FRAUD MITIGATION PRACTICES AND FINANCIAL PERFORMANCE OF INSURANCE COMPANIES IN KENYA

SARAH WAMBUI NG'ANG'A

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DECLARATION

I declare that this project is my original work and has not been presented for any academic award in any other university.

Signed……. Date…08/12/2022……

SARAH WAMBUI NG'ANG'A

D61/90092/2016

Approval by the Supervisor

This project is submitted for examination with my approval as the university supervisor.

Signed..... ..... Date.....7.12.2022.....

DR. CAREN ANGIMA

SENIOR LECTURER

DEPARTMENT OF BUSINESS ADMINISTRATION

UNIVERSITY OF NAIROBI

DEDICATION

I dedicate this research project to my father Harris Gitau Ng'anga and my mother Jecintah Wanjiku Gitau who provided me with their immense support and motivation throughout my studies. Their love, care, encouragement and support enabled me to achieve this goal. God bless you.

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ABBREVIATIONS AND ACRONYMS

AKI	Association of Kenya Insurers
APT	Arbitrage Pricing Theory
GDP	Gross Domestic Product
IIK	Insurance Institute of Kenya
IRA	Insurance Regulatory Authority
MIP	Medical Insurance Providers
ROA	Return on Assets
ROE	Return on Equity
SMEs	Small and Medium enterprises

ABSTRACT

Many insurance firms have failed as a result of fraud. Insurance firms face the possibility of fraud from both their internal and external settings. Fraud presents both policyholders and insurance companies with significant and costly challenges. Insurance fraud causes a company high settlement costs and losses eventually affecting their performance. This research aimed to assess how fraud mitigation practices affect the financial performance of insurance companies in Kenya. This study was founded on the Fraud Triangle Theory, Fraud Diamond Theory and the Fraud Management Life Cycle Theory. A descriptive research design was adopted and a target of all the 56 licensed insurance firms in Kenya. A census of the 56 licensed insurance firms in Kenya was applied. Both secondary and primary methods were used in data collection. The respondents were the claims manager in each of the insurance firms. The completed questionnaires were sorted, edited and coded for easy inputting in the computer system for analysis. Descriptive statistics and inferential statistics were employed in the data analysis. The study found that fraud mitigation practices affect the financial performance of insurance companies in Kenya. Fraud prevention, fraud detection and fraud response practice have positive and significant effects on the financial performance of insurance companies in Kenya. The organisations perform fraud risk assessments on a regular basis. Human resource departments do thorough pre-employment screening, and organisations have robust anti-fraud procedures in place. There are internal and external audits that detect any fraud. The businesses have fraud detection systems in place, and firm resources are counted on a regular basis. Employees who are accused of or related to fraud risk disciplinary action. The organisations have developed risk response plans and carry out fraud investigations. To help the government comprehend the scope of the issue, the Insurance Regulatory Authority should create regulations mandating all insurance providers to gather and submit statistics on fraud. The insurance firms should ensure that they provide adequate training to their employees on fraud management. The insurance firms should have harsh penalties and disciplinary actions for any employee linked to fraud since such employees could be a major loophole in the fraud mitigation process. The insurance companies should also place a primary emphasis on the prevention of fraud through the use of cutting-edge technology and rely on the aid of specialized vendors to assist them in achieving this goal.

CHAPTER ONE:

INTRODUCTION

1.1 Background of the Study

All economic sectors are faced with hurdles and challenges that require innovations to develop new ways of doing business as a way of surpassing the challenges brought about by change, improved technology, rules, and regulations set by governments. Businesses now place a lot of focus on risk management since it affects their ability to survive and operate (Durst & Zieba, 2019). Since insurance companies are in the risk-taking industry, they insure a wide range of hazards for people, organizations, and corporations. Many insurance firms have failed as a result of fraud. Insurance firms face the possibility of fraud from both their internal and external settings. Fraud presents both policyholders and insurance companies with significant and costly challenges (De Leeuw, 2014). Insurance fraud causes a company high settlement costs and losses eventually affecting their performance. A strong fraud risk management strategy can assist firms in reducing their exposure to fraud risks while also improving their financial performance (Pumsirirat & Yan, 2018).

Various theories anchor this study; Fraud Triangle Theory, Fraud diamond theory and the fraud management life cycle theory. The Fraud Triangle Theory outlines why someone would decide to commit fraud. The opportunity, motive, and rationalization are the three factors identified by the fraud triangle as factors that raise the risk of fraud (Cressey, 1953). The Fraud Triangle idea evolved from the Fraud Diamond theory, in which despite the presence of the opportunities, pressures and rationalizations, Ruankaew (2016) argue that fraud is not conceivable unless capacity, the fourth ingredient, is present. Potential actors must be skilled and capable of committing fraud. The theory of fraud management life cycle on the other hand presents eight stages for fraud risk mitigation that consist of deterrence stage, prevention, detection, mitigation, analysis, policy, investigation and prosecution (Wilhelm, 2004).

According to a report by Cytonn (2021), fraudulent claims have increased recently in Kenya's insurance industry, especially in the fields of medical and automobile insurance, where it is estimated that one in five claims are false due to hospitals forcing patients to undergo pointless tests and inflating medical bills. A total of 143 fraud instances were reported in 2020, with 16.8%

of those involving motor vehicle accident injury claims and 16.1% involving agent theft. The majority of companies in the country have developed assessment centers in order to more precisely analyze real remuneration, and the sector as a whole has accepted the usage of block chain technology and artificial intelligence in order to cut down on fraudulent activity. Research interests have been drawn to the field in response to the rise in fraudulent activities in an effort to broaden understanding of the subject and give potential answers to the issue.

1.1.1 Fraud Mitigation Practices

Fraud is a dishonest deed that encompasses intentionally distorting the truth or making a false statement or hiding a substantial fact to get an unfair gain over someone else, get something for free, or take away their right (Duffield & Grabosky, 2011). It happens when a criminal makes false claims to steal something valuable from a victim. Albrecht et al. (1984) put fraud into nine categories: spending more than one earns, harboring an unhealthy obsession with material success, carrying a heavy debt load, and keeping a low distance from one's clientele, thinking that one's pay doesn't match up with their duties or feeling too much pressure from family or peers. Richard Hollinger and John Clark concluded that most employees steal because of how the workplace is set up.

To intentionally mislead an insurance company or agent for financial benefit is considered insurance fraud (Al Rawashdeh & Al Singlawi, 2016). It is possible for fraud to occur at any stage of the claims process, including by applicants, policyholders, third-party claimants, and professionals providing services to claimants. However, insurance fraud can also be conducted by in-house employees and brokers. "Padding," or exaggerating claims, is a common form of fraud, as does providing false information on an insurance application; submission of faked damage and claims for injuries and staging incidents. Fraud in the insurance industry has metamorphosed in form from making fraudulent claims to collusion by market players with the intent to deceive and obtain undue gains from the process (Okumu, 2017). Insurance fraud has crippled cash flows in most companies as claims that did not deserve payment continue to be paid. Liquidity risks that have threatened the survival of firms continue to rise, and the need to address the challenge increases by the day (Insurance Regulatory Authority, 2018).

The insurance firms have been tasked to undertake various practices that would result in the mitigation of fraud practices. Audits, forensic investigations, internal control systems, and legal

sanctions have been frequently used by firms to ensure that they mitigate exposure to fraud. According to Zamzami et al. (2016) to mitigate fraud, it was vital to ensure that the company undertakes extensive audits, reviews its internal processes and controls set in place; reviews cash management policies, and set controls to sanction suppliers, contractors and other important officers. The Association of Certified Fraud Examiners (2014) asserts that an ordinary company incurs a 5% loss; of its annual revenue through fraud perpetrated by employees, which is exercised in three different ways: Asset mismanagement, misstatements of financial records and outright corruption. The fraud could be detected and mitigated by understanding and monitoring employees, ensuring that proper internal control measures are well established, hiring experts in project implementations, and inculcating positive organizational culture that is free from corruption and fraud-proof.

