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SOCIO-CULTURAL INFLUENCE ON FEMALE GENITAL MUTILATION PRACTICE IN NAROK COUNTY, KENYA

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ABSTRACT

Female Genital Mutilation (FGM) is known to bring about many serious medical problems, is a financial burden to the families, and causes gender inequalities, however, the question on how the sociocultural factors that contribute to the practice are interrelated is still partly answered. The main areas of investigation of the study were: the impact of religion on FGM frequency, family socioeconomic position curtains the family structure's influence on FGM, and education levels in the communities where FGM laws are practiced. The study used both quantitative (survey) and qualitative (focus group and interviews) data collection methods. The Structural-Functionalist Perspective, which considers FGM as a necessary evil that must be tolerated as a means to maintain social order, and the Social Exchange Theory, which regards FGM as a matter of choice depending on the perceived benefits and costs, were the two theoretical frameworks that guided the research. The study was conducted using a mixed-methods approach and a descriptive survey methodology was used to draw a combination of qualitative insights from focus groups and interviews and quantitative data through questionnaires. Through cluster and purposive sampling 85 participants were selected comprising women, religious leaders, healthcare professionals, and affected girls. Data was analyzed using descriptive statistics and thematic analysis, and then finding a large number of insights was the result. The researchers see FGM as a cultural aspect that still needs to be dealt with through multiple methods of eradication. Among the suggestions were the following strengthening the position of religious leaders in the fight against FGM, setting up economic empowerment programs such as microloans and vocational training, conducting education campaigns targeting both adults and kids, and offering alternative rites of passage instead of FGM. Next researchers should perform longitudinal studies that will look at the impact of alternative rites, the effectiveness of anti-FGM law enforcement, and the psychological consequences for survivors. In the end, the research pointed out how urgent it is for different sectors to work together to eliminate FGM and promote gender equality in Narok County.

Key Words: *Religion, Family Socio-Economic Status, Family Structures, Level of Education*

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INTRODUCTION

Female circumcision, female genital mutilation (FGM), is a procedure that involves the removal of the external genitalia and is carried out for cultural reasons, as defined by Ida and Saud (2020). The practice is deeply rooted in different ways of thinking, such as religion and culture, or through socio-spiritual beliefs about the woman's sexuality that imposes controlling measures and the guaranteeing of her chastity during the period leading to marriage. Osoro (2022) considers FGM to be a violation of the most basic human rights of women, a perception that has been globally accepted. The operation later results in physical, mental, and sexual health complications (Osoro, 2022). It was first practiced in Ancient Egypt but over the years it has extended its geographical reach to Africa, the Middle East, and some Asian communities (Kiplagat, 2022). International organizations, governments, and grassroots movements have continually directed their efforts towards eradicating female genital mutilation through educating the public about the implications of the practice, advocating, and introducing legal measures for the same. Even though FGM has been resisted by communities and support given to the causes of culture and social norms have still been recognized as major obstacles in the global fight against this unhealthy practice (Otieno, 2021).

Although the Female Genital Mutilation (FGM) is not a common practice in Europe, the arrival of immigrant communities from FGM countries is a cause for alarm. Delaunay and co-workers (2019) concluded that girls living within the FGM practicing communities are in danger, as in some cases, the procedure is done during family visits to their native countries. The practice is justified by the social pressure and cultural practices in the girl's families' native countries. All countries in the European Union have put laws against FGM; additionally, many provide healthcare protocols for the detection and prevention of FGM among girls (Li, 2020). Data gathering about FGM in Europe is far from easy; nevertheless, some rough estimates point to a number of 50-600 thousand girls and women who have either experienced FGM or are susceptible to it. Elnashar et al. (2021) revealed the extent of FGM in Dagestan, a Russian region, mainly among the Avars and Dargins, two ethnic groups. The justifications for FGM in this area are based on culture and tradition, and even though the religious basis is not there, the perceived religious mandates still play a role. The researchers claim around 80% of the women in Dagestan are subjected to it. FGM has been banned under the Federal Acts of 1993 in the United States, but the issue of girls from FGM practicing communities being taken overseas or secretly undergoing the procedure within the US still exists. Khan's (2020) research pointed out the hidden nature of the practice as the main reason for the difficulty in monitoring girls at risk. Like in Europe, the practice is sustained by the social norms and cultural traditions coming from the practicing communities. The study also made an estimate suggesting between 500,000 to 2 million female populaces were affected.

