

BUREAUCRATIC CORRUPTION, GENDER EQUALITY AND GENDER STRATIFICATION: EVIDENCE FROM HEALTHCARE FINANCING POLICY PROCESSES IN SUBNATIONAL GOVERNMENTS IN KENYA

Justa Mwangi

Abstract

The present article examines bureaucratic corruption in the form of nepotism, cronyism, elite capture, bribery, sextortion and embezzlement, and its relationship to gender inequality and, more specifically, gender stratification. This is explored in the context of policymaking processes relating to health-care financing in the county governments of Kiambu and Nairobi City, two subnational governments in Kenya. The empirical research presented in this article is shaped by radical feminist theory and methodology. Responses from 58 women were gathered through interviews and focus group discussions. It was found that bureaucratic corruption affected women and men differently and produced outcomes that exacerbated gender inequalities within the subnational policymaking processes. The results indicate that reducing bureaucratic corruption could improve gender equality and decrease gender stratification.

Introduction

Corruption is often conceptualized as a breach of public trust and an abuse of position for private gain (Alfano, Baraldi and Cantabene, 2019). Thus, by its very definition, corruption is often construed as a public sector crime. In that connection, the discussion in this article is confined to bureaucratic corruption as perpetrated by public officials in the forms of nepotism, cronyism, elite capture, bribery, sextortion and embezzlement, which are defined as follows:

- Nepotism: the favouring of relatives (ibid.)
- Cronyism: the favouring of friends or associates by giving them jobs, opportunities or informal power (ibid.)
- Elite capture: the favouring of a certain clique of individuals who monopolize and influence decisions and resources (ibid.)
- Bribery: a crime that involves offering money or something of value to influence a decision (Opalo, 2020)
- Sextortion: bureaucratic sexual corruption and an abuse of office in which non-physical coercion is utilized to extort sexual favours from a victim (ibid.)
- Embezzlement: a crime of fraud that involves the misappropriation of money or property belonging to the public (ibid.)

Bureaucratic bribery is of great concern globally; the World Bank (2020) estimates that over 3 per cent of worldwide income is lost to this form of corruption. On the African continent, bureaucratic embezzlement is a particular concern, as it has resulted in estimated losses of over \$50 billion annually (ibid.). In Kenya, nepotism, cronyism and elite capture have been identified as existential threats to devolution (Opalo, 2020). Studies conducted at the subnational level have found that 63 per cent of Kenyans have to pay bribes in order to obtain health services (Kenya, Ethics and Anti-Corruption Commission, 2015). Such bureaucratic corruption creates gendered health disparities and, more specifically, exacerbates gender inequality and gender stratification (Alexander, 2021).

Gender stratification refers to the social ranking of genders by which men are given more power, privileges and societal resources, and women experience greater oppression (Acker, 2006; Walsh-Fuhring, 2018). Throughout history, men have generally benefited from gender stratification, while women have been systematically disadvantaged by it (Walsh-Fuhring, 2018).

Studies show that bureaucratic corruption significantly bolsters gender inequality and gender stratification, as it limits women's access to public resources and their participation in public policymaking processes, thereby reinforcing gender-based discrimination and marginalization (Hesse-Biber, 2011). Research further shows that reducing bureaucratic corruption could increase gender equality, to the benefit of women and to developing economies more broadly (Alexander, 2021). Many scholarly debates revolve around which dimensions of gender inequality are most affected by corruption, as well as the degree to which such inequalities are generated or exacerbated by corrupt practices (Conerly, Holmes and Tamang, 2021, p. 341).

In the context of healthcare specifically, there is growing evidence that women are invisible in healthcare financing policy processes, yet shoulder a disproportionate burden in supporting healthcare systems through unpaid labour, such as when performing unpaid caregiving duties for spouses, children and relatives (Kairu and others, 2021). This gender paradox in healthcare financing is compounded by bureaucratic corruption that reinforces and exacerbates entrenched gender inequality (Geist and Myers, 2020). Women are generally excluded from policymaking processes, yet must bear the financial and social burden of the resulting policies.