1.1.2 Financial Performance

Bhunia and Mukhuti (2019) describe the financial performance of a firm as the degree to which a company or organization has met its financial goals. It shows the efficiency as well as competence with which organizations utilize their assets in bringing value to the organization and meeting the overall objectives. The most used and suggested gauges of economic performance scrutiny consist of productivity, liquidity along with solvency. The important ratios used and usually recommended for profitability are; the operating profit margin in addition to net revenues, return on assets (ROA); return on equity (ROE) (Chung & Young, 2019).

The financial performance of a company can also be utilized to gauge the financial status of a company in a particular period and be utilized to evaluate comparatively companies that are alike in a particular industry or to conduct comparisons across industries or divisions. There are many approaches employed to determine a firm's financial achievement. For example, revenue generated from income operations and also cash flows derived in the operation of the business are reflectors of financial performance (Shabbir & Wisdom, 2020). In the knowledge that making a profit is the core objective of business, it can also be a measure of the company's financial performance. ROA adds to the crucial ratios for measuring the productivity of insurance companies. Schiniotakis and Divini (2018) assert that Return on Assets (ROA) is an important measure that would be effective in determining financial performance in institutions and firms dealing with financial services.

1.1.3 Insurance Companies in Kenya

The Insurance Institute of Kenya (IIK) is a professional organization that is responsible for the certification of competent employees and the maintenance of professional standards in the delivery of insurance services. It has also set up a self-regulatory body Association of Kenya Insurers (AKI) that works under the government regulatory body, the Insurance Regulatory Authority (AKI, 2017). The industry operates under an Act of Parliament in Company Laws CAP 487. Underwriting practices divide Kenya's insurance industry in two distinct ways. The two categories are Life and General insurance. There are more insurance companies participating in general insurance than there are in life assurance, and general insurance has a significant market share. The main stakeholders in the insurance sector in Kenya comprise of the insurance companies, insurance brokers, risk managers, insurance agents, and reinsurance companies. There was a 13.4-fold increase in insurance industry insider fraud in 2020, with total losses reaching Sh258.4 million, up from Sh19.2 million the year before.

As per AKI (2020) report, it is estimated that 25% of insurance industry claims are related to fraudulent claims. False motor insurance claims and theft by insurance agents accounted for the majority of reported fraud cases in 2019 and totaled KES 386 million over the course of four years (2016–2019). General insurance fraud cases are more common than life insurance fraud cases. According to the data, motor vehicle insurance fraud cases accounted for almost 80% of all reported incidents in the insurance sector. Criminal aspects such as murder, impersonation, and data manipulation, among others, have been revealed in reported fraud cases involving life insurance (Insurance Regulatory Authority, 2021). The industry had incurred losses to the point where some businesses were put into receivership. Insurance firms such as Standard Assurance, Concord Insurance, United Insurance Company Ltd and Blue Shield Insurance Company could no longer hold and were therefore placed under receivership. The extent to which their state was aggravated by fraud has not been officially communicated but it may not be wished away (Ernst & Young, 2012). According to a survey by the Rural Private Hospitals Association, insurance fraud in the medical sector alone costs Kenya up to Sh33 billion.

During the Covid-19 period, IRA (2021) found that fraud cases in general increased by 53%, reaching 127 instances with a total value of Sh327.7 million. The motor, medical, and theft by agent cases were the most prevalent types of fraud, followed by insider fraud. The goods that

insurance firms provide are, for the most part, the same; nevertheless, every insurance provider also provides customers with a unique collection of value-added services. The mitigation measures applied are similar for both Life and Non-life insurers.

1.2 Research Problem

Fraud poses substantial and expensive challenges to both policyholders and insurance companies (De Leeuw, 2014). For genuine policyholders, the existence of fraud delays the settlement of claims when they incur a loss. Fraud results in high settlement costs on the insurer that would strain its resources. The insurer may also lose the trust of its clients, particularly in the instances when it is incapable of paying off claims on time as stated in the policy. The strenuous relationship between the two parties decreases revenue to the insurer as fewer and fewer clients underwrite with them and eventually, the financial performance of the insurance firm is adversely affected. However, studies highlight that despite the increase in fraud mitigation practices introduced in insurance companies, the sophistication and volume of fraudulent claims have been increasing over the years, more so, electronic fraud. As a result, insurance firms must undertake due diligence in ensuring that they invest in risk mitigation practices that are effective in combating the vice. If the current trend is not reversed, then the risk will continue to have a negative consequence on the firm performance (Chege et al., 2019).

The issue of claims fraud and build-up is a major concern among insurance companies. Fraudulent activities affect the internal operations of an insurance firm. Therefore, most firms prefer to handle cases regarding fraud internally rather than exposing them to the public. Kanana (2018) asserts that fraudulent activities in insurance firms continue to be unreported on public forums, as the management conceals such information as it may be damaging to their potential market and client. The information might also increase panic among their clients which would additionally affect their cash flows. AKI (2016) indicates that the underwriting of motor vehicle insurance in Kenya has become a high-risk venture because of unwarranted claims imposed on the insurance companies. From 2019 to 2020, insider fraud at insurance businesses increased to the tune of Sh 258.4M, up from Sh19.2M in 2019. The Insurance Fraud Investigation Unit (IFIU) received reports and discovered a total of 127 instances of insurance fraud in 2020, which is an increase from the 83 cases that were discovered in 2019 (IRA, 2021). It is, therefore, crucial to determine

the consequences of various practices and fraud detection techniques on the financial performance of insurance corporations in Kenya.

Grima and Bezzina (2018) assessed techniques in risk management implemented by European financial institutions. Nonetheless, the European setting of the study precludes extrapolation of the results to other regions. Chifwelu (2020) investigated how risk management has affected Zambia's insurance firms' profitability. The study however presents contextual gaps as the insurance firms in Zambia may not reflect the status of the insurance firms in Kenya. Kimathi (2018) sought the fraud risk management on NGOs in Nairobi County. The focus was on NGOs whose findings cannot be generalized to suit insurance firms. While Ohando (2015) studied fraud risk management and the financial success of Kenya's commercial banks, the same has not been done for the country's insurance companies. Onyango (2021) looked at how Kenyan general insurers handle the threat of fraud and how that affects their bottom line. The study was limited to general insurance only. The study adopted causal descriptive design which is designed to determine causes and effects while the current study seeks to adopt descriptive research design. Kiprono and Ng'ang'a (2018) evaluated fraud administration practices at Kenya Ports Authority and financial performance. The scope of the study differs in the sector of focus thus cannot suit the insurance sector. The study, therefore, ignored the private sector that forms the majority of insurance companies in the country.

From the past studies on risk management and financial performance, very little evidence has been found to show how fraud mitigation practices impact the financial performance of insurance firms in Kenya. The studies have either presented contextual gaps or methodology gaps that this study ought to fill. So, the goal of this study was to answer the question; how do fraud mitigation practices influence the financial performance of insurance firms in Kenya?

1.3 Research Objective

This research aimed to assess how fraud mitigation practices affect the financial performance of insurance companies in Kenya.

1.4 Value of the Study

This research might be helpful to the government as the policy maker and the regulating body, IRA by providing information on fraud and the impact on insurance firms' financial performance.