In Ghana, the proportion of women undergoing FGM is pretty small, especially when compared to many other African nations. The research of Tadele (2022) was carried out in Ghana, and mostly the issue is about FGM in the case of some ethnic groups, particularly in the northern regions. Main reasons for FGM in Ghana are connected with cultural traditions and beliefs even though there is no medical justification at all. Ghana has made FGM illegal, but public awareness campaigns and law enforcement are two of the major areas where progress has been made. The rate of FGM among women aged 15-49 in Ghana is about 4% (MICS, 2011). Okonofua (2022) analyzed the rate of FGM and the factors determining it in Nigeria. Among the reasons justifying FGM in Nigeria are culture, religion and the way women are perceived to be feminine. The federal government of Nigeria has outlawed FGM, but its implementation is not consistent across the states. About one in five women aged 15-49 has been subjected to the procedure (NDHS, 2018). In Tanzania, the practice of FGM is still present and despite the campaign against it many women still undergo the procedure. Korfker (2021) did a study in Tanzania that talked about FGM and stated that it is a problem of certain ethnic groups, especially in the rural areas. Reasons for FGM in Tanzania are mainly taken from cultural and traditional beliefs such as participants of initiation rites and social acceptance. Among the measures taken in Tanzania to combat FGM is the criminalization of the practice, and the implementation of various awareness-raising and community-support projects. According to the 2015-2016 Tanzania Demographic and Health Survey (TDHS),

about 10% of women in the reproductive age of 15-49 have been subjected to FGM, while in Kenya the rate was even higher at 21% in 2023 (KDHS, 2023).

The practice of FGM is very old and usually linked with initiation rites going into womanhood, perceived purity, and compliance with cultural norms. It is still very common in some areas even though there have been campaigns against FGM. The law in Kenya has been passed that forbids and makes FGM a crime including the Prohibition of Female Genital Mutilation Act which punishes by giving a fine or prison terms those who are found guilty of operating or supporting FGM (Ontiri, 2022). The current academic paper is directed at evaluating factors that lead to FGM in Kenya. The study took into consideration the socio-cultural factors and aimed to evaluate their impact in the country, especially in Narok County.

According to Mwendwa (2022), socio-cultural factors are the social and cultural influences that shape a society's behaviors, beliefs, attitudes, and practices. These factors consist of cultural norms, traditions, values, religious beliefs, social and economic statuses, gender roles, family interrelations, and community structures, which are very important for the understanding of human behavior in a diverse way. In a similar vein, Chen (2021) looked into Asian American non-medical prescription drug use, taking into account acculturation stress and cultural norms. Moreover, Gele (2020) studied the Somali population in Oslo and revealed some of the reasons for FGM to take place such as the adherence to culture and the pressure from people. Besides, Molla (2020) was researching the problem of HIV/AIDS treatment adherence in Ethiopia, the effects of stigma and cultural beliefs on it. Kisa (2022) choice of topic was male circumcision in Uganda, where he discovered the impact of masculinity norms and social influences. Muteshi (2022) evaluated the role of community education on FGM/C in Kenya and analyzed the influence of traditional beliefs and socio-economic factors. Furthermore, the present study took out factors like religion, family socio-economic status, family structure, and education level into account.

Religion is a term applied to a broad repertoire of beliefs, rituals, and ideas that touch upon the spiritual and moral spheres of existence, and these are often revolving around the veneration of one or several gods. Among the many facets of religion are its various rites, ceremonies, moral rules, and creeds that together form the very fabric of the religious community and their perception of the divine as well as their interaction with nature (Barker, 2013). People receiving influence from religion in different ways—individuals' society's views, actions, and interactions—are the main areas of life religion to family relationships, community participation, and moral judgments (Cadge, 2024). Religion is a necessary factor in comprehension of the socio-cultural provenance of female genital mutilation (FGM) practices. Religious beliefs establish the social norms and behaviors that are accepted and practiced which might vary according to the dissemination and reception of particular religious doctrines. The clergy and churches are considered to be the most powerful players in this area, and they often determine the standpoints taken by society and the level of social unity surrounding matters such as FGM. Religion can be a tool or a barrier in the intersections of cultural and religious beliefs that are very powerful both in shaping the attitudes and the behaviors of the people residing in Narok County with regard to FGM and in the similar contexts.

