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The Effect of Perceived Pressure on Occupational Fraud among Insurance Companies in Kenya

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Abstract

Purpose: Insurance companies have recurrently fallen prey to fraudulent activities, as criminals actively target them with the aim of illicitly benefiting from premium payments and other forms of payments which they do not rightfully deserve. The study assessed the effect of perceived pressure on occupational fraud in insurance companies in Kenya.

Methodology: The study adopted the explanatory research design. The target population comprised of the 58 insurance companies that are registered under the Insurance Regulatory Authority (IRA). The validity and reliability of the research instruments was tested before the actual data is collected. The validity and reliability of the research instruments was tested before the actual data is collected. The study adopted stratified random sampling procedure. The sample size for the study was 384 employees. The study collected primary data through Semi –structured questionnaires and interview guides. The data collected was then edited, coded and analyzed using the SPSS v27 statistical software. Descriptive statistical analysis was used to determine mean, standard deviation, frequency counts and percentages which was also be presented in output tables as results. Inferential statistics involved simple and linear regression and correlation analyses. The research findings were presented in tables and graphs.

Findings: The findings were both the correlation and regression results. ($r = 0.666$, $R^2 = 0.444$; $\beta = 0.578$, $p < 0.05$) showed there is a statistically significant relation between perceived pressure and occupational fraud.

Unique Contribution to Theory Practice and Policy: The study recommended that insurance companies should implement robust financial wellness programs and counseling services to help employees manage financial stress, especially during economic challenges.

Keywords: *Illegal Behavior, Law Enforcement, Insurance, Personnel Management*

JEL Codes: *K42, G22, M52*

INTRODUCTION

Occupational fraud is defined as the misuse of organizational resources by trusted individuals, is especially damaging due to its internal nature and prevalence in sectors such as insurance, where complex claims processes, large financial transactions, and reliance on trust heighten vulnerability (Sonal, 2022). Perceived pressure refers to the subjective sense of financial, performance, or personal stress experienced by employees, which may influence their ethical decision making and rationalization of misconduct (Mat, Ismawi, and Ghani, 2019). Common schemes include embezzling premiums, falsifying claims, colluding with service providers, and manipulating financial records to meet performance targets (Morgan, 2021). Weak internal controls and environments characterized by high pressure further increase risk, as perceived pressure from financial strain, unrealistic targets, or organizational culture can drive employees to rationalize fraudulent acts (Kalovya, 2023). Globally, occupational fraud causes billions in losses, with asset misappropriation being the most frequent and financial misstatement the most-costly (ACFE, 2022). Detection often depends on whistleblower tips and audits, while the broader impact includes erosion of public trust and increased systemic inefficiencies (Saylor, 2023).

Globally, occupational fraud in insurance companies has led to substantial financial losses, reputational damage, and operational disruptions. In the United States, insurance fraud costs exceed forty billion dollars annually, driven by complex processes, low detection rates, and social tolerance of fraud as a victimless crime (Dabbugudi, 2022). Similar trends are observed in Australia and Germany, where economic stress, ethical lapses, and inadequate internal controls have created fertile ground for fraud schemes such as premium diversion, collusion, and falsification of records (Bowley, 2022). Across these contexts, perceived pressure, whether financial, organizational, or societal, emerges as a critical factor influencing fraudulent behavior, often interacting with weak oversight and limited use of data analytics (Kon et al., 2024). Reports from PwC and ICA highlight that without robust ethical cultures and monitoring systems, individuals under pressure may rationalize or justify fraudulent acts, especially in environments where accountability is low and incentives are misaligned (Taylor, 2022). These global insights underscore the relevance of examining how perceived pressure contributes to occupational fraud within Kenya's insurance sector.

Across Africa, occupational fraud in insurance companies remains a pressing concern, exacerbated by rapid market expansion, technological adoption, and socio-economic pressures. In countries such as Nigeria and South Africa, fraud schemes including false claims, premium diversion, and identity theft have led to billions in annual losses, increased premiums, and diminished public trust. These trends are often fueled by weak internal controls, regulatory gaps, and financial stress among employees' conditions that heighten perceived pressure and create opportunities for misconduct. As insurers struggle to balance profitability with fraud mitigation, the need for robust oversight, ethical cultures, and advanced detection systems becomes increasingly urgent. Similar patterns are evident in Egypt, Morocco, and Tanzania, where occupational fraud has undermined financial performance and sector credibility, often driven by inadequate supervision, low staff compensation, and ineffective auditing mechanisms (Geldenhuys, 2020).