The information may be used in developing necessary regulations that would ensure that fraudulent activities are discouraged and thus not adversely affect the operations of insurance companies.

In the insurance sector, firms may also be in a position to develop tailor-made policies that would guarantee that clients', as well as the firm's objectives, are achieved tactfully and strategically. The management would therefore devise specific solutions and fraud risk management practices for their specific firms to maximize their returns.

The study may be of value to academicians. The study may contribute to existing theories by either critiquing or supporting the theories and therefore contribute to knowledge. Future scholars may also find this study helpful as it may contribute to their literature review and be important in assessing their research gaps.

The study may be of value to the theoretical foundation. It may add value to the theories underpinned in the study such as the fraud management life cycle by revealing the practices in the fraud mitigation among the insurance firms and comparing with the theory propositions to add to its strengths or weaknesses.

CHAPTER TWO:

LITERATURE REVIEW

2.1 Introduction

This section reviews the literature and focuses on the theoretical foundation, the empirical literature, a summary of empirical literature and study gaps and the conceptual framework.

2.2 Theoretical Foundation

This study relies on provisions of various theories that relate to fraud mitigation practices and financial performance. These theories comprise Fraud Triangle Theory, Fraud Diamond Theory and The Fraud Management Life Cycle Theory.

2.2.1 Fraud Triangle Theory

Fraud Triangle Theory (FTT) started from the works of a criminologist Cressey (1953). He proposed that there must be a reason behind everything that people did. From the research he conducted by interviewing 250 criminals; he grouped the reasons of committing fraud into pressure, opportunity besides rationalization. He said that any or all of these three factors must exist before a person commits fraud. On pressure, he found out that people who commit fraud are under internal pressure or external pressure such as debt, drug addiction, meet personal goals among others. Similarly, some people commit fraud since an opportunity arises where they can be able to commit fraud without being caught, or if they are caught, the consequences are not dire. According to Cressey (1953), some people are led into committing fraud as a result of rationalization. They rationalize that they are not paid enough for their efforts. They may also justify that the organization does not appreciate and recognize their vital contributions and therefore they get involved in fraud.

Several criticisms have been brought forth on FTT despite the huge acceptance that the theory received in both the accounting and auditing field. In the first instance, the theory was criticized for lack of rigorous scientific testing. The scientific testing that was undertaken has been put into question on the ability of the proposition of the theory to be applied to all societies. Cressey (1953) did not focus on the personality traits of the offenders. This may also have a great impact on perpetration of fraud and may bias results when an individual with similar personality traits are

interviewed as in the case with the theory where they only tested known criminals. Critics further argue that the theory fails to emphasize the critical contribution of rationalization to the decision of committing fraud. Critics suggest that the critical link between the fraudster's mind and the fraud itself is rationalization. Downplaying its role, therefore, undermines full understanding of why people commit fraud (Ganon & Donegan, 2008).

The theory is useful to the research as it expounds the motivation for undertaking fraud. Firms that desire to mitigate fraud, ensure that they address motivations to undertake fraud. The fraud mitigation practices would include ensuring that employees are well remunerated equivalent to their contribution to the firm, they ensure that a robust internal control mechanism is established in the firm to prevent incidence of opportunity to undertake fraud and also implement measures that address personal employees' problems and institute programs that help to address personal employees' challenges. The implementation of these measures to prevent fraud costs a lot of money, therefore businesses need to be mindful of those expenses if they want to keep their companies profitable. This means that there is a need for a balance where fraud is not encouraged and where too much mitigation practices are not adopted that would escalate the costs of operations and reduce the profitability of the firm.

2.2.2 Fraud Diamond Theory

This theory is characterized as an expansion of the Fraud triangle theory. It was first proposed by Wolfe and Hermanson (2004) where it adopts the three factors that lead people to undertake fraud. However, they added the element of capability. Where they argued that for fraud to take place, pressure, rationalization or perceived opportunity may not be enough but there must exist capability for the fraud to take place. This means that potential fraud perpetrator must also have the capacity, skills and the power for him/her to undertake fraud. The theory is based on the notion that having perceived pressure, having an opportunity and rationalizing fraud is not enough but a potential fraud perpetrator must be able to recognize that there is an opportunity and able to take the opportunity. The theory therefore focuses not only on available set of incentives to commit fraud, but also on the personality of the person who intends to defraud.

This theory is important to the research as it assists organizations to narrow down to not only individuals who have opportunity and are under pressure to commit fraud, but also have a

personality which makes them undertake fraud. Wolfe and Hermanson (2004) further proposed that people who are able to defraud have a high understanding of the internal control system in place and understands how to beat it to commit fraud undetected. They are also confident and they are aware that if caught they are able to deal with consequences of fraud. This theory has however been criticized by the fact that it is quite difficult to single out personality types that are able and can commit fraud. It becomes an exercise in futility when an organization goes on a hunting expedition trying to fish out employees who have the capacity and ability to commit fraud. This would absorb quite a lot of resources and time in trying to study the behavior and personality traits of employees (Mackevicius & Giriunas, 2013).

2.2.3 The Fraud Management Life Cycle Theory

The theory of fraud management life cycle was first proposed by Wilhelm (2004) who proposed that in the management of fraud, it goes through eight stages cycle that consist of deterrence stage, prevention, detection, mitigation, analysis, policies, investigations and prosecution. These eight stages need to strike a balance as some stages involves competing and others complementary actions. In the first stage, the deterrence stage, involves undertaking actions that deter fraud from taking place before it does, This include setting mechanisms and controls that ensures that people would not breach the internal control system in place to perpetuate fraud. The next stage, prevention, prevents fraud from taking place, the third stage involves activities that detect fraud as quickly as it takes place, and these activities include monitoring programs, surveillance activities among others. The other stage is mitigation which aims to ensure that the organization does not incur losses or rather does not continue to incur losses due to repeated fraud activities. These activities are aimed at curbing the possible losses that would emanate from any fraudulent activity. In the fifth stage, analysis, it involves activities that are undertaken to identify and study the factors which led to loss situation that was occasioned by fraud. The other stage is policy where from studying the cause and determinants of fraud, then policies are developed that would ensure that there would be no future attempts on fraud. Investigation, the seventh stage involves ensuring that all facts pertaining to the fraudulent activity are investigated and documented in order to be prosecuted in the last stage.

The theory is imperative to the research as it details all the stages an organization goes through in order to mitigate fraud. This study would therefore rely on provisions of this theory in identifying

the stages that have been put in place by firms in the insurance industry to curb losses that arise from fraud. Worth noting is that as an organization increases its robust mechanism of mitigating fraud, then the more costly it becomes to the firm and therefore increases operational costs that would lead to reduced profitability. On the other hand, if a firm is reckless or does not invest adequately in fraud mitigation practices, then it gives a green light to fraud perpetrators to perpetrate fraud, which may lead to massive losses. This study, therefore, bring out techniques and modalities that have been implemented by varied organizations in the insurance business to deal with fraud and how that decision has impacted their financial performance (Barney, 2001).

2.3 Fraud Mitigation Practices and Firm Performance

Preventive fraud mitigation processes are measures that aim to decrease fraud and misconduct first and foremost. Building effective internal controls, creating a moral framework and related principles, performing due diligence, communicating with and training employees, and carrying out procedures are just a few examples. Structured risk assessment, according to Levin and Bulow (2016), is the cornerstone for fraud prevention and detection because it addresses the genuine risks that the business faces in light of its mission, product line, market, degree of complexity, size, and vulnerability to network attacks. The goal of the evaluation in a typical expected value framework is to determine the kind, likelihood, and potential cost of threats. This helps the company to modify program efforts in order to mitigate costs effectively, which may involve having a higher or lower tolerance for a specific risk.