Sirin (2020) views the socio-economic status (SES) of a family as the sum of the economic and social position of a family, defined by the educational background, the amount of money they can spend, the social esteem and the job of the head of the family. SES shows the resources, opportunities and the privileges a family has, which can determine their access to healthcare, education, housing and other essential services (Bradley & Corwyn, 2002). Socio-economic status that is higher is often linked to financial stability, educational attainment and social mobility to a greater extent, while lower SES could mean the opposite of economic hardship, limited educational opportunities and increased susceptibility to social inequalities (Duncan & Magnuson, 2012). The socio-economic status of the families in Narok County being understood allows the identification of the socio-cultural factors that determine FGM prevalence. Families with lower SES may continue to practice FGM more than others for the reasons of economic hardship, social pressure, or just the

lack of alternative opportunities for their daughters. On the other hand, families with higher SES may not only have the resources but also the inclination to resist the traditional norms and seek education and healthcare services that are contrary to FGM.

The scope of the present study was Emurua Dikirr, in the larger Narok County, located in southwestern Kenya, bordered by several counties and has a population of around 1.1 million people. The county is known for its rich cultural heritage, particularly the Maasai traditions. The Maasai are a semi-nomadic pastoralist group who rely on herding livestock for their livelihood. They practice community-based living, with a strong sense of community and land ownership. According to the KNBS (2021) Emurua Dikirr has a population of 111, 183, 309.81Km² area giving a density of 358.9 persons per square Km. KIHBS indicates that Narok, as a county, has a 36.1 % poverty index. The sub conty of Emurua Dikirr does not have any hospital but only 19 heath centres and dispensaries and a ratio of 1 doctor to 165,000 patients. The prevalence of HIV/AIDS prevalence is at 12% among the productive of age between 15 and 49 years while its spread is associated with high poverty levels, outdated socio-cultural practices including early marriages and FGM. Despite the interventions by government agencies, the anticipated behavioural changes remain a mirage (Kiplagat, 2022).

Statement of the Problem

The practice of female genital mutilation (FGM) still poses a major issue in Kenya especially in those areas that are outlying where cultural traditions are very strong. Even though there are legal interdictions and awareness campaigns, FGM still goes on in societies where it is very much rooted (Magara, 2023). From the economic standpoint, FGM increases the gap between the rich and the poor since families usually bear a large part of the cost for FGM ceremonies, with the ones living in poverty being the most affected (Kirui, 2022). FGM strengthens the existing gender inequality, as it continues to promote the harmful gender stereotypes that prioritize male power over female freedom and authority (Omingo, 2021). Young girls undergoing FGM may not be able to continue their education because of health problems or social stigma, which in turn, further deepens gender inequities. Besides, the health risks of FGM are severe for women and girls, such as intense pain, infection and long-term complications during childbirth and psychological trauma. FGM not only violates the rights of girls and women but also subjects them to deprivations of bodily integrity, health, and non-violent conditions (MoH, 2022).

Researching FGM issue and its roots has been a topic of interest for many researchers. Riskesdaswati (2022) specifically addressed the issue of FGM in Indonesia by looking at the different religions and cultures present in the country. Out of all the possible reasons for FGM, it put religion in the forefront because the communities performing the ritual believed it to be a step in the girls' lives. The study, however, did not consider other socio-cultural factors like, for instance, the educational level. Aputaa's (2022) study on the causes and protective factors of female genital mutilation (FGM) in Ghana revealed a complex interplay of factors that included traditions, religious beliefs, and gender norms. One of the most powerful influences in this process is the social pressure to live up to the cultural expectations and the idea that FGM will make a girl more eligible for marriage. M'Inoti (2012) looked at the cessation of FGM in Kenya using an anthropological approach. The study employed qualitative methods, which included in-depth interviews with clan elders and traditional birth attendants as the main data collection ways

The study identifies the influence of community stakeholders, such as elders who perpetuate FGM traditions and TBAs who can be both obstacles and agents of change. However, the study's rich detail may not be applicable to the entire country. The study however failed to utilize quantitative techniques of research. This study aimed to address the above research gaps by examining the influence of sociocultural factors on the practice of FGM in Narok County.

Objectives of the Study

The main objective of the study was to assess the socio-cultural influence on female genital mutilation practice in Narok County, Kenya

The Specific objectives of the study were as below

- To establish the extent to which religion influenced the practice of FGM in Narok County, Kenya.
- To determine the relationship between family socio-economic status and the practice of FGM in Narok County, Kenya.
- To examine the influence of family structures in the practice of FGM in Narok County, Kenya.
- To evaluate how the level of education of the household influenced the practice of FGM in Narok County, Kenya.

LITERATURE REVIEW

Theoretical Review

Social Exchange Theory

Blau (1960) developed social exchange theory, which Emerson (1962) and Homans (1961) incorporated as part of their conception of society that encompasses social activities based on integration in small groups and social trade (reciprocity). Social networks, which arrange patterns of interaction between various social positions, make up Blau's (1977) concept of social structure. Men and women, as well as the rich and the impoverished, are examples of social classes. According to Blau, discussing social structure entails discussing individual differences. Blau means a social distinction along some discernible social trait that ultimately determines who interacts with whom, for example, there is less interaction between two groups if they can be distinguished from one another (Manu, 2021).

According to the social exchange theory, social behavior in comparatively free societies arises from individual decisions between the best possible costs and rewards (Ahmad, 2021). The theory is closely related to the economics-based rational choice theory. According to this view, people would act logically and try to maximize their own gains when making decisions in life (ibid). Social exchange theorists contend that a subjective CBA and alternative comparison are the foundations of all human relationships. For instance, the theory predicts that a person will decide to end a relationship if they believe the costs of the partnership outweigh the apparent benefits (Wanjiru, 2022).

When people choose to participate in FGM, they are relating the social exchange perspective to the procedure. The practice's alleged advantages for the individual may have an impact on this decision. Despite their education, some women choose to get cut, according to MYWO (2009). To avoid losing prospective husbands from circumcising cultures, some girls from non-circumcising societies embrace the cut. For example, laws prohibiting female genital mutilation have been criticized for having no bearing on women who voluntarily undertake the procedure. According to the social exchange theory, people interact with others based on their potential benefits and drawbacks. Efforts to remove FGM within the Emurua Dikirr Community are negatively impacted by the practice of these women, who view it as an integral part of who they are. Additionally, this situation allows circumcised women to exert intense peer pressure on uncut girls.

Structural - Functionalist Perspective

A framework for developing theory, the structural-functional approach views society as a complex system whose components cooperate to foster stability and solidarity. The method emphasizes the significance of social structure, or any comparatively consistent pattern of social activity, as its name implies. Our lives are shaped by social structure in our communities, workplaces, and families. Second, the method searches for the social functions of every structure and the effects of any social pattern on how society performs overall. Auguste Comte, who recognized the importance of social integration in an era of fast change, is largely responsible for the structural-functional approach. This perspective also served as the foundation for the work of Emile Durkheim, who helped create sociology in French universities.

Spencer (1896) likened society to the human body, stating that social structures cooperate to maintain society

in the same way as the skeleton, muscles, and other internal organs of the human body work together to support the organism's survival. Thus, the structural-functional method guides sociologists in recognizing different societal structures and examining their roles. By pointing out that any social organization most likely serves a variety of purposes, some of which are more apparent than others, Merton (1957) broadens our knowledge of social function. He makes a distinction between hidden functions, which are the unexpected and unacknowledged effects of any social pattern, and manifest functions, the planned and acknowledged effects of any social pattern.

Therefore, it is important to consider how societal norms influence and normalize behavior while analyzing the practice of FGM. Everyday social interactions teach and reinforce norms, which in turn mold and impact behavior (Berger & Luckmann, 1967). This normalizes the control of women's sexuality and bodies. The Emurua Dikirr Community views female genital mutilation as a significant transition from a girl to a respected woman; a woman who has been circumcised is regarded as mature, submissive, and conscious of her place in the family and society—qualities that are highly prized in the community. However, the negative effects of FGM include physical injury and the resulting health complications during childbirth (Earp, 2022).

The fear of not accessing resources and opportunities as a young woman, pressure from peers including acceptance in the society, and the desire to secure marriage chances are all factors that contribute to the widespread practice of female genital mutilation (FGM) (UNICEF 2022). This social norm is associated with various tangible socio-cultural perceptions, the majority of which are associated with regional views on religion, gender, and sexuality. Therefore, it is necessary to incorporate the sociocultural background of the practicing community into attempts to stop FGM practices. According to Aisha (2021), social and cultural events must be evaluated within a certain context in order to produce meaningful outcomes. She also offers a solid foundation for the understanding of the compelling and persistent patterns evident in practicing societies. In raising awareness and educating all about the effects of FGM on the general development of women in society, all stakeholders including NGOs, governments, partners in development and all non-state actors should be cognizant of the importance of FGM to communities that practice it. Abandonment techniques would be more successfully accepted by practicing groups as a result of this social interaction.

Empirical Review

In the UK, Smith (2020) looked into the effects of faith-based beliefs on FGM rates among the continual flow of immigrants who come from a certain religious background. The aim was to get a clear picture of how the interpretation of religion and the practicing of different cultures got FGM to be a thing of the past. Using social identity theory as a starting point, the migration study focused on the communities from the UK where the residents came from FGM-tolerating countries. Following qualitative study and coming up with a total of 50 participants through purposeful selection, the main data was obtained by means of personal interviews which were then analyzed using themes. Communities' religious variations were uncovered as a result of the research, which in turn affected the FGM practices being followed or completely rejected. The research pointed out that interventions depending on culture and community involvement to deal with FGM in the UK immigrant population are crucial.

Zhang (2019) did a research study that was aimed at determining the extent of FGM among the minority ethnic groups. The main question that the study tried to answer was what religious and cultural factors were at the root of FGM practices in certain parts of China. By using mixed-methods research, the project focused on the minority ethnic communities that were suspected to have FGM in their midst. Data collection occurred through a combination of surveys, interviews, and focus group discussions and the total sample size was 200 people. The results revealed that there were small areas with a high prevalence of FGM due to cultural and social factors, especially in the secluded areas that had limited access to education and healthcare. The research suggested that such measures should be directed to specific people and that community-based education should be part of the strategies for the eradication of FGM practices in these places.

In 2019, Mwangi conducted a study in Kenya to analyze the role of religions in regard to the different tribes' preferences and practices towards FGM. The chief objective was to identify the contribution of religious teachings and cultural practices to the continuation of FGM in spite of the laws forbidding it. The qualitative research design used targeted communities with high FGM prevalence. The data was collected through document analysis, group discussions, and individual interviews. The results revealed the close connections between religious beliefs, cultural practices, and the socio-economic status among the people that allowed for the continuance of FGM practices. The research pointed out the need for community-based approaches and collaboration between various sectors to tackle the underlying issues of FGM in Kenya.

In the research done by Jones (2019), one of the factors that were examined was the family socio-economic status (SES) in relation to the prevalence of FGM among the immigrant communities. The main goal of the study was to check the impact of socio-economic factors on the attitudes and practices related to FGM in immigrant families. Based on the social stratification theory, the study focused on the immigrant communities from the countries where FGM is a common practice and who have been relocated to the USA. For this purpose, a quantitative approach was taken, and the sample size was of 300 participants who were selected through random sampling. Data was analyzed through various statistical methods, one being regression modeling. The results pointed to a robust connection between low SES and the prevalence of FGM being higher in immigrant communities. The researchers argued that it is important to tackle economic disparities first to be successful in stopping FGM in immigrant populations in the USA.

Abubakar (2020) has explored the impact of the economic and social status of a family on the FGM rate in various ethnic groups. The goal was to evaluate the contribution of socio-economic disparities to the different FGM rates in various culturally and ethnically mixed areas. Based on the social ecological theory, the researchers focused on different ethnic groups where FGM prevalence was high or low. The researchers used a mixed-methods approach and collected data from a sample size of 400 respondents chosen by multi-stage cluster sampling. Surveys, interviews, and participant observation were the three methods of data collection and analysis of qualitative and quantitative techniques were both ways of interpretation. The results pointed out a link between lower family SES and higher incidence of FGM in different ethnic groups. The researcher pointed out the fact that it is very important to tackle socio-economic inequalities if the fight against FGM in Nigeria is not to be In vain.

Kimaro (2021) on the other hand, has conducted a research in Tanzania about the relationship between family SES and FGM prevalence in both rural and urban populations. The aim was to evaluate the effect of socio-economic factors on the attitudes and practices related to FGM in different socio-cultural contexts. The research was based on social epidemiology theory and was targeting urban and rural communities where FGM was practiced and the prevalence was documented. The researchers employed a quantitative research design and collected data from a sample of 500 individuals who were selected using the stratified random sampling method. The study made use of surveys and structured interviews as the primary data collection methods. The results showed that lower socio-economic status was associated with higher prevalence of FGM, especially in rural areas. The research pointed out that there is a strong need for socio-economic empowerment initiatives that will help the fight against FGM in Tanzania.

Smith (2019) aimed to determine the relationship between family structure and FGM occurrence in the immigrant communities. The specific objective was to study the influence of family dynamics (such as household makeup and parental roles) on the attitudes and practices of FGM in immigrant families. The research applied family systems theory and was focused on immigrant populations from countries where FGM is practiced, living in the USA. The study employed convenience sampling and collected data from 400 subjects while using a quantitative approach. The researchers conducted the analysis of the data using chi-square tests and logistic regression methods. One of the main findings indicated that family structure was a major factor that contributed to the continuing of FGM practices in immigrant communities, particularly in the

case of both extended and patriarchal family systems. The researchers also suggested that working on family dynamics and promoting gender equity in immigrant families are the key factors in combating FGM in the USA.

In a similar study conducted in Indonesia, Wijaya (2021) analyzed the impact of family structure on the variance of FGM among the rural and urban populations. The aim was to evaluate how differences in family structures, consisting of kinship networks and household composition, gave rise to different FGM attitudes and practices in various socio-cultural contexts. The research was based on social exchange theory and had its sights set on rural and urban areas known for FGM prevalence. The research was of the mixed-methods type and the sample consisted of 300 participants. Surveys, interviews, and participant observation were some of the data-gathering methods used, and the data was analyzed both thematically and quantitatively. Among the key findings, family structure, e.g. strong kinship ties and hierarchical family dynamics, affected the continuation of FGM practices, particularly in rural environments. The study emphasized the need for family-centered interventions to address FGM in Indonesia.

Muthoni (2022) studied the correlation between FGM prevalence and the family unit in different ethnic groups. The aim was to investigate how differences in the structure of families such as the composition of households and relations between family members would influence views and practices concerning FGM in the different areas. Guided by the social determinants of health theory, the research chose diverse ethnic groups with varying prevalence rates of FGM in the regions where the targeted communities were located. Through a quantitative research approach, 450 respondents were sampled, who were identified purposively, and data were collected in the form of interviews, surveys, and focus group discussions. Both inferential and descriptive statistics were used in the analysis of the data. The findings indicated that the family structure, in particular the extended family networks and the observance of traditional gender roles, played a major role in the continuation of FGM practices among different ethnic groups. The results not only showed but also underscored the necessity for family-oriented interventions to fight against FGM in Kenya.

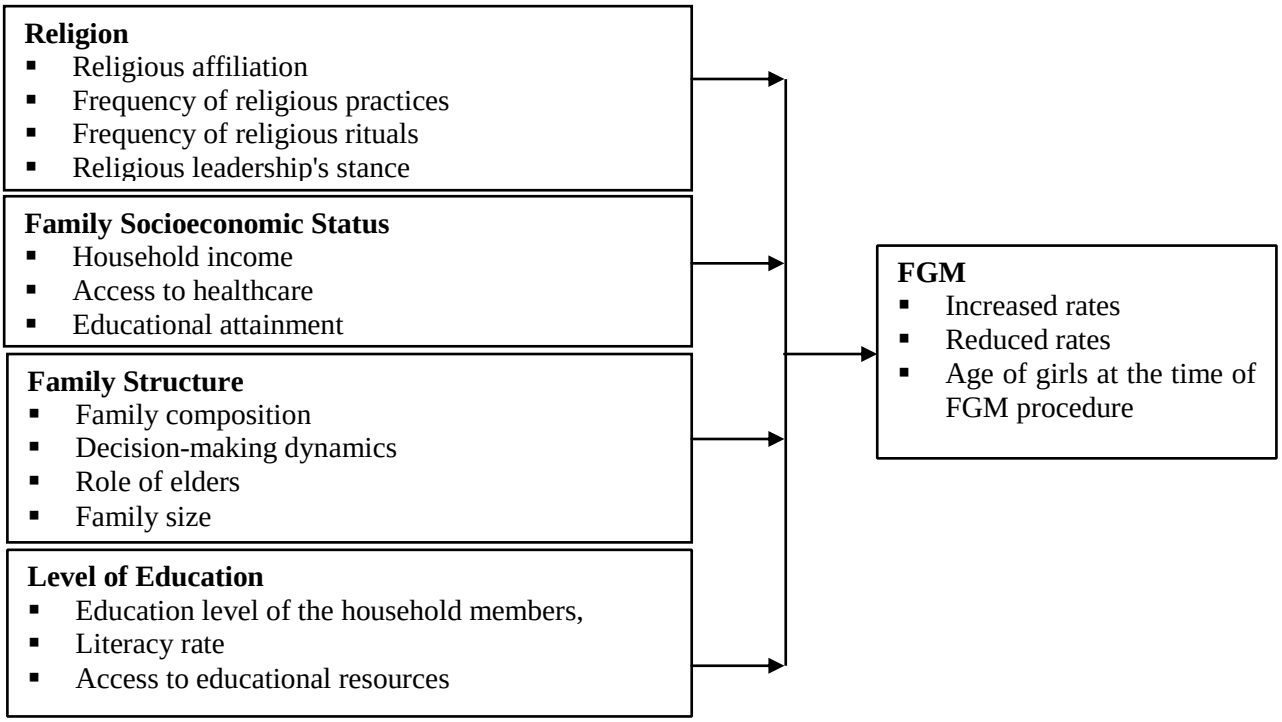
Rodriguez (2019) investigated how the education level and the incidence of FGM in immigrant communities were interrelated. The study aimed at evaluating the role of the educational level in changing attitudes and the FGM-related practices of immigrant families from FGM-practicing countries who live in South America. Conducted on the basis of social cognitive theory, the study focused on a specific immigrant community already having reported cases of FGM. A sample of 300 people was taken through a non-random method in a quantitative design. The study indicated that educated people supported reducing FGM practices in immigrant communities in South America. Therefore, the study emphasized the importance of educational interventions and literacy programs in the complete eradication of FGM among the immigrant communities in the area.

Nakato (2022) carried out a study to evaluate the effect of community education programs on the prevalence of FGM in rural populations. The study highlighted the educational interventions as effective in both FGM rate reduction and change of community's perception towards the practice. It was planned under the diffusion of innovations theory and targeted those rural communities where FGM was still prevalent and had been documented. The researchers used a mixed-methods approach and took a sample of 400 participants selected through stratified random sampling. A combination of surveys, interviews, and community outreach activities was used to collect data, which were analyzed thematically and quantitatively. The results showed that community education programs played a major role in the prevalence reduction of FGM and increased the positive social acceptance of gender equality and women's rights in rural Uganda. The findings showed the value of community-led educational initiatives in combating FGM.

Kiprop (2021) conducted research on parental education and FGM, among different ethnic groups, and their relationship, examining the impact of variations in parental education on the acceptance and practice of FGM in different cultures. He used social cognitive theory and targeted communities that represented different ethnicities with varying prevalence of FGM. The study followed a quantitative approach data was collected

from 600 households identified through clustering. The findings showed that the education of parents played a significant role in reducing the number of children undergoing FGM in households of different ethnic groups in Kenya. The study highlighted the key role of education in enabling parents to make informed choices and safeguarding their children from pernicious practices like FGM.

Conceptual Framework



Independent Variable **Dependent Variable**

Figure 1: Conceptual Framework

Source: Researcher (2024)

METHODOLOGY

The study adopted the Descriptive Survey approach to research. The study was intended to be conducted in Emurua Dikirr Sub-County. In the 2017 demographic and health survey, 91% of the women interviewed from the Kalenjin population had undergone circumcision, making it one of the most prevalent and deeply ingrained places for the ritual.

Emurua Dikirr Sub- County has a total population of approximately 108, 000 residents (National Census, 2019). However, the study targeted only the girls affected with FGM together with women, administrative officers, health professionals and religious leaders in those areas. According to World Health Organization (2023), there are 500 girls affected by FGM Emurua Dikirr Sub- County and the regions where these girls reside have a total of 150 women, 50 Administrative Officers, 100 Health Professionals and 50 Religious

The population was divided into strata from which the sample was identified including 50 girls, 15 women, 5 administrative officers, 15 professionals in the health sector and 10 religious leaders. The sampling technique that was used was stratified sampling, a probability sampling technique, as the population was divided into the selected groups. A census survey was conducted to enhance the veracity of the collected research data and improve the response rate. The study adopted a 10% portion of each group's target population in the following manner

To meet its goals, both secondary and primary data was utilized. Data that is already being used for objectives other than the researcher's own is referred to as secondary data. For example, information about FGM cases in

health centers. On the other hand, primary data is information that the researcher has directly collected from field respondents. The researcher studied female genital mutilation (FGM) using both quantitative and qualitative data collection approaches.

The study used questionnaires as a primary data collection tool, specifically semi-structured ones, to gather information on the relevance of FGM among the Emurua Dikirr community, its health implications, and people's knowledge of FGM laws.

The research instrument was tested for validity and reliability before it could be deployed to the filed. The pilot study was conducted in Kilgoris sub county targeting 22 respondents (10% of the study sample). The piloting is necessary in ensuring that the instrument is not only valid and reliable but also eliminating errors, ambiguity and confusion that it may bring about (Neuman, 2014).

Creswell (2020) defines validity as the extent to which conclusions drawn from the examination of primary data collected during research truly represent the subject under study. The degree to which the researcher's data accurately depicts the phenomenon being studied is known as validity. Utilizing content validity, it was possible to determine whether the question tests were suitable for the purposes for which they were designed.

The study employed SPSS software to calculate the reliability of a questionnaire applying Cronbach's Alpha Coefficients. The reliability indicator varies between 0 and 1, with a number closer to 0 signifying a greater error and a number closer to 1 signifying the complete absence of variable error. Reliability estimation methods included: internal consistency, split-half method, parallel-form methodology, and test-retest. The measure of internal consistency was done using Cronbach Alpha which should have at least 0.70 or above, for it to be deemed reliable. The qualitative paradigm was utilized to eliminate bias and enhance the researcher's truthfulness. University supervisors and experts were involved in data collection to ensure validity. The instrument's reliability was established through a pilot study, followed by modifications to enhance clarity.

In order to make the data ready for analysis, the researcher used the raw data, then coded it to the minimum quality standards, next assigned the numerical values to different responses, and finally entered the data into the SPSS software for the purpose of conducting the analysis. The whole process assures that the data used for the analysis in the statistical software is of high quality and accurate. The main method used in the study was descriptive statistics together with measures of dispersion. In organizing and summarizing data, these descriptive statistics were applied, considering the nature of the subject (Sharp, 2021; Kirigo, 2022. The Pearson Correlation Coefficient and regression analysis. The variation among the study variables was assessed by ANOVA and Fