 Responsibility in the TB case

Unlike Wings to Fly, responsibility does not become primarily individualised in the TB case. Instead, it becomes distributed. The patient depends upon a chain:

patient → clinician → facility → laboratory → medicine →
programme → procurement → financing → health system

A disruption at one point may affect the others. This is a different form of afterlife: the intervention becomes embedded in a network rather than transferred into a single individual. That suggests a second proposition: institutional embeddedness distributes responsibility across multiple actors, but distribution can also make responsibility difficult to see.

8. Case III: The 2025 U.S.-Supported Health-Financing Disruption

8.1 A system-wide stress test

The third case differs from the first two because the intervention's afterlife is unfolding in real time. Kenya's health system has experienced more than four decades of health cooperation with the United States. Kenya's Ministry of Health states that this cooperation has supported HIV, TB and malaria responses as well as laboratory services, surveillance, epidemiology, data systems, emergency response and the health workforce. This is not a discrete project; it is an architecture. The significance of the 2025 disruption is therefore that it exposed the embeddedness of external financing within ordinary health-system functions.

8.2 The disruption

Following the U.S. foreign-assistance pause in early 2025, UNAIDS documented significant consequences for Kenya's HIV response. In February, UNAIDS reported that PEPFAR-supported health workers had been instructed to stop work and that implementing partners and sub-grantees had also been affected; the report identified risks to commodities, laboratory services and community-led monitoring. By March, UNAIDS reported impacts across doctors, clinical officers, nurses, laboratory technologists, pharmacists and community health workers. Some ART facilities had closed or were operating under constrained conditions, while community-led and peer-led services had stopped.

A regional UNAIDS assessment estimated that approximately 41,000 doctors, nurses, technical and management staff and community workers in Kenya were supported by the U.S. government. The figure is important not because it proves that all Kenyan health services depended on U.S. financing; it does not. It demonstrates instead the scale at which external financing had become incorporated into human-resource capacity.

8.3 The architecture becomes visible

The disruption made previously invisible components visible.

Human resources became visible because people stopped working.

Commodities became visible because stocks began to matter.

Laboratory services became visible because testing capacity was threatened.

Community services became visible because outreach stopped.

Data systems became visible because information functions were affected.

Referral systems became visible when facilities closed or reduced services.

This is the central empirical insight of the case: disruption converts embedded infrastructure into visible infrastructure.

8.4 Responsibility redistribution

The disruption immediately raised questions about who should assume responsibility. UNAIDS documented proposals for domestic resource allocation, Global Fund support, government counterpart financing and alternative commodity-distribution arrangements. This demonstrates that responsibility was not simply transferred from the United States to Kenya; it was potentially redistributed across the national government, county governments, Global Fund mechanisms, implementing organisations, UN agencies, civil society and health facilities and professionals.

The case therefore illustrates contested responsibility redistribution. Different actors may agree that services must continue while disagreeing about who should finance them, who should administer them and what level of capacity exists to do so.

8.5 From disruption to reconfiguration

The 2025 disruption did not produce a simple binary of “funding present” versus “funding absent.” Instead, the system moved through several stages:

pause → disruption → mitigation → partial restoration →
renegotiation → reconfiguration

This is important because it prevents the case from being mischaracterised as a permanent withdrawal. By December 2025, Kenya and the United States had signed a five-year Health Framework for Cooperation. UNAIDS reported that the United States committed up to US\$1.6 billion over five years while Kenya committed approximately US\$850 million in domestic funding. By 2026, Kenya's Ministry of Health was explicitly framing the relationship around stronger national systems, country ownership and sustainable financing. The case is therefore better understood as reconfiguration of the financing architecture than simple donor exit.