Examining how employees, particularly senior management, interact with the organization's resources is necessary for assessing fraud threats. Their incentives and opportunities, one of the fraud triangle aspects, are heavily influenced by the organization. As a result, the risk assessment process needs to be extremely explicit and thorough regarding how specific roles interact with controls, rules, and procedures. It's critical to keep in mind that these risks could have internal and external origins, particularly in highly networked and data-dependent processes (Kazemian & Vakilifard, 2019).

Fraud prevention is preferred above fraud detection, claims Khrawish (2019). In reality, fraud may be detected using the same policies and controls that were put in place to prevent it like duty segregation. A culture of fraud awareness, comprehension of generalized norms and practices; a protected environment for informants, and continual communication about the need for fraud prevention from the top down are all components of prevention, according to Khrawish (2019).

When everyone is aware that fraud is a real potential and a serious issue for which the company has established detection processes, it is less probable to happen.

According to Tasiou's research in 2019, concerns with financial management that are unique to insurance businesses are challenges that are faced by very few other types of organisations. However, the problems can be fixed by implementing a number of controls, such as internal controls, service adequacy, prudential management standards, external oversight, and transparent financial reporting methods.

Fraud detection involves actions and activities that facilitate the quick detection of fraud before heavy losses are incurred (Pourhabibi et al., 2020). It helps to ensure that despite any fraudulent activity that was neither deterred nor prevented is identified, soon enough before heavy losses are incurred by the firm and therefore cripple its financial performance. The activities that are associated with fraud detection embrace applied mathematics observance applications used to establish and to unearth fraudulent behavior before, during, and after it has been committed. The objective of detection gives evidence of the perpetuation of fraud or a fraud trial. Fraud detection activities monitor irregularities in the operations of the firm and seek logical clarifications for activities that are outside the norm. It also assesses changes in employees' behavior that have the capacity or an opportunity in undertaking fraud (Macailao, 2020).

Fraud detection can reveal both active frauds and crimes that have already taken place. The use of preventative strategies may have little effect on such schemes, and even if the fraudsters were to be stopped in the future, the only method to recover damages incurred in the past would be through fraud detection (Pumsirirat & Yan, 2018). However, a detection program's primary objective is not to recoup damages, so fraud should not be disregarded merely because some losses may not be recovered. The improvement of internal systems and controls is another benefit of fraud detection. Control system weaknesses are frequently used in fraud. By screening such plans, potential offenders can face tighter controls to execute (Alghofaili, 2020). Detecting fraud helps to make sure that any fraudulent behaviour that wasn't stopped or avoided is found quickly enough to prevent the company from suffering severe losses that would impair its ability to make money. Applications of applied mathematics are used to establish and uncover fraudulent activity before, during, and after it has been committed. These activities are related with fraud detection. The goal of detection provides proof of ongoing fraud or a fraud trial. Fraud detection efforts keep an eye

out for abnormalities in the company's operations and look for logical justifications for actions that are out of the ordinary. Additionally, it evaluates behavioural shifts among personnel that might indicate a potential for fraud.

Implementing corrective measures and repairing fraud-caused harm are the objectives of responsive fraud management. Every time fraud is found, Line Management should assess the internal control environment, focusing on controls that directly affect fraud, to decide whether any changes are needed. Division management must analyse the internal control environment and execute its recommendations (Fakunmoju & Olukayode, 2021).

According to Nyanga (2018), internal audit is a service that provides unbiased and impartial auditing and consulting to ensure that the CEO and Board are satisfied that the entity's controls are effective, ethical, and efficient, and to support management in enhancing the entity's operations. In addition to this, it may assist a company in managing fraud management by providing advice on fraud risk as well as monitoring and preventive strategies (Hussaini, Bakar & Yusuf, 2018). An effective strategy for internal auditing is crucial.

2.4 Empirical Studies and Knowledge Gaps

In 2017, Abdul and Syahira conducted an investigation of the efficiency of fraud prevention and detection strategies used by Islamic financial institutions in Malaysia. Based on the results of 146 surveys distributed, it was determined that fraud prevention techniques most effectively used protection software/applications. In contrast, when evaluated separately, successful solutions include bank reconciliation, password security, and internal control evaluation and improvement. The study's context is different from the current study. The earlier study was carried out in Malaysia and concentrated on Islamic banks, whereas the present study would concentrate on insurance companies in Kenya.

Rehman and Hashim (2020) conducted research to determine how the presence of fraud risk influences effective corporate governance in publicly listed firms in Oman. We went with a quantitative approach, and PLS-SEM was the method that we used to examine the data. The findings showed that adopting fraud assessment and implementing it will help achieve excellent corporate governance. Additionally, the results showed that adopting and implementing it will help achieve excellent corporate governance. Due to the fact that the research was carried out in Oman, the results may not be applicable to the situation in Kenya; thus, a study in Kenya was required.

Matsoro (2020) set out to measure the impact of fraud risk management systems on the profitability of mobile financial services: evidence from MTN Uganda. The findings showed that mobile service provider employees implication was key source of fraud. The assessment revealed a positive link between the number of complaints, mobile money provider employee's implication in the fraud, use of valid identification, customer due diligence and the financial performance. The study presents knowledge gaps as it is conducted in the Ugandan context and focus on mobile financial services while the current study focused on insurance firms.

Ohando (2015) on the other hand focused on investigating fraud risk management and the overall monetary performance of banks in Kenya. The study collected primary study by the utilization of structured questionnaire and regression and multivariate analysis was used. The study identified a significant association. Detective and preventive fraud risk management had superior correlation. The major knowledge gap in this study is the focus on commercial banks and neglected insurance companies. Therefore the current study's focus was on insurance companies.

Nyongesa (2017) conducted a study that examined financial management techniques and bottom lines of insurance firms in Kenya. It was shown that the use of claims management best practises has a beneficial and statistically significant influence on the profitability of Kenyan insurance businesses. It was shown that company variables also play a role in the association between successful claims management strategies and financial performance for Kenya's insurance companies. The research presents conceptual gaps as it focused on financial management practices while the current study focuses on fraud risk mitigation practices.

In Nairobi City County, Kenya, Gachuru (2020) evaluated the impact of internal reconciliation procedures on fraud prevention in listed insurance firms. The study population consisted of 147 employees from the aforementioned insurance businesses. The data was gathered using a standardized questionnaire. The study's findings indicated that internal reconciliation tactics and fraud prevention had a favorable, significant, and statistically significant association. The study did not compare fraud mitigation practices to financial performance but focused on how internal reconciliation strategies enhanced fraud prevention in the insurance industries, a gap which the current study sought to fill.

Ndichu (2019) aimed to identify the financial performance and fraud risk management procedures of Kenyan insurance businesses. From the quantitative data, the study established detective

financial risk management resulted in overall increase in the performance of the insurance firms. Responsive financial risk management resulted in an overall decrease in the performance of the firms. The study adopted correlational analysis method.

Kariuki et al. (2021) conducted research to determine how the liquidity of Kenyan insurance businesses affected their overall financial performance. A correlational approach to research design was used for this study. Liquidity boosts financial success, the investigation found. Conceptual gaps exist between the research on liquidity and the current study on fraud mitigation methods and financial performance. The current study used descriptive research whereas the previous study used correlational research thus presenting methodology gaps.

Kimathi (2018) examined Nairobi County NGO financial performance and fraud risk management. Descriptive research was used, where structured questionnaires were used to gather data from 170 finance managers in various NGOs in Nairobi County. The study found that most NGOs in Nairobi monitored fraudulent activities on weekly basis. Fraud deterrence and fraud detection significantly impacted the financial performance of the NGOs. The main knowledge gap between the study and the current research is in the subject of the research. This study concentrated on NGOs in Nairobi County whose fraud risk exposure may not be comparable to insurance companies.