In Kenya, occupational fraud in insurance companies poses a growing threat to financial stability and public trust, despite regulatory oversight by the Insurance Regulatory Authority, which

governs licensing and compliance across the sector (Onyango, 2021). Reported cases include false claims, policy manipulation, and misrepresentation during application processes, with a twenty four percent rise in fraud incidents between two thousand eighteen and two thousand nineteen resulting in Kenya shillings three hundred sixty-three million in losses, primarily from deceptive fire policy claims (IRA, 2020). Although insurers have adopted measures such as data analytics, internal investigations, and stricter claims verification to curb fraud (Gachuru, 2020), perpetrators continue to exploit system loopholes and digital platforms to evade detection (Mwongela, 2022). The persistence of such schemes underscores the role of perceived pressure, whether financial, organizational, or technological, in driving fraudulent behavior, and highlights the need for more adaptive, collaborative, and technology driven responses across the sector (Onyango, Kariuki and Musumba, 2023).

Problem Statement

Insurance companies in Kenya are expected to operate with transparency, ethical discipline, and robust internal controls to safeguard stakeholder interests and maintain public trust. However, this expectation is increasingly threatened by rising cases of occupational fraud committed by employees within organizations. These fraud cases are often driven by internal pressures such as financial strain, unrealistic performance targets, and weak ethical cultures (Onyango, Kariuki and Musumba, 2023). Data from the Insurance Fraud Investigation Unit (IFIU) reveal a troubling trend: reported cases of insurance fraud rose from 83 in 2019 to 127 in 2020, with occupational fraud contributing significantly to the Kenya shillings 363 million in documented financial losses (IRA, 2020). It is important to note that fraud data is often underreported due to detection challenges and reputational concerns, suggesting that actual figures may be considerably higher. These fraudulent practices range from embezzlement and false claims to manipulation of financial records. The causes of occupational fraud are primarily internal, including financial stress, performance pressure, and inadequate ethical oversight. The effects, on the other hand, include compromised financial stability, impaired ability to meet legitimate claims, and erosion of public confidence in the sector (Otiso, 2021).

The consequences of occupational fraud ripple across multiple stakeholders. Customers face higher premiums and reduced benefits, while companies suffer reputational damage, diminished market share, and increased operational costs due to investigations and litigation (Mwongela, 2022). Internally, unchecked fraud weakens organizational culture and employee morale, especially when accountability systems are perceived as ineffective. Although prior studies have examined the role of governance, internal controls, and regulatory frameworks in mitigating fraud, few have explored how perceived pressure acts as a psychological trigger for occupational fraud in the Kenyan insurance context. This study aims to fill that gap by investigating the relationship between perceived pressure and occupational fraud, thereby contributing to a more nuanced understanding of fraud dynamics and informing targeted interventions for risk mitigation and ethical resilience in the sector.

LITERATURE REVIEW

Theoretical Framework

The Fraud Triangle Theory, developed by Donald Cressey in 1953, posits that fraud arises when three key conditions converge: pressure, opportunity, and rationalization. In the context of insurance companies, perceived pressure, such as financial strain or performance demands, can motivate employees to commit fraud, especially when internal controls are weak and rationalizations are easily constructed to justify unethical behavior (Cressey, 1953). In Kenyan insurance firms, perceived pressure often manifests through commission-based sales roles, personal debt burdens, and high target expectations, which may heighten vulnerability to fraudulent behavior. This theory informs the current study by offering a psychological and situational lens through which occupational fraud can be examined, emphasizing how internal pressures within organizations may trigger fraudulent actions. It helps construct the actual framework by guiding the identification and operationalization of perceived pressure as central to understanding fraud dynamics.

While the theory has limitations, such as its individual-centric focus and limited predictive power, it also does not fully account for emerging forms of technological fraud, collusive schemes involving multiple actors, or cultural and contextual factors specific to Kenyan insurers, such as informal networks and regulatory enforcement gaps. Nevertheless, it remains a foundational model for analyzing fraud risk. Its relevance to this study lies in its ability to dissect the motivations and vulnerabilities that drive occupational fraud, thereby supporting the development of targeted interventions for fraud prevention in Kenya's insurance sector.