9. Cross-Case Findings

Dimension	Wings to Fly	TB care	2025 health financing
Primary analytical level	Individual	Institutional	Systemic
Main external input	Education, mentorship, material support	Financing, technical and health-system resources	Financing, commodities, workforce, systems
Main embedding	Biographical/social	Institutional/professional	Systemic/material
Normal experience	Scholarship/schooling	Healthcare	Health services
External origin	Increasingly backgrounded	Often invisible at point of care	Revealed by disruption
Trigger	Formal completion	Repeated treatment/clinical pathway	Financing disruption
Responsibility trajectory	Individualisation	Distribution	Reconfiguration/ contestation

Three comparative findings emerge.

9.1 Finding 1: *Embedded development becomes ordinary*

Across all three cases, development becomes less visible as it becomes embedded.

The scholarship becomes education.

The health programme becomes healthcare.

The donor-supported health worker becomes part of the workforce.

This suggests that invisibility is not evidence of insignificance. Indeed, the opposite may sometimes be true: the more deeply an intervention becomes integrated into ordinary life, the less visible its external origin may become.

9.2 Finding 2: Disruption reveals architecture

The second finding concerns visibility. Normal operation hides the architecture; disruption reveals it. This is most obvious in the 2025 case, where the interruption of external financing revealed dependence across human resources, commodities and community services. But the same principle appears in the TB case, where a patient who experiences TB care as a relationship with clinicians may not see the procurement, financing and programme structures beneath it. The same principle applies to Wings to Fly: a student experiences education rather than the financial architecture that made continued schooling possible.

9.3 Finding 3: Responsibility does not disappear when financing changes

This is perhaps the paper's central finding. When external financing changes, responsibility must be redistributed, and the destination varies. In Wings to Fly, responsibility becomes more individualised. In TB care, responsibility remains distributed across institutions and professionals. In the 2025 health-financing case, responsibility becomes actively reconfigured across governments, donors, multilateral organisations and implementing actors.

The key issue is therefore not simply whether an intervention is sustainable. It is sustainable by whom, through which institution, with which resources, and under what definition of responsibility.

10. Discussion

10.1 Embeddedness is not the same as dependency

One danger in analysing external financing is to assume that embeddedness necessarily demonstrates dependency. The cases do not support such a simple conclusion. Wings to Fly illustrates an intervention becoming incorporated into a person's capabilities and biography, which does not necessarily mean permanent dependence on the original financier. TB care illustrates external and domestic resources becoming intertwined within an institutional system; the presence of external financing does not prove that government

institutions have no capacity of their own. The 2025 case demonstrates something different: external financing had become important enough that a sudden change could produce visible system-level effects. Embeddedness therefore describes relationship and incorporation, not a predetermined normative condition.

10.2 The paradox of successful integration

A central paradox emerges: the more successfully an intervention becomes integrated into ordinary systems, the less visible it may become. This produces what can be described as the paradox of successful embedding. An intervention can become so ordinary that its financing architecture disappears from view.

This is desirable from one perspective, since development should ideally become institutionalised rather than permanently exceptional. But it creates a risk: if the external support is withdrawn before alternative responsibility structures have acquired sufficient capacity, the system may discover that what appeared to be institutionalised was partly being sustained by external resources. The question then becomes whether the intervention was truly institutionalised, or whether the external financing was simply institutionalised within the system. These are not equivalent.

10.3 The problem of invisible responsibility

Embeddedness also creates a problem of accountability. Suppose the government has formal responsibility for a service, while an external partner pays for personnel, another organisation provides technical assistance, and another actor procures commodities. Who is responsible when the service stops? The answer cannot be derived from formal mandates alone, nor can it be derived from financing alone. The paper therefore proposes distinguishing responsibility for mandate from responsibility for financing from responsibility for functioning.

10.4 The afterlife is not necessarily continuity

The term “afterlife” should not imply that development interventions continue unchanged. Afterlife can involve continuation, adaptation, appropriation, institutionalisation, decay, substitution or abandonment. The Wings case illustrates continuity through biography and institutional pathways. The TB case illustrates incorporation into routine institutional practice. The 2025 case illustrates disruption followed by reconfiguration. Thus, the afterlife is a process rather than a condition.