CHAPTER THREE:

RESEARCH METHODOLOGY

3.1 Introduction

The systematic approach the study employed to achieve the study objectives is outlined in this chapter. The research design is presented. It points out the population of the study, data collection methods and the approaches that were adopted in the analysis of data.

3.2 Research Design

The study used a descriptive research design which is utilized to describe study variables. It answers questions on what, but does not answer the question on why. According to Kothari (2005), a research design should be appropriate in helping the researcher address the research questions and therefore meet the research objective adequately. It helps to relate fraud mitigation practices and financial performance for licensed insurance firms in Kenya.

3.3 Population of the Study

A population is a group of objects, items, or people who share observable traits. The study targeted all the 56 licensed insurance firms in Kenya (IRA, 2022) (See appendix III). The study was a census of the 56 licensed insurance firms in Kenya.

3.4 Data Collection

The study collected data in a number of different ways, including both secondary and primary sources. Secondary data were derived from the audited yearly financial reports filed with the IRA by insurance firms. On the other hand, data on fraud mitigation practices were gathered by using primary data gathering strategies. A questionnaire was used to gather data on fraud mitigation practices.

The study respondents were the claims manager in each of the insurance firms. The data was collected through a drop and pick method where the researcher administered the questionnaire to the claims managers and pick at a later date. The claims managers were selected since they are the ones responsible for analyzing and predicting risks and thus have the required knowledge on fraud mitigation. The questionnaires had closed-ended questions with likert scale type questions. For the

secondary data, the research reviewed the financial statement of the insurance firms and obtain the required data to calculate the return on assets.

3.5 Data Analysis

The completed questionnaires were sorted, edited and coded for easy inputting in the computer system for analysis. SPSS computer package was used in the analysis. Descriptive statistics were used for the analysis and presentation of data. This included standard deviations, proportions, means, and frequencies. The results were presented in tables and interpreted based on the study objectives. In addition to descriptive statistics, inferential statistics was employed to evaluate the relationship between the variables. As illustrated below, the relationship was evaluated using a multiple regression model:

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon_i$$

Whereas

Y= Financial performance (profitability)- was determined by return on Assets.

β_0= Constant

β_1, β_2, and β_3 are coefficients of X_1, X_2, and X_3 respectively.

X_1 represents Fraud prevention practice that was determined through a 5-point likert scale from the questionnaire.

X_2 represents Fraud detection practice that was determined through a 5-point likert scale from the questionnaire.

X_3 represents Fraud response practice that was determined through a 5-point likert scale from the questionnaire.

ε_i is the error term.

CHAPTER FOUR:

DATA ANALAYSIS RESULTS, INTERPRETATION AND DISCUSSION

4.1 Introduction

The interpretation and presentation of the results are covered in this chapter. The purpose of this study was to evaluate how fraud mitigation practices impact insurance firms' financial performance in Kenya. The chapter begins with the response rate, then general information, findings on fraud prevention, fraud detection and fraud response. The chapter further covers the regression analysis.

4.2 Response Rate

This study targeted 56 claims manager one from each of the insurance firms. Questionnaires were distributed to all targeted respondents. All responders who were targeted received questionnaires. Nonetheless, only 51 of the 56 questionnaires issued were entirely completed and returned, contributing to a 91% response rate. For the data analysis, this response rate was sufficient.

4.3 General Information

4.3.1 Years of Existence

The goal of the research was to determine how long the organization has been in operation. The findings are as reflected in table 4.1

Table 4.1: Years of existence

	Frequency	**Percentage**
Below 5 years	1	2.0
6-10 years	3	5.9
11-20 years	9	17.6
Over 20 years	38	74.5
Total	**51**	**100**

Source; Research Data

According to the results of the study, over three quarters of the companies have been operating for more than 20 years, 17.6% from 11-20 years, 5.9% for 6-10 years and only2% has been in

existence for less than 5 years. The findings imply that the majority of the firms have been in operation for some time to have experienced fraud cases and to have had fraud mitigation practices.

4.3.2 Experience of Fraud

The study sought on the extent to which the firm experience fraud. The findings are reflected in Table 4.3

Table 4.2: Experience of fraud

	Frequency	**Percentage**
Small extent	18	35.3
Moderate extent	26	51.0
Large extent	7	13.7
Total	**51**	**100**

Source; Research Data

According to the data, slightly more than half of those who responded (51%) indicated that their firm experience fraud to a moderate extent, 35.3% indicated small extent and 13.7% indicated large extent. The findings imply that the insurance firms experience notable level of fraud and further supporting the value for the study.

4.3.4 Annual Income in Millions

The sought the firm's annual income over the years. The findings are revealed in table 4.3

Table 4.3: Annual income in millions over the years

Year	**Less than 250M**	**250-350M**	**351-450M**	**451-600M**	**Over 600M**
2017	3.9	13.7	23.5	35.3	23.5
2018	9.8	15.7	19.6	33.3	21.6
2019	5.9	5.9	27.5	43.1	17.6
2020	100	0	0	0	0

Source; Research Data

The study found that most of the firms had an annual income of 451-600M in 2017, 2018 and 2019. For the year 2020 all the firms had an annual income of less than 250M. The findings shows the trend in annual income and also imply that all the firms experienced economic hardships in

2020 and 2021 that reduced their financial performance which may be attributed to the Covid-19 pandemic.

4.4 Fraud Prevention Practice

In assessing the fraud prevention practice, the responders were asked to rank their degree of of agreement on fraud prevention practice based on their firm. The results are summarized in in Table 4.4.

Table 4.4: Fraud Prevention Practice

Fraud prevention	N	mean	Std.dev
The organization conducts frequent fraud risk assessments	51	4.10	0.95
The organization has strong internal controls through separation of duties	51	3.86	1.09
We have an established code of conduct	51	3.95	0.63
All the staff are trained on fraud risks and their management	51	3.68	1.04
The human resource department conducts comprehensive pre-employment screening	51	4.05	0.65
We conduct due diligence in the organization's operations	51	3.84	0.73
Access controls have designated employees	51	3.79	0.84
The company has effective antifraud policies	51	4.02	0.76
Average		**3.911**	**0.836**

Source: Research data

The study results reveal that the respondents agreed that the organization conducts frequent fraud risk assessments (mean=4.10,std,dev=0.95), the human resource department conducts comprehensive pre-employment screening(mean=4.05,std.dev=0.65) and the company has effective antifraud policies(mean=4.02, std.dev=0.76). The respondents further agreed that they have an established code of conduct(mean=3.95, std,dev=0.63), the organization has strong internal controls through separation of duties(mean=3.86, std,dev= 1.09). The respondents also agreed that they conduct due diligence in the organization's operations(mean=3.84, std,dev=0.73), that access controls have designated employees(mean=3.79, std,dev=0.84) and that all the staff are trained on fraud risks and their management(mean=3.68, std,dev=1.04). The average mean was

3.911 and average standard deviation of 0.836 implying that the firm undertakes fraud prevention practice.

4.5 Fraud Detection Practice

The respondents were requested to rate their level of agreement on statements provided on fraud detection practice based on their firm.