Conceptual Framework

A conceptual framework helps explain the various structures of research work in a visual or textual format and their linkages by incorporating the fundamental elements of research theory (Bryman, 2017). The independent variable in this study was perceived pressure and the dependent variable is occupational fraud in insurance companies in Kenya. Empirical studies have demonstrated that perceived pressure, whether financial, organizational, or societal can significantly influence employees' intention to commit fraud, particularly when opportunity and rationalization are also present (Awalluddin et al., 2022). These findings support the theoretical linkage proposed in this study and reinforce the relevance of examining perceived pressure as a psychological and situational driver of occupational fraud within the Kenyan insurance sector.

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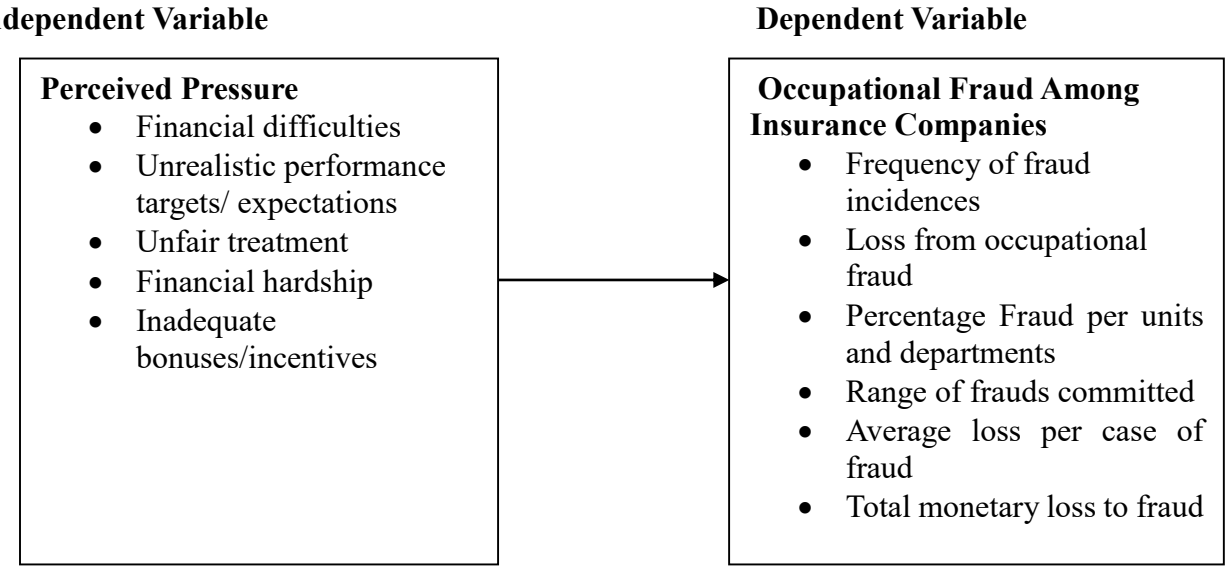

Figure 1: Conceptual Framework

Empirical Review

Smith, Jones and Brown (2020) examined the relationship between perceived pressure and insurance fraud in the U.S. federal government, and to identify the sources and types of pressure that influence the insurance personnel to engage in fraudulent behavior. The study adopted a quantitative approach and a cross-sectional survey design. The sample size was 300. The data were collected using a self-administered questionnaire and analyzed using descriptive and inferential statistics, such as frequency, percentage, mean, standard deviation, correlation, and regression. The study found that perceived pressure had a positive and significant relationship with insurance fraud in the U.S. federal government and concluded that perceived pressure was a significant factor for explaining insurance fraud in the U.S. federal government, and that different sources and types of pressure had different effects on insurance personnel's fraudulent behavior. There is a contextual gap in this study as it was limited to the private insurance sector in US while the current study seeks to bridge this gap by expanding its research scope to target both insurance and reinsurance companies in Kenya. Additionally, the study did not account for cultural, regulatory, or technological factors that may influence fraud dynamics in developing economies, nor did it explore sector-specific pressures such as commission-based sales or informal accountability systems.