In Kenya, the healthcare financing policy process is multilayered and is aimed at standardizing budgeting processes, as well as transitioning health facility financing away from its current reliance on user fees and donor funding, towards self-financing (Kairu and others, 2021). These policies address budgetary allocations, procurement, taxation-based financing, community-based health insurance, donor funding, social health insurance, private health insurance and out-of-pocket payments, among other mandate areas (*ibid.*). The policies are also aimed at introducing sectoral reforms that enhance access to health insurance and reduce health burdens for vulnerable and poor households, particularly women (*ibid.*). They are further aimed at increasing funding to counties, as counties are the main implementers of primary and secondary healthcare policies, and at increasing health budgets overall, in a bid to meet health targets as outlined in the Kenya Vision 2030 development framework (*ibid.*).

The policymaking process itself has several stages: the emergence of specific problems, agenda-setting, policy formulation, decision-making, and policy implementation and evaluation. Although women have participated in such processes at the subnational level, bureaucratic corruption has posed a major challenge and has prevented greater participation among women (Kenya, Office of the Auditor General, 2018, and Ethics and Anti-Corruption Commission, 2015).

This article is informed by feminist theory, which sees gender as a social construct by which women are oppressed for being women and for having to be women (Hesse-Biber, 2011). In the article, it is concluded that the misuse of power through bureaucratic corruption contributes to gender-based inequality, stratification, marginalization and violence (Lindberg and Stensöta, 2018).

Methodology

In the present study, the researchers applied a radical feminist methodology, which is a means of conducting research and generating theories from an explicitly feminist viewpoint (Code, 2011). The use of that methodology ensured that the study engaged and was accessible to women, and allowed women to share information freely without fear of repercussions. The researchers also recognized the deeply patriarchal nature of Kenyan society, thus no men were included in the study.

In total, 58 women were targeted for interviews and focus group discussions, and an emphasis was placed on women who held public office within the selected subnational governments, particularly those in offices that interacted with healthcare financing policy processes. Among them were supply chain-related staff who managed tenders and procurement tasks, administrators working at the subcounty level who oversaw the collection of revenue from user fees, finance personnel who handled payments and budgeting, suppliers who engaged in tenders and payment systems, human resources personnel who hired relevant staff, staff with the authority to incur expenditure¹ who were responsible for the authorization of payments, information and communications technology staff, and communications personnel who managed data and disseminated information.

¹ These staff members dealt with more than just payment authorization. Their role was more akin to a budget holder or an accounting officer in charge of accounts at a ministry. However, in some government departments, the functions of an accounting officer or a budget holder are sometimes performed by persons in other positions, owing to the nature of political appointments, therefore, for the study, it was necessary to interview the specific officer holding the authority to incur expenditure, whether that officer was a director or a junior officer. It is a highly coveted role and prone to corruption, as the person performing that role has the legal powers to authorize the use of public funds for all expenditures within a given ministry.

One focus group discussion was carried out in each county, and the participants were drawn from key stakeholder groups in a bid to collect as many diverse views as possible. The focus groups consisted primarily of women involved in the healthcare financing policy process who identified themselves as members of underrepresented minority groups, young people, business leaders, professionals, persons with disabilities, religious leaders and members of civil society. The views of those women were critical for the study, as they were directly involved in and affected by healthcare financing policy processes. Other participants were female members of the public found at healthcare service delivery points, such as parking lots, licensing offices and markets. Women who supplied services and goods to the subnational governments were also interviewed. Individual interviewees were identified through convenience sampling, using lists of potential respondents obtained from the county governments. The interviews were transcribed and subjected to rigorous thematic analysis.

As shown in figures I and II, six types of respondents participated in the study: (a) public officials from the executive² who carried out strategic functions; (b) public officials from the legislature³ who carried out strategic functions; (c) suppliers to the executive;⁴ (d) suppliers to the legislature;⁵ (e) members of the public;⁶ and (f) members of focus groups comprising key stakeholders (members of civil society, politicians, persons with disabilities, religious leaders, business leaders and members of minority groups).

² “The executive” refers to the executive arm of the county governments. County governments have two arms, the executive arm and the legislative arm. The only arm of the Government not devolved to the county government is the judiciary.

³ “The legislature” refers to the legislative arm of the county government.

⁴ This refers to government contractors who provide services to the executive arm of the county government.

⁵ This refers to government contractors who provide services to the legislative arm of the county government.

⁶ This refers to members of the public who were at healthcare service delivery points, such as parking lots, licensing offices and markets, during the time of the study.