Table 4.5: Fraud Detection Practice

Fraud detection	N	Mean	Std.dev
There are internal and external audits that detect any fraud	51	3.88	0.88
The companies data is analyzed to detect any inconsistencies	51	4.00	0.77
The firm has a fraud profiling mechanism	51	4.02	0.81
The firm performs reconciliations for financing reporting verification	51	4.08	0.83
There are periodic inventory counts	51	3.82	0.86
The employees are encouraged to report or confess to fraud activities	51	3.98	0.88
The firm has fraud detection systems	51	3.86	0.69
The firm has surveillance and monitoring systems	51	4.05	0.91
Average		**3.961**	**0.829**

Source: Research data

The results indicate that the respondents agreed that the firm performs reconciliations for financing reporting verification(mean=4.08 std,dev=0.83), the firm has surveillance and monitoring systems(mean=4.05 std,dev= 0.91), the firm has a fraud profiling mechanism (mean=4.03 std,dev= 0.81), the companies data is analyzed to detect any inconsistencies (mean=4.00 std,dev= 0.77) and that the employees are encouraged to report or confess to fraud activities (mean=3.98 std,dev= 0.88). The respondents also agreed that there are internal and external audits that detect any fraud(mean=3.88 std,dev=0.88), the firm has fraud detection systems(mean= 3.86 std,dev= 0.69) and that there are periodic inventory counts(mean= 3.82 std,dev= 0.86). The findings show that the insurance firms undertake fraud detection practice (overall mean =3.961, std.dev=0.829).

4.6 Fraud Response Practice

The respondents also indicated their level of agreement on statements regarding fraud response practice based on their firm.

Table 4.6: Fraud Response Practice

Fraud response	N	Mean	Std.dev
Our organization has outlined risk response strategies	51	3.97	1.07
New controls are implemented and existing ones are modified to curb fraud	51	3.89	1.00
The firm conducts fraud investigations	51	3.92	1.22
We have a recovery process in case of fraud	51	3.91	0.95
Our systems are periodically updated	51	3.80	0.38
Work instructions are updated to bridge gaps in the procedures of the company operations when detected.	51	3.82	1.09
Employees suspected or linked to fraud face the disciplinary committee	51	4.05	0.41
Our disciplinary procedures are clear and effective	51	3.77	1.07
Average		**3.891**	**0.899**

Source: Research data

According to the data, the respondents had a viewpoint that employees suspected or linked to fraud face the disciplinary committee (mean=4.05, std,dev= 0.41), their organization has outlined risk response strategies (mean=3.97, std,dev=1.07), the firm conducts fraud investigations (mean=3.92, std,dev= 1.22) and that new controls are implemented and existing ones are modified to curb fraud(mean=3.89, std,dev =1.00). The results also show that work instructions are updated to bridge gaps in the procedures of the company operations when detected (mean=3.82, std,dev=1.09), their systems are periodically updated (mean=3.80, std,dev= 0.38), their disciplinary procedures are clear and effective(mean=3.77, std,dev= 1.07) and that they have a recovery process in case of fraud (mean=3.91, std,dev= 0.95). The findings imply that the firms undertakes fraud response practice (overall mean=3.891, std.dev=0.899).

4.7 Financial Performance

The research intended to examine the degree to which the fraud mitigation practices have impacted the financial performance components of the organisations.

Table 4.7: Financial Performance

	N	Mean	Std.dev
Increased the return on Assets	51	3.92	0.96
Increases sales	51	3.39	0.81
Market share growth	51	3.97	0.93
Cost reduction	51	3.41	1.02
Increased the return on equity	51	4.08	0.66
Improved the profit margin	51	4.11	0.97
Average		**3.813**	**0.892**

Source: Research data

The respondents indicated that the fraud prevention practices have improved the profit margin to a great extent (mean=4.11, std.dev=0.97) and also increased the return on equity to a great extent (mean=4.08, std.dev= 0.66). The respondents also indicate that to a great extent fraud prevention practices has led to market share growth (mean=3.97, std.dev= 0.93) and increased the return on assets (mean=3.92, std.dev= 0.96). In addition, the respondents indicated that the fraud prevention practices lead to cost reduction to a moderate extent (mean=3.41 std.dev=1.02) and increases sales to a moderate extent (mean=3.39, std.dev= 0.81). The findings imply that the fraud mitigation practices have influenced the financial performance aspects in the firms. To a great extent as illustrated by an overall mean of 3.813 and a standard deviation of 0.892.

The study further obtained secondary data on the return on assets of the firms. The descriptive statistics for ROA is reflected in table 4.8

Table 4.8: Descriptive Statistics for Return on Assets

Year	N	Min	Max	Mean	Std.dev
2017	51	-0.67	0.22	0.02	0.12
2018	51	-0.20	0.32	0.03	0.07
2019	51	-0.11	0.48	0.02	0.06

2020	51	-0.87	0.12	0.01	0.32

The return on assets shows the net income returned as percentage of the total assets. The findings show that when compared between the years, the insurance firms performed better in 2018 (mean 0.03) and worst in 2020 (mean=0.01).

4.8 Regression Analysis

A multiple linear regression analysis was carried out in order to investigate the extent to which fraud mitigation practices are linked to financial success of insurance firms in Kenya.

Table 4.9: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.785[a]	.616	.604	.38940

a. Predictors: (Constant), fraud prevention, fraud detection, fraud response

Source: Research data

From the model summary results in Table 4.9, the value of R squared is 0.616. As a result, fraud mitigation practices are responsible for 61.6% of the variation in the financial performance of insurance businesses in Kenya. Other variables that were not taken into consideration in the research model are responsible for the remaining 38.4% of the variance in the financial performance of insurance businesses in Kenya.

Table 4.10: ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	41.37	3	13.79	30.046	.000b
	Residual	21.571	47	0.459		
	Total	62.941	50			

a. Dependent Variable: Financial Performance

b. Predictors: (Constant), fraud prevention, fraud detection, fraud response

Source: Research data

The ANOVA table shows that, $F(3, 47) = 30.046$, $P < 0.05$. The model is significant. As a result, the model proved appropriate for assessing the relationship between fraud mitigation practices and the financial performance of insurance enterprises in Kenya.

Table 4.11: Coefficients

		Unstandardized Coefficients		Standardized Coefficients		
		B	**Std. Error**	**Beta**	**t**	**Sig.**
1	(Constant)	0.865	0.34		2.544	0.012
	Fraud Prevention	0.410	0.116	0.452	3.534	0.001
	Fraud Detection	0.247	0.084	0.209	2.940	0.001
	Fraud Response	0.307	0.101	0.32	3.040	0.012

a. Dependent Variable: Financial Performance

Source: Research data

The regression equation depicting the outcome of the research is thus;

$Y = 0.865 + 0.41X_1 + 0.247X_2 + 0.307X_3$

Regression coefficients show that fraud prevention had a positive and significant effect on the financial performance of insurance companies in Kenya. (β =.410, p=.001<.05). The results also imply that a unit increase in fraud prevention leads to an improvement of financial performance of insurance companies in Kenya by 0.410 units. Regression coefficients reveal that fraud detection had a positive and significant effect on the financial performance of insurance companies in Kenya. (β =.247, p=.001<.05). The results also imply that a unit increase in fraud detection leads to an improvement in financial performance of insurance companies in Kenya by 0.247 units. Regression coefficients demonstrate that the financial performance of Kenyan insurance firms was significantly and favorably impacted by fraud response. (β =.307, p=.012<.05). The results also infer that a unit increase in fraud response leads to an improvement in financial performance of insurance companies in Kenya by 0.307units.

4.9 Discussion of Results

The results show that fraud prevention had a positive and significant effect on the financial performance of insurance companies in Kenya. The findings corroborate with Ohando (2015) who identified a significant association between detective and preventive fraud risk management and financial performance. The firms conduct due diligence in the organization's operations Similarly, Matsoro (2020) found a need for due diligence in fraud prevention.