Okeke, Okafor and Nwankwo (2019) study investigated on the influence of perceived pressure on fraud incidences in public sector organizations in Nigeria. It also explored the moderating role of ethical climate on the relationship between perceived pressure and fraud incidences. The study adopted a mixed-methods approach, combining quantitative and qualitative data collection and analysis. It utilized a sample size of 250 respondents to collect primary data using structured questionnaire and semi-structured interviews. The results revealed that perceived pressure had a positive and significant influence on fraud incidences in Nigerian public sector organizations. The study also found that ethical climate had a negative and significant moderating effect on the

relationship between perceived pressure and fraud incidences. The study concluded that perceived pressure was a major driver of fraud incidences in Nigerian public sector organizations. There exists a contextual gap in this study since it examined on fraud incidences in the public sector organization while the current study was limited to insurance companies in Kenya. Moreover, the study did not isolate industry-specific pressures such as sales targets or policy manipulation incentives, nor did it assess the role of digital platforms in shaping perceived pressure among insurance employees.

Gachuru, Kiragu and Ngunyi (2020) study explored on the effects of internal control on fraud prevention among insurance companies in Kenya, focusing on the dimensions of control environment, risk assessment, control activities, information and communication, and monitoring. The study adopted a descriptive survey research design and a quantitative approach. The target population was 64 insurance companies registered by IRA in Kenya. The sample size was 56 insurance companies, selected using stratified random sampling technique. The study also found that control environment, risk assessment, control activities, and information and communication had positive and significant effects on fraud prevention, while monitoring had a positive but insignificant effect on fraud prevention. The study concluded that internal control was an important factor for mitigating fraud risks in the insurance sector. While it is essential to understand the role of internal controls, the study did not delve into the psychological aspects or rationalization factors that might influence employees' behavior in relation to fraud. While it is essential to understand the role of internal controls, the study did not delve into the psychological aspects or rationalization factors that might influence employees' behavior in relation to fraud. It also did not examine how perceived pressure interacts with internal control systems to either exacerbate or mitigate fraud risks.

Morera, Kiragu and Ngunyi (2019) study examined on the drivers of motor vehicle insurance fraud risk among insurance companies in Kenya. The study adopted a mixed-methods approach, combining quantitative and qualitative data collection and analysis. The target population was the employees of insurance companies in Kenya where a sample of 200 respondents was selected using systematic sampling technique. Primary data was collected using a survey questionnaire and semi-structured interviews. The study found that macro-economic, individual, and institutional factors had positive and significant effects on motor vehicle insurance fraud risk among insurance companies in Kenya. The study also found that macro-economic factors had the highest effect on fraud risk, followed by individual factors and institutional factors. The study concluded that motor vehicle insurance fraud was a serious risk in Kenya, and that various factors influenced the motivation and opportunity of fraud perpetrators. The study has a conceptual and contextual gap as it did not extensively explore internal drivers within the organizations themselves, such as perceived pressure and it was also limited to examining motor vehicle insurance fraud incidences. Furthermore, it did not investigate psychological triggers or employee-level stressors that may influence fraudulent behavior across broader insurance product lines, nor did it consider the role of organizational culture in shaping fraud vulnerability.

METHODOLOGY

This research utilized a sample size of 384 employees in four key departments including underwriting, claim, finance and risk management departments. The 384 employees comprised the