Figure I. Average number of respondents in Kiambu County

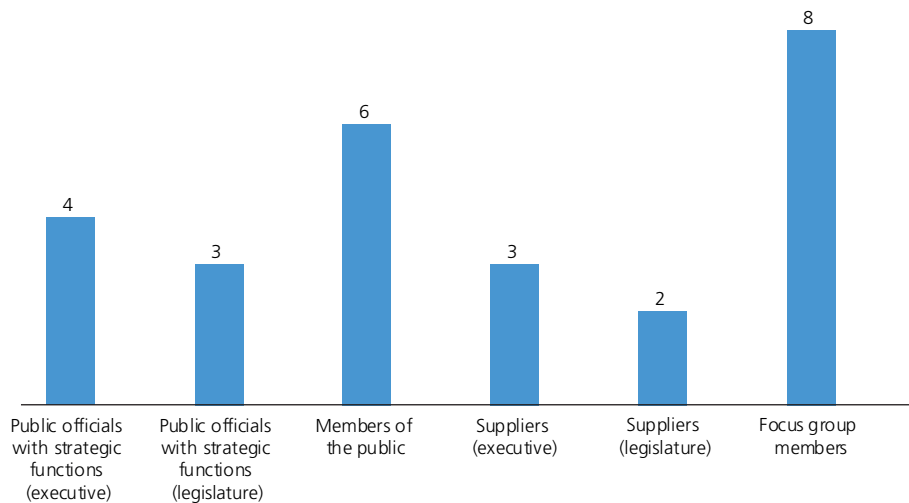
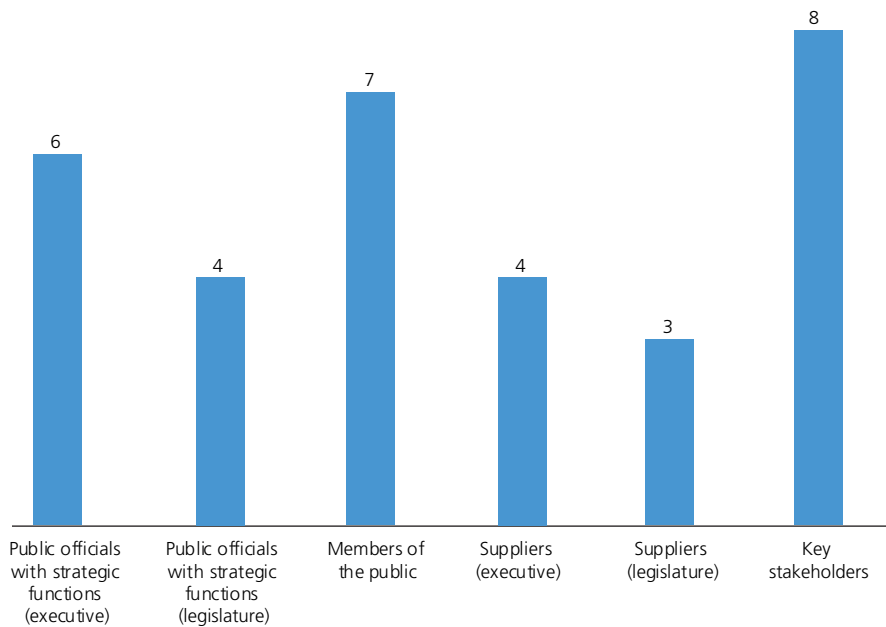


Figure II. Average number of respondents in Nairobi City County



Results and discussion

The findings from this study reflect the views of women in key strategic public offices within the subnational governments of Kiambu and Nairobi City Counties, women at various healthcare service delivery points, female suppliers of healthcare services and key female stakeholders. Respondents offered their opinions on bureaucratic corruption, gender equality and gender stratification within healthcare financing policymaking processes in the selected subnational governments. In the present article, codes are utilized when referring to the respondents, with “K” representing respondents in Kiambu County and “N” representing respondents in Nairobi City County. The respondents have also been assigned numbers from 1 to 58. In this way, they have been anonymized. The data from the interviews and focus group discussions have been analysed and categorized into the five thematic areas set out below.

Bureaucratic nepotism

Respondents discussed rampant bureaucratic nepotism within healthcare financing policy processes, which adversely affected women and exacerbated gender inequality. For example, respondent N22 described the high costs that women must pay when seeking health services:

Men are the ones most of the time in the big seats ... they do not consult us on who should meet the costs of healthcare ... their relatives are favoured, as they do not pay for services.