The findings reveal that fraud detection had a positive and significant effect on the financial performance of insurance companies in Kenya. The findings concur with Nyongesa (2017) who found that fraud detection had a favorable and statistically significant effect on the performance of

Kenyan insurance companies. The findings reveal that the firms perform reconciliations for financing reporting verification, have surveillance and monitoring systems and a fraud profiling mechanism. There are internal and external audits that detect fraud. Consistent with the study findings, Tasiou (2019) coined that fraud detection controls include internal controls, service adequacy, prudential management standards, external oversight, and transparent financial reporting methods. In addition, Gachuru (2020) found that internal reconciliation tactics and fraud prevention had a favorable, significant, and statistically significant association.

Regression coefficients showed that fraud response had a positive and significant effect on the financial performance of insurance companies in Kenya. Similarly, as per the findings by Ndichu (2019) fraud risk management practices resulted in overall increase in the performance of the insurance firms. The findings also show that employees suspected or linked to fraud face the disciplinary committee and new controls are implemented and existing ones are modified to curb fraud. The results also show that the systems are periodically updated. Consistently, Kimathi (2018) found that system should be periodically updated and an active fraud response strategy should be put in place in response to fraud.

CHAPTER FIVE

SUMMARY CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The chapter provides a recap of the study findings. The chapter includes the findings, conclusions, recommendations, the limitations implications for policy and practice and suggestions for further studies. This research aimed to assess how fraud mitigation practices affect the financial performance of insurance companies in Kenya.

5.2 Summary of the Findings

According to the findings of the research, fraud prevention has an impact on the financial performance of insurance companies. The organisations perform fraud risk assessments on a regular basis. Human resource departments do thorough pre-employment screening, and organisations have robust anti-fraud procedures in place. The respondents also agreed that they have a code of conduct in place and that their businesses have robust internal controls in place via separation of roles. The findings imply that the insurance firms have various mechanisms for fraud prevention.

The results demonstrated that fraud detection has an impact on the financial performance of insurance companies. The insurance firms do reconciliations in order to verify funding reporting. and have surveillance and monitoring mechanisms in place, as well as a fraud profiling process. According to the report, there are internal and external audits that catch any fraud. The businesses have fraud detection systems in place, and inventory is counted on a regular basis. Thus the insurance firms have ways for detecting fraud.

The data reveal that insurance businesses' financial success is influenced by their reaction to fraud. Employees who are accused of or related to fraud risk disciplinary action. The organisations have developed risk response plans and carry out fraud investigations. To combat fraud, new controls are installed and old ones are adjusted. The findings also revealed that work instructions are revised to bridge gaps in corporate operations processes when they are discovered, and that systems are updated on a regular basis. The findings imply that the firms respond to fraud occurrences in the firms.

5.3 Conclusion

The study concludes that fraud mitigation practices affect the financial performance of insurance companies in Kenya. Fraud prevention, detection and response have positive and significant effects on the financial performance of insurance companies in Kenya. In the prevention of fraud, the insurance firms conduct frequent fraud risk assessments and comprehensive pre-employment screening by the human resource department. In fraud detection, the insurance firms perform reconciliations for financing reporting verification. More so, the firms have surveillance and monitoring systems and fraud profiling mechanism. In response to fraud, employees suspected or linked to fraud face the disciplinary committee and risk response strategies are well outlined. To reduce the risk of fraud, new controls are introduced, while old systems undergo revisions.

5.4 Recommendations of the Study

The insurance firms should ensure that they provide adequate training to their employees on fraud management. This should be done periodically so that the employees are up to date with the knowledge of the emerging fraud strategies to further assist in the mitigation. The insurance firms should have harsh penalties and disciplinary actions for any employee linked to fraud since such employees could be a major loophole in the fraud mitigation process. The insurance companies should place a primary emphasis on the prevention of fraud through the use of cutting-edge technology and rely on the aid of specialized vendors to assist them in achieving this goal. Organizations that implement next-generation fraud technologies and modern methods have a better chance of staying ahead of fraudsters, mitigating risks, and reducing leakage. Those that continue doing business as usual risk increased vulnerability and losses. To help the government comprehend the scope of the issue, the Insurance Regulatory Authority should create regulations mandating all insurance providers to gather and submit statistics on fraud. This would serve as additional guidance for the creation of rules and regulations regarding fraud cases.

5.5 Limitations of the Study

The respondents were a bit uncooperative to provide information at the start fearing that the information they might fill in the questionnaire might be used against them. The researcher also faced difficulties in reaching out to some of the target respondents due to their tight schedules at

their places of work. The lack of availability of secondary data for certain insurance firms due to the absence of yearly reports from both the Insurance Regulatory Authority and the Association of Kenya Insurers posed a challenge for the study.

5.6 Implications for Policy and Practice

The findings have revealed that fraud mitigation practices namely fraud prevention, detection and repose influence the financial performance of the insurance firms. This implies that the insurance firms have to consider investing more in the fraud mitigation practices for better financial performance of the firms. For the policy maker- the Insurance regulatory Authority, the findings shed light on the positive influence of fraud mitigation practices on financial performance of the insurance firms thereby implying that the regulator has to consider strong policies that govern fraud issues in the sector.

5.7 Suggestions for Further Research

This study evaluated how fraud mitigation practices impact the financial performance of Kenyan insurance businesses. According to the report, fraud mitigation practices are responsible for 61.6% of the variation in the financial performance of Kenyan insurance firms. The study suggests that further research look for other, unaccounted-for variables that explain the remaining 38.4% difference in the financial performance of insurance businesses in Kenya. This study focused on insurance firms. Future studies should focus on other sectors of the economy since fraud is also evident in other sectors.

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APPENDICES

Appendix I: Questionnaire

SECTION I: GENERAL INFORMATION

1. How many years has the organization existed?
   Below 5 years ( )
   6-10 years ( )
   11-20 years ( )
   Over 20 years ( )
2. To what extent does the firm experience fraud?
   Small extent ( )
   Moderate extent ( )
   Large extent ( )
   Average return on equity
3. What is the annual income in millions over the years?

	Less than 250M	250-350M	351-450M	451-600M	Over 600M
2017					
2018					
2019					
2020					
2021					

SECTION II: FRAUD PREVENTION

4. Use the scale 1-5 where 1=strongly disagree, 2= disagree, 3=neutral, 4=agree and 5= strongly agree to rate your level of agreement on fraud prevention practice based on your firm.

Fraud prevention	1	2	3	4	5
The organization conducts frequent fraud risk assessments					
The organization has strong internal controls through separation of duties					
We have an established code of conduct					
All the staff are trained on fraud risks and their management					
The human resource department conducts comprehensive pre-employment screening					

We conduct due diligence in the organization's operations					
Access controls are have designated employees					
The company has effective antifraud policies					

SECTION III: FRAUD DETECTION

5. Use the scale 1-5 where 1=strongly disagree, 2= disagree, 3=neutral, 4=agree and 5= strongly agree to rate your level of agreement on fraud detection practice based on your firm.

Fraud detection	1	2	3	4	5
There are internal and external audits that detect any fraud					
The companies data is analyzed to detect any inconsistencies					
The firm has a fraud profiling mechanism					
The firm performs reconciliations for financing reporting verification					
There are periodic inventory counts					
The employees are encouraged to report or confess to fraud activities					
The firm has fraud detection systems					
The firm has surveillance and monitoring systems					

SETION IV: FRAUD RESPONSE

6. Use the scale 1-5 where 1=strongly disagree, 2= disagree, 3=neutral, 4=agree and 5= strongly agree to rate your level of agreement on fraud response practice based on your firm.

Fraud response	1	2	3	4	5
Our organization has outlined risk response strategies					
New controls are implementing and existing ones are modified to curb fraud					
The firm conducts fraud investigations					
We have a recovery process in case of fraud					
Our systems are periodically updated					
Work instructions are updated to bridge gaps in the procedures of the company operations when detected.					
Employees suspected or linked to fraud face the disciplinary committee					
Our disciplinary procedures are clear and effective					

SECTION V: FINANCIAL PERFORMANCE

7. Use the scale 1-5 where 1= very low extent, 2= low extent, 3= moderate extent, 4= great extent and 5= very great extent to rate the extent to which the fraud prevention practices have influenced the financial performance aspects in your firm.

	1	2	3	4	5
Increased the return on Assets					
Increases sales					
Market share growth					
Cost reduction					
Increased the return on equity					
Improved the profit margin					

THANK YOU

Appendix II: Data Collection Form

Year	Net Income	Total Assets	Return on Assets
2017			
2018			
2019			
2020			
2021			

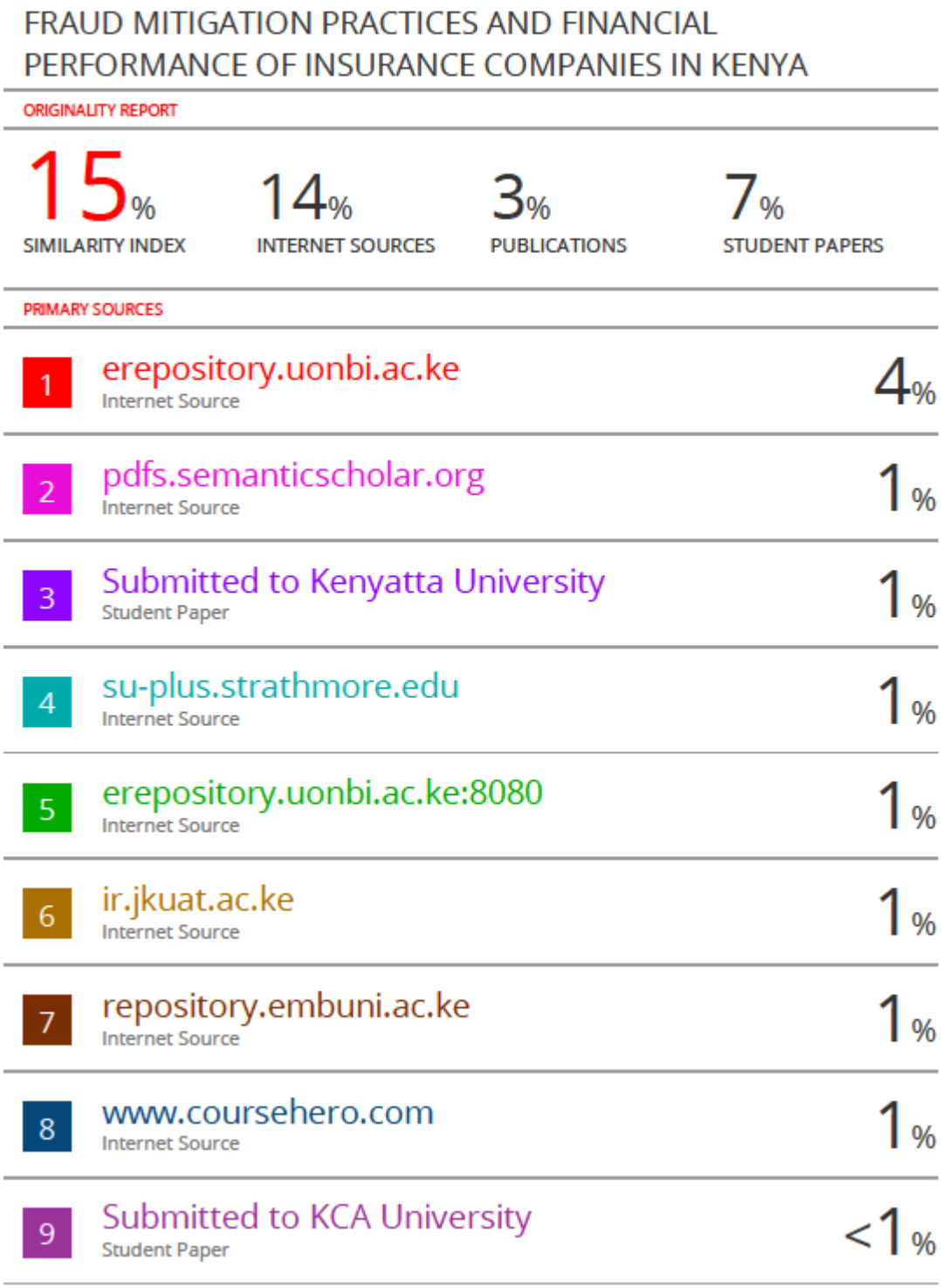
Appendix III: List of Insurance Firms

1. APA Insurance Limited
2. Xplico Insurance Co. Ltd
3. Pioneer Assurance Co. Ltd
4. UAP Insurance Co. Ltd
5. The Kenyan Alliance Insurance Co. Ltd
6. Trident Insurance Co. Ltd
7. The Monarch Insurance Co. Ltd
8. Metropolitan Cannon General Insurance Co. Ltd
9. The Heritage Insurance Co. Ltd
10. Tausi Assurance Company Limited
11. Takaful Insurance of Africa Limited
12. Sanlam General Insurance Co. Ltd
13. Resolution Insurance Co. Ltd
14. Prudential Life Assurance Kenya Limited
15. Jubilee Allianz General Insurance (K) Limited
16. Pacis Insurance Co. Ltd
17. Old Mutual Life Assurance Limited
18. Occidental Insurance Co. Ltd
19. MUA Insurance (Kenya) Limited
20. UAP Life Assurance Co. Ltd
21. Metropolitan Cannon Life Assurance Limited
22. Mayfair Insurance Co. Ltd
23. Madison Life Assurance Kenya Limited
24. Madison General Insurance Kenya Limited
25. Sanlam Life Insurance Limited
26. Liberty Life Assurance Kenya Limited
27. Kuscco Mutual Assurance Limited
28. Kenya Orient Life Assurance Limited
29. Pioneer General Insurance Limited

30. Kenindia Assurance Co. Ltd
31. Intra Africa Assurance Co. Ltd
32. Jubilee Health Insurance Limited
33. Invesco Assurance Co. Ltd
34. ICEA LION Life Assurance Co. Ltd
35. ICEA LION General Insurance Co. Ltd
36. Jubilee Life Insurance Limited
37. Geminia Insurance Co. Ltd
38. GA Life Assurance Limited
39. First Assurance Co. Ltd
40. CIC Life Assurance Limited
41. Fidelity Shield Insurance Co. Ltd
42. Directline Assurance Co. Ltd
43. Corporate Insurance Co. Ltd
44. GA Insurance Limited
45. CIC General Insurance Limited
46. Capex Life Assurance Co. Ltd
47. AIG Kenya Insurance Co. Ltd
48. Britam General Insurance Co. Ltd
49. APA Life Assurance Co. Ltd
50. Geminia Life Insurance Co. Ltd
51. Allianz Insurance Ltd
52. Kenya Orient Insurance Limited
53. Africa Merchant Assurance Co. Ltd
54. AAR Insurance Co. Ltd
55. ABSA Life Assurance Kenya Limited
56. Britam Life Assurance Co ltd

(Source: IRA, 2022)

Appendix IV: Plagiarism Report



FRAUD MITIGATION PRACTICES AND FINANCIAL PERFORMANCE OF INSURANCE COMPANIES IN KENYA

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