10.5 What does responsible exit require?

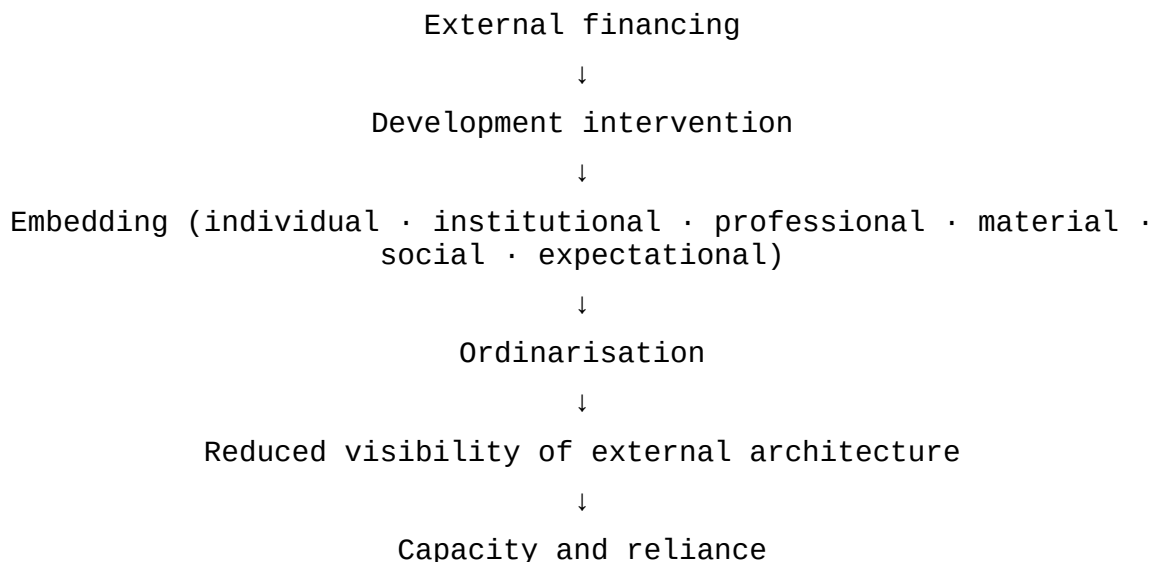
The cases suggest that responsible exit should begin by mapping embeddedness. Before external financing changes, actors should identify:

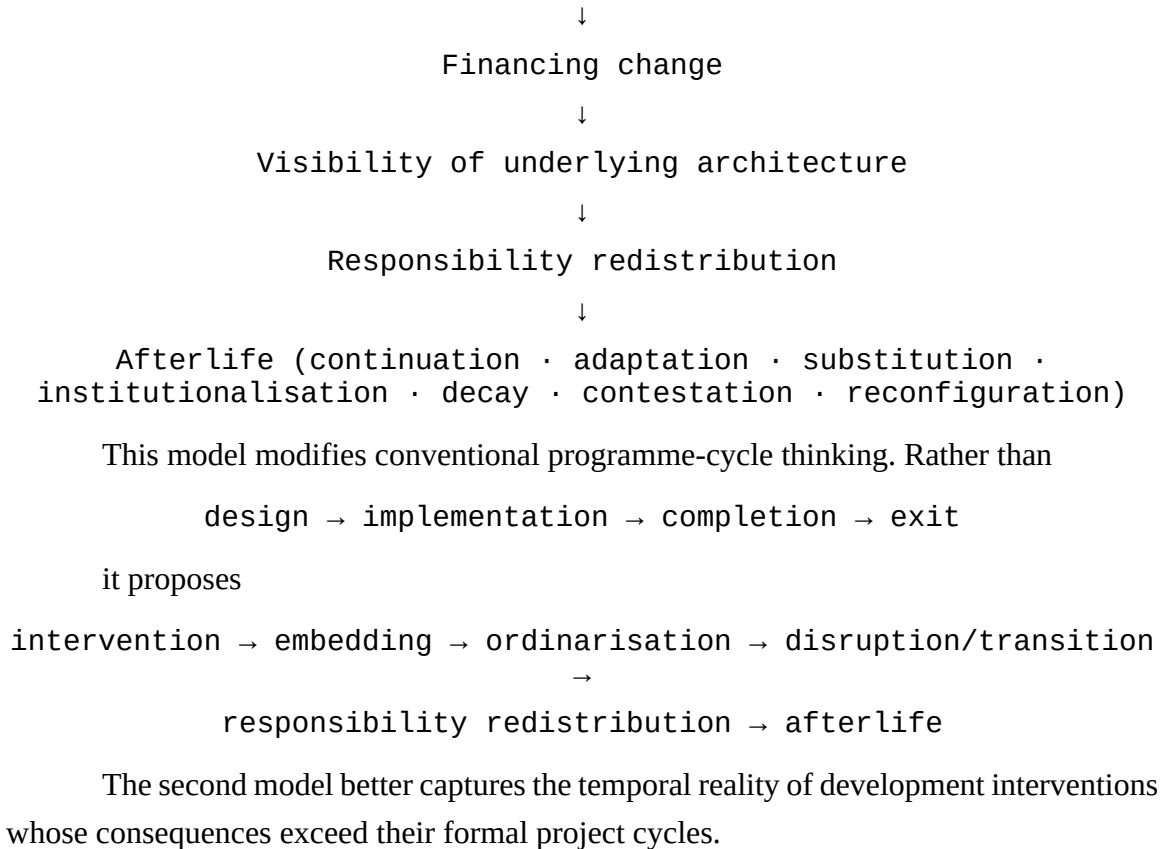
1. what functions the intervention currently performs;
2. which institutions perform those functions;
3. which resources sustain them;
4. which relationships have become necessary;
5. which expectations have developed;
6. who formally owns the function;
7. who currently finances it;
8. who actually has the capacity to sustain it.

This produces an embeddedness map. The second step is a responsibility map: for every function, who should do it, who can do it, who currently does it, who currently pays for it, and what happens if that actor disappears? The third step is a transition stress test. Instead of asking merely whether a programme has an exit plan, planners should ask what breaks first if financing changes tomorrow. The 2025 health-financing disruption demonstrates why this question matters.

11. A Revised Model of Aid Afterlife

The findings support the following analytical model:





12. Implications

12.1 For development organisations

Donors should document not only outputs but embedded functions. A project completion report should identify:

- what routines were created;
- which relationships became necessary;
- which personnel remain dependent on project financing;
- which institutions now rely on project systems;
- which expectations have been created among beneficiaries.

12.2 For governments

Government ownership should be assessed through effective capacity, not solely formal institutional mandate. An institution may legally own a function while lacking the

personnel, financing, procurement systems or infrastructure needed to sustain it. Transition planning should therefore distinguish ownership from capacity.

12.3 For health financing

Health financing transitions require particular attention because interruptions can affect life-sustaining services. The 2025 Kenyan experience demonstrates how rapidly financing arrangements can become visible when workforce and commodity systems are disrupted. Kenya's subsequent emphasis on sustainable domestic financing and coordinated health investment indicates that the question of transition remains active rather than settled.

12.4 For evaluation

Evaluation frameworks should include an afterlife period. Instead of asking only whether the intervention achieved its objectives, evaluators should also ask:

- What remained?
- What disappeared?
- What was absorbed?
- What became ordinary?
- What became expected?
- Who inherited responsibility?
- Was the inherited responsibility actually resourced?

13. Limitations and Reflexivity

This study has several limitations.

First, the three cases are theoretically selected and are not statistically representative of Kenyan development interventions. Second, the Wings and TB cases currently contain a substantial retrospective component; memory can reconstruct experiences meaningfully but is subject to recall limitations. Third, the researcher's positionality creates both access and interpretive risk, since the researcher has personally experienced the education and health systems examined in the paper, making reflexivity and documentary triangulation essential.

Fourth, the external financing attached to specific services cannot always be established from patient experience alone: a patient may encounter a service supported by a complex mixture of domestic and external resources without knowing which financier supported which component. Fifth, the 2025 health-financing case is still developing, and its eventual afterlife cannot yet be known; the paper therefore treats it as an ongoing reconfiguration rather than a completed transition.

Finally, the study deliberately avoids treating external financing as either inherently beneficial or inherently harmful. The analytical question is what financing arrangements become embedded within, how responsibility is organised around them, and what happens when those arrangements change.

14. Conclusion

Development interventions rarely disappear at the moment their formal financing ends.

They remain in people.

They remain in institutions.

They remain in professional practices.

They remain in material infrastructures.

They remain in expectations.

They may even remain in the definition of what a society considers an ordinary service.

This paper has used three Kenyan cases to examine these afterlives. *Wings to Fly* illustrates the biographical afterlife of development: a scholarship formally ends, but education, relationships, identity and possible institutional pathways remain. TB care illustrates institutional and professional embeddedness, in which the patient encounters a health system whose external and domestic components may be difficult to separate at the point of care. The 2025 disruption of U.S.-supported health financing illustrates systemic embeddedness: when financing arrangements changed, the underlying architecture of health workers, commodities, community services and institutional relationships became visible.

Across the cases, therefore, the end of financing is not equivalent to the end of responsibility. Instead, financing change creates a redistribution problem.

Someone must continue the function.

Someone must finance it.

Someone must possess the institutional capacity to perform it.

And someone must be accountable when it fails.

The paper's central proposition is consequently not that greater aid necessarily creates greater dependency. Rather, the deeper development becomes embedded within individual lives, institutions, professional systems and material infrastructures, the more distributed and potentially less visible responsibility becomes. When external financing changes, the challenge is therefore not simply to replace money, but to identify and reassign the functions, capacities, relationships and expectations that the money had helped sustain.

This reframes development transition. The relevant question is not simply when aid ends. It is what aid has become part of by the time it ends, and who is responsible for what remains. That question places the afterlife, not merely the project cycle, at the centre of understanding development.

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Appendix A: Proposed Interview Framework

Former Wings to Fly beneficiaries

1. What did the programme provide beyond school fees?
2. Which parts of the programme remained important after secondary school?
3. Did your relationship with the programme end when the scholarship ended?
4. What relationships or opportunities continued?
5. At what point did you stop thinking of these things as part of a scholarship programme?
6. Who was responsible for your next stage after the scholarship ended?
7. Did that responsibility feel like a transfer, a continuation or something else?

TB health workers

1. Which functions of TB care depended on external financing?
2. Which functions were formally the government's responsibility?
3. Which functions were actually performed by external partners?
4. How were patients followed when they missed treatment?
5. What happened when commodities or nutrition support were unavailable?
6. Which professional practices remained after externally supported programmes ended?
7. If external financing disappeared tomorrow, what would stop first?
8. Who would be expected to take over?
9. Who would actually be able to take over?

2025 health-financing actors

1. Which health-system functions were most affected by the financing disruption?
2. Which functions were formally government responsibilities?
3. Which functions were financially dependent on external support?
4. Which functions could the government immediately absorb?

5. Which functions required another partner?
6. What happened to health workers?
7. What happened to commodities?
8. What happened to data and laboratory systems?
9. Which temporary arrangements became permanent?
10. What does “country ownership” mean operationally?
11. What responsibilities have actually shifted?
12. Which responsibilities remain externally financed?

Appendix B: Analytical Coding Framework

Code family	Indicative codes
Embeddedness	individual, institutional, professional, material, social, expectational
Resources	money, commodities, personnel, training, infrastructure, information
Visibility	visible, invisible, normalised, revealed by disruption
Responsibility	formal, financial, effective, transferred, contested
Time	arrival, embedding, completion, disruption, transition, afterlife
Capacity	existing, created, borrowed, retained, lost
Continuity	continuation, adaptation, substitution
Discontinuity	interruption, abandonment, closure, decay
Actors	government, donor, NGO, professional, community, beneficiary
Outcome	individualisation, distribution, reconfiguration