unit of analysis in this study while the 58 registered insurance companies in Kenya were the unit of observation and target population. This study adopted an explanatory research design. To determine the appropriate sample size from these target population, the researcher used the Fischer's (1961) formula, since the target population was more than 10,000 employees. Thus, the sample size was 384 employees. Further, the study also used the stratified random sampling technique to select a representative sample of employees from four key department in the insurance companies that are affected by occupational fraud incidences, including underwriting department, claims department, finance department and risk management department. Therefore, each stratum had a representative sample of 96 employees. This sampling technique ensures that subgroups (or strata) within a population are adequately represented in the sample. This study used structured questionnaire and interviews. The questionnaire was designed to capture both quantitative and qualitative data. A 5-point Likert scale was used for most closed-ended questions to allow respondents to express the degree of their agreement or disagreement with given statements. In this study, pilot testing was done on respondents randomly selected from other insurance departments and used 10 per cent of the sample size. This translated to 38 respondents undertaking the pilot testing. Content validity was ensured by subjecting the instrument to the review and opinion of the study supervisors. The pilot findings indicated the internal consistency for all the items were within KMO acceptable level of 0.5-1. The study adopted a Cronbach alpha reliability method to measure the extent in which results are consistent. The pilot study conducted yielded a Cronbach alpha of 0.818 for perceived pressure which indicated the internal was within Cronbach's alpha acceptable level of 0.7-1. Data was cleaned to get read of possible outliers, and entered into SPSS version 27 ready for analysis. Descriptive statistical analysis determined mean, SD, frequency counts and percentages which was also be presented in output tables as results. Inferential statistics involved simple and linear regression and correlation analyses. Study's multiple regression model was as follows;

$$Y = \beta_0 + \beta_1 X_i + \varepsilon_i \quad \text{(i)}$$

RESULTS

Response Rate

A total of 384 questionnaires were administered, out of which 269 were properly filled and returned, resulting in a high response rate of 70%, as illustrated in Table 1. According to Mugenda and Mugenda (2003) and Kothari (2004), a response rate of 50% is considered adequate for a descriptive study. Therefore, the achieved response rate of 70% surpasses the minimum acceptable threshold, indicating a robust level of participation.

Table 1: Response Rate

Response	Frequency	Percent
Returned	269	70%
Unreturned	115	30%
Total	**384**	**100%**

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www.iprjb.org

Demographic Characteristics

This section presents descriptive statistics of the respondents in terms of department, level of education and years of service in the company.

Department

The respondents were asked to indicate in which department they work in and the findings are shown in the figure 2. The findings indicate that majority of the respondents work in claim department (27.9%), followed by Risk Management department (24.9%), then Finance department (24.2%) and the minority being those who work in Underwriting department (23%). The predominance of respondents from the Claim department (27.9%) reflects the department's central role in fraud detection and resolution, as supported by Kiana (2010), who identified claims units as critical touchpoints in managing and investigating insurance fraud in Kenya.

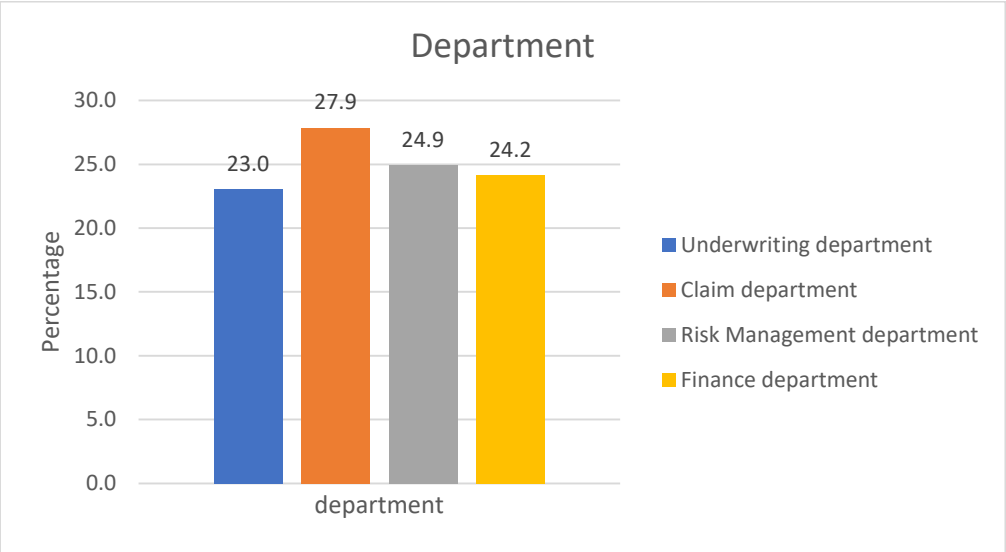

Figure 2: Department

Level of Education

The respondents were asked to indicate their level of education. The findings are shown in the figure 3. The findings indicate that the majority of respondents are bachelor's degree holders (70%), followed by master's degree holders (18%) then those who attained diploma (10%) and the minority being PhD holders (2%). This educational distribution is consistent with workforce trends in Kenya's insurance sector, where tertiary education serves as a core prerequisite for professional roles. The Insurance Regulatory Authority (IRA, 2021) highlights this pattern, noting that Bachelor's qualifications dominate mid-level staffing, with growing adoption of postgraduate credentials in managerial positions.

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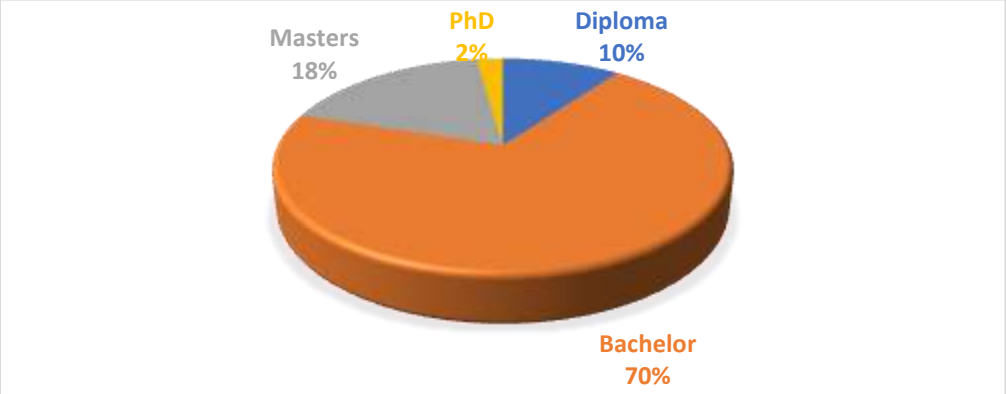

Figure 3: Level of Education

Time of Service

The respondents were asked to indicate the number of years they have worked in the company. The findings are shown in figure 4 below. The findings indicate that most of the respondents have worked for 6-10 years (60%), while the rest of them have worked for 1-5 years (10%), 11-15 years (10%) 16-20 years (10%) and those that have worked for over 20 years (10%). The predominance of respondents with 6–10 years of service (60%) aligns with sectoral trends observed by Masese (2013), who found that mid-career professionals constitute the bulk of operational staff in Kenyan insurance firms, particularly in departments vulnerable to occupation fraud.

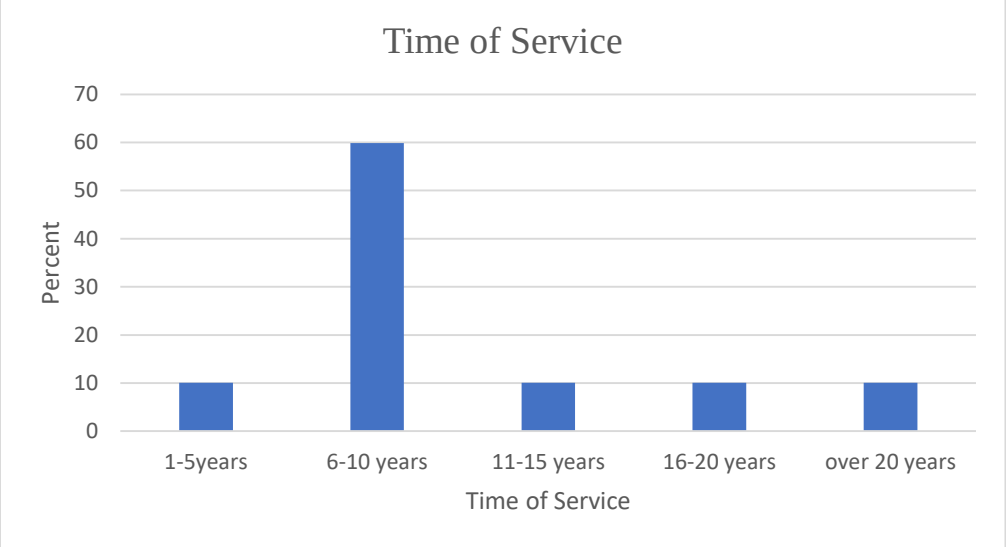

Figure 4: Time of Service

Descriptive Statistics

The first objective of the study was to examine the effect of perceived pressure on occupational fraud in insurance companies in Kenya. The respondents were asked to indicate their level of agreement or disagreement with the statements relating to perceived pressure and their responses were rated on a five-point Likert scale. The results are presented in the Table 2.

Foremost, the results indicated agreement among respondents on having experienced financial difficulties in the last 12 months (mean=3.70). The findings also show that the respondents agree that there is pressure to meet unrealistic sales or performance targets (mean=3.69). Respondents agreed with a mean of 3.60, some employees feel the compensation is not fair compared to their responsibilities. The respondents also agreed to have observed fellow colleagues facing financial hardship (mean=3.63). The respondents moderately agreed that pressure to achieve bonuses or incentives is high (mean= 3.61).

The overall average across all the statements was 3.64, with a standard deviation of 1.36, indicating that respondents generally agreed that perceived pressure has an effect on occupational fraud. These results concur with those of Okeke, Okafor and Nwankwo (2019) who investigated on the influence of perceived pressure on fraud incidences in public sector organizations in Nigeria and concluded that perceived pressure was a major driver of fraud incidences in Nigerian public sector organizations.

Table 2: Perceived Pressure on Occupational Fraud in Insurance Companies

Statement	N	Min	Max	Mean	Std.
Some employees have experienced financial difficulties in the last 12 months	269	1	5	3.70	1.431
There is pressure to meet unrealistic sales or performance targets.	269	1	5	3.69	1.363
Some employees feel the compensation is not fair compared to the responsibilities.	269	1	5	3.60	1.359
Fellow colleagues face financial hardships	269	1	5	3.63	1.339
The pressure to achieve bonuses or incentives is high	269	1	5	3.61	1.327
Average				**3.64**	**1.36**

Correlation Analysis

A correlation is used to estimate the strength of the linear relationship between two variables representing how closely two variables co-vary ranging from -1 termed as perfect negative correlation through 0 or no correlation to +1 termed as perfect positive correlation (Schober, Boer & Schwarte, 2018). Correlation is measured by correlation coefficient that represents the strength of the putative linear association between the variables in question (Mukaka, 2012). The interpretation of correlation coefficients follows the classification as suggested by Cohen (2013): Weak correlation: $0.10 \leq r < 0.30$; Moderate correlation: $0.30 \leq r < 0.50$; Strong correlation: $r \geq 0.50$.

The research study focused on obtaining the correlation between perceived pressure and occupational fraud. From the findings in Table 3, Correlation coefficient of $r = 0.666$ indicates a strong positive correlation between perceived pressure and occupational fraud. The relationship is statistically significant ($p = .000$). These results concur with those of Smith, Jones and Brown (2020), who examined the relationship between perceived pressure and insurance fraud in the U.S.

federal government and found out that perceived pressure had a positive and significant relationship with insurance fraud in the U.S. federal government and concluded that perceived pressure was a significant factor for explaining insurance fraud in the U.S.

Table 3: Correlation Analysis

		Avrg_Pressure	Avrg_Occupationalfraud
Avrg_Pressure	Pearson Correlation	1	.666**
	Sig. (2-Tailed)		0.000
	N	269	269
Avrg_Occupationalfraud	Pearson Correlation	.666**	1
	Sig. (2-Tailed)	0.000	
	N	269	269

Regression Analysis

To ascertain how perceived pressure influences occupational fraud in insurance companies, regression analysis was performed. The model fitness findings were shown in Table 3.4.

The R Square value is 0.444, meaning that 44.4% of the variation in occupational fraud is explained by perceived pressure. In other words, perceived pressure explains a portion of the changes in the occupational fraud in insurance companies, while the remaining 55.6% is influenced by other factors not included in the model.

The ANOVA results presented in Table 4 shows that the regression model is statistically significant with p-value of 0.000. This indicates that perceived pressure has a significant impact on the occupational fraud in insurance companies. These results are in line with those of Okeke, Okafor and Nwankwo (2019) who investigated the influence of perceived pressure on fraud incidences in public sector organizations and that perceived pressure had a positive and significant influence on fraud incidences in Nigerian public sector organizations.

The regression of coefficients results was presented in Table 4. The coefficient for perceived pressure is (β = 0.578), meaning that for every one unit increase in perceived pressure, the occupational fraud in insurance companies is expected to increase by 0.578 units, assuming all other factors remain constant. This is statistically significant, as evidenced by the p-value of 0.000.

The null hypothesis on perceived pressure variable stated that:

H_{01}: *There is no statistically significant relation between perceived pressure and occupational fraud among insurance companies in Kenya.*

Therefore, the null hypothesis (H_{01}) was rejected in favour of the alternative hypothesis (H_1) and the study concluded that there is a statistically significant relation between perceived pressure and occupational fraud among insurance companies in Kenya. In addition, based on the findings from the interviews with the four senior officers, the study found that perceived pressure significantly influenced occupational fraud. The senior officer in insurance institute of Kenya emphasized the by noting "*The major drive of occupational fraud is financial hardship by the employees.*" These results are similar to those of Gachuru, Kiragu and Ngunyi (2020) who investigated the role of

perceived pressure the occupational fraud and the findings he got indicated that perceived pressure positively affects occupational fraud.

Hence the resultant regression model was;

$Y = \beta_0 + \beta_1 X_1 + \varepsilon$

occupational fraud = **1.810**+ **0.578** perceived pressure + ε

Table 4: Regression Analysis for Perceived Pressure

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.666[a]	0.444	0.442	0.68854

a. Predictors: (Constant), Avrg_Pressure

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	101.007	1	101.007	213.055	.000[b]
	Residual	126.582	267	0.474		
	Total	**227.589**	**268**			

A. Dependent Variable: Avrg_Occupationalfraud

B. Predictors: (Constant), Avrg_Pressure

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.810	0.150		12.048	0.000
	Avrg_Pressure	0.578	0.040	0.666	14.596	0.000

a. Dependent Variable: Avrg_Occupationalfraud

CONCLUSION AND RECOMMENDATIONS

Conclusion

Based on the findings, the study concluded that experiencing financial difficulties, pressure to meet unrealistic sales or performance targets, high pressure to achieve bonuses or incentives, and feeling that compensation is not fair compared to the responsibilities given may lead individuals to consider fraudulent activities. Therefore, these factors influence occupational fraud in insurance companies. These results agree with those of Okeke, Okafor and Nwankwo (2019) study on the influence of perceived pressure on fraud incidences in public sector organizations in Nigeria, which found that perceived pressure had a positive and significant influence on fraud incidences in Nigerian public sector organizations. However, the Kenyan insurance environment presents unique dynamics that may intensify this relationship. The rapid adoption of digital platforms for claims processing and customer engagement has introduced new vulnerabilities, while oversight gaps within the Insurance Regulatory Authority (IRA), particularly in enforcement and audit follow-through, may weaken deterrence mechanisms. Additionally, commission-based compensation structures and informal performance cultures in Kenyan insurers can amplify

perceived pressure among employees, making fraud rationalization more likely. This study sheds light and concluded that perceived pressure is a major driver of fraud incidences in Kenyan insurance companies, warranting targeted interventions that address both psychological and systemic risk factors.

Recommendations

Based on the study's finding that perceived pressure has a statistically significant and strong positive correlation with occupational fraud ($p = .000$), several targeted interventions are recommended to mitigate this risk within Kenyan insurance companies. First, the study revealed that financial difficulties are a key driver of perceived pressure, which in turn increases the likelihood of fraudulent behavior. In response, insurance companies should implement robust financial wellness programs and counseling services to support employees in managing financial stress, particularly during periods of economic uncertainty.

Additionally, the study identified that unrealistic sales and performance targets contribute significantly to occupational pressure. To address this, management should regularly review and adjust performance expectations to ensure they are both achievable and fair, thereby reducing undue stress and discouraging unethical conduct. The pressure to attain bonuses and incentives was also found to be a contributing factor to occupational fraud. Consequently, companies should design incentive schemes that are transparent, ethically grounded, and aligned with realistic performance goals, ensuring they motivate employees without inadvertently encouraging misconduct.

Finally, the perception that compensation is unfair relative to responsibilities was shown to exacerbate occupational pressure. To counter this, insurance companies should conduct regular compensation reviews to ensure that remuneration structures reflect employees' roles and workloads appropriately. By addressing these specific sources of perceived pressure, organizations can foster a more ethical and resilient work environment, thereby reducing the incidence of occupational fraud.

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