This and similar responses indicate that male bureaucrats use nepotism to favour their own relatives and abuse their power by giving priority to those relatives when they access public services. Another respondent, N42, echoed the concerns regarding the exclusion of women from healthcare financing policy processes, in particular from decisions regarding healthcare costs. Given that the healthcare policies of the two counties are aimed at transitioning health facility financing from donor funding and user fees to self-financing, such exclusion represents a significant lapse on the part of the bureaucrats. Women in Kenya, as in many parts of the world, carry a disproportionate burden of care, and self-financing reforms risk failure if those disproportionate effects on women are not taken into account.

According to K41, the preferential treatment of bureaucrats' relatives sidelined the voices of women. Similarly, respondent N16 said:

Even if they take [away] my position at the healthcare financing meeting, I do not care. We only go there to rubber-stamp what their relatives have already agreed on.

This shows that, even during meetings in which key decisions and issues were discussed, many women were not keen to participate, knowing that nepotism gave disproportionate power to the relatives of bureaucrats. These findings are similar to those of a study conducted in Türkiye which did not focus on the gendered impacts of corruption, but found that bureaucratic nepotism affected the motivation and job satisfaction of healthcare workers (Yavuz, Gürhan and Genis, 2020).

Bureaucratic cronyism

Responses confirmed that bureaucratic cronyism also exacerbated gender inequality and gender stratification in healthcare financing processes in Kiambu and Nairobi City Counties. Respondent N16 explained how she was used as the “work donkey” within the healthcare financing policy process, while the cronies of bureaucrats did not do any work. She felt that she was treated unfairly and not accorded the same treatment and privileges as the cronies of bureaucrats, who were mostly men. For example, such cronies were excused from duties and granted allowances, while she was denied the allowances that she had earned.

Similarly, respondent K33 complained that, despite being a member of senior management, she did not wield any decision-making power. The key decision makers were all low-status staff members who were cronies of the male bosses. She felt excluded from the healthcare policy process and claimed that her voice as a woman was not heard. The situation described echoes studies that show that, in patriarchal societies, women are expected to shoulder more duties than men and are not expected to have career ambitions, make important decisions or hold any power (Bearman, Korobov and Thorne, 2009). Respondents K27 and N35, who worked in public-facing roles within the healthcare financing policy process, reported that most women were fighting to become cronies of the bureaucratic bosses in order to survive. Respondent N31 added that:

You see, these men expect us to fight for them, and those who are lucky to be their cronies get special treatment. Those of us who are not yet cronies, we get it rough ...

This shows that women involved in healthcare financing policymaking processes were viewed as people of low status who must fight for the attention of men for their careers to succeed. It also supports the findings of studies in which sexist stereotypes were identified as a basis for the targeting and oppression of women (Fernández and Coello, 2010). Because the bureaucrats and their inner circle were predominantly male, rampant cronyism exacerbated gender inequality and gender stratification throughout the healthcare policymaking process.

Moreover, even when they were cronies, women did not receive the same treatment as their male counterparts. Respondent K13 explained that female cronies were made to do less desirable tasks, while male cronies were given easier tasks. For example, one male crony was given the task of checking attendance lists, while a female crony was tasked with registering attendants, writing reports and dispatching correspondence. She added:

I am his supervisor here, yet I am given the big tasks and he is given a task that includes supervising me.

This type of role reversal was gendered; as highlighted by respondent K13, it did not happen to men. These findings reflect studies of sexism in which it has been found that women are generally treated less favourably than men for no other reason than because they are women (Bearman, Korobov and Thorne, 2009).

Bureaucratic elite capture

Respondents described how bureaucratic elite capture crippled objective decision-making and worsened gender inequality within the subnational governments. Respondent N25 explained:

These human resources policies we have are just a joke. They are never followed. Those who have connections to the top cartels are the ones who call the shots.

This statement shows that human resources policies served the interests of the bureaucratic elite, who could manipulate the policies for their own benefit. However, this was not the case for the rest of the staff.

In addition, respondents N21, K28 and K25 described the discrimination that women experienced when it came to procurement contracts. Men often colluded with and awarded large tendered contracts to their cronies, while women did not have access to such opportunities. This reflects patriarchal

norms by which women are viewed as lesser beings and therefore excluded from financial and professional growth opportunities (Mackay, 2015).

Respondent N31 stated that bureaucratic elites made rules and regulations to the exclusion of other groups, including women. As the elites were predominantly male, their agendas advanced male interests. When asked to pinpoint why women were generally excluded, N31 said that women were viewed as unimportant and not taken seriously. “It was a boys’ club,” she said. This reflects points of view adopted in sexist societies where patriarchy is deeply entrenched, with women being regarded as inferior and their opinions disregarded (Bjarnegård, 2018). Such views are used to justify gender inequality and disadvantage women.

The low status of women and their exclusion from elite bureaucratic circles also reflects research that has found that, in patriarchal societies, women are expected not to partake in important decision-making processes, but are expected to remain in the home (Mackay, 2015). Respondent K23 described “male privilege” as a club into which only men were invited. This phenomenon, according to respondents K13 and N30, represented an effort to compel women to tend to domestic chores instead of working overtime to complete tasks or attend late-night meetings. Respondents reported that there was a sense of degradation among women that made them take a back seat and accept their low status, putting men’s needs first. This observation further reflects studies that have shown how women internalize sexism and behave according to societal expectations (Bearman, Korobov and Thorne, 2009). It also relates to studies that have found that women prioritize the needs of their male partners over their own needs (Bjarnegård, 2018). When women internalize such stereotypes and perceive themselves to be unworthy, they too contribute to gender inequality and stratification in society.

Respondents also echoed studies that have concluded that men have always had the upper hand in society (Mackay, 2015). This view was supported by respondents K23 and N34, who argued that men always had it easy. Male privilege was common within healthcare financing policy processes. Respondent K11 was particularly conscious of male privilege when it came to setting meeting agendas. She said:

The men decide what to put on the table. You, as a woman, have no say. Even if I bribe [someone], it does not matter. If I contribute, they just ignore [me] or laugh. Or sometimes [they] pretend they like the idea [, but] then it’s suddenly dropped. I have not seen this happen to the men. We women are considered as mattresses for men, not the other way round.

Ultimately, the respondents felt that they were not taken seriously during decision-making or agenda-setting processes in the healthcare financing system. They were considered to be below men, “as mattresses”, which notably also has a sexual connotation, as it implies that women ought to lie down and wait for men to “do their thing”. They were often ignored and could tangibly feel their lower status.

Bureaucratic bribery

The interviews and focus group discussions revealed that bureaucratic bribery affected women and men differently. Respondent N23 explained that women had to pay bribes to obtain tender information for healthcare financing projects and that those who did not have the money were excluded. Since many women could not afford those payments, they ended up being left out. Respondent N45 added that even women who had the money to pay bribes faced difficulties in obtaining tender information, as they were pressured to provide sexual favours instead of money. This finding supports studies that have found that women are doubly disadvantaged by corruption, as they face both financial and physical costs when sexual favours are expected (Martins and others, 2018). It also affirms studies that have found that many women are locked out of corrupt networks, even when they have the financial resources to participate in them (Bjarnegård, 2018).

In the words of respondent K19:

We women are not subject to the same rules as men. When it comes to money, our money does not count for anything. Men tell us we have God-given bodies that should be free and available for them. So, if there is a deal, a woman won't get it, even if she has the money, unless she gives her body.

These findings highlight the dispossession and disempowerment of women, as compared to men, when it comes to accessing opportunities and participating in decision-making processes. Women were prevented from accessing lucrative opportunities and were not treated as equals, which worsened existing gender inequalities. The findings also confirm empirical evidence that points to women being excluded from decision-making processes, unless they give sexual favours (Bearman, Korobov and Thorne, 2009).

Respondent N33 stated that:

This sexual exploitation is too much. Sometimes you find a man slapping you for demanding your rights, and nothing is done to them. If you don't

give in to sex, they will not accept your money. They will frustrate you until you give in.

In addition to underlining the prevalence of sexual corruption, this statement highlights the connection between bureaucratic bribery and gender-based violence, the latter of which was imposed on women who refused to give in and provide sexual favours in such situations. Women were, first and foremost, regarded as sexual objects, before they were regarded as public officials. Notably, men were not subjected to the same treatment, demonstrating that even when both men and women participated in bribery, women were conferred a lower status than men. The disparity in treatment may also account for the smaller number of women represented in the upper echelons of leadership (Ilyas, Rasheed and Faiz, 2020).

Bureaucratic sexual corruption, or sextortion

The abuse of power to obtain sex or acts of a sexual nature, often referred to as sexual corruption or sextortion, was mentioned by multiple respondents. The data gathered provides details of the sexual corruption endemic in healthcare financing policymaking processes in the selected subnational governments; for example, respondent N22 provided the following details:

I am forced to give them sex to obtain health services.

Respondent K57 had this to say:

If you refuse to remove your underwear and have sex with him, your problem will not be attended to ...

Many women stated that they were expected to engage in sex in exchange for services. Respondent K41 discussed the effect that this had on her rights as a woman and the benefits that were withheld when she refused to comply. The missed opportunities included appointments to represent community stakeholders in healthcare financing subcommittees. This type of corruption adversely affected women and disproportionately impacted on their participation in healthcare financing policy processes. The prominence of sexual corruption in healthcare service delivery and policymaking reflects the view put forward in some feminist literature that women are, first and foremost, sexualized and treated as sexual objects by men (Code, 2011). This expression of gendered societal hierarchy enables the mistreatment of women, disempowers them and affects their status, rights and opportunities.

Bureaucratic embezzlement

Lastly, respondents described the various ways that bureaucratic embezzlement worsened gender inequality and gender stratification. As expressed by respondent K15, when bureaucrats steal public funds, the amount of money allocated for healthcare is reduced. Respondent N20 put it this way:

Now there are no drugs for me in this facility. I hear the money allocated was stolen. And they want to bring in new policies which they have not involved us in. How will this facility be self-sustaining if someone up there is busy stealing the money?

Women expressed that they were suffering as a result of the lack of medicinal drugs, as were other users, including men. However, the disproportionate number of women suffering was captured by respondent K15, who argued that women were the ones who went through childbirth and had young children to care for, thereby suggesting that women therefore had a greater need for such drugs and were thus more affected by the situation. The gendered and imbalanced burden borne by women when it comes to healthcare costs has also been demonstrated in previous studies (Ilyas, Rasheed and Faiz, 2020). These findings speak to the dire threat that bureaucratic embezzlement poses to the well-being of women in Kenya and to the implementation of healthcare financing policies.

Respondents K16 and N12 explained that theft and gender inequality went hand in hand in the healthcare financing process, because male bosses developed and organized seminars and workshops in which the main attendees were male. When asked why women did not participate fully in such seminars and workshops, respondents said that the meetings were set up in venues and neighbourhoods that were not safe or accessible for women. Moreover, respondent N12 noted that the allocation of funds for such meetings was inflated and manipulated, allowing proceeds to go to male bosses. Respondent N32 had this to say:

If you are told to steal, as a woman, can you really do it? The men are very clever; they steal by pretending to have workshops. Then they ensure they hold them near bars and in insecure places at odd hours. Surely, as a woman, can you attend?

Such experiences show that women were marginalized in every aspect of the healthcare financing policy process – both those aspects that were productive and those that were corrosive – including acts of embezzlement.

Respondent K19 lamented that women were not allowed to voice concern when acts of bureaucratic embezzlement were carried out. She said that women were considered “troublemakers” and could not successfully advocate for change. Her sense of helplessness illustrates another manifestation of the marginalization of women within the healthcare financing system. It also recalls gendered stereotypes in which certain traits are assigned to men, such as being “assertive”, while women are supposed to be “meek” and “submissive” (Bjarnegård, 2018).

Conclusion

The main limitation of this study is that no data were collected from male respondents. Nevertheless, the experiences and perceptions of the women interviewed exemplified their sense of gender-based marginalization and inequality. Moreover, the experiences of the respondents show that bureaucratic corruption affected gender inequality within healthcare financing policy processes in both Kiambu and Nairobi City Counties. The effect was significant, as it worsened existing gender-based stratification, stereotypes and violence. Notably, the interviews show that women were not only marginalized in policy-making processes, but also in situations involving bureaucratic corruption. Men dominated the political and decision-making processes while women were forced to play an insignificant supporting role. The evidence makes clear that women have been negatively and disproportionately affected by bureaucratic corruption in healthcare financing processes in the selected subnational governments. On the basis of this research, it is clear that the relationship between corruption and gender inequality is a topic that warrants additional attention and more empirical data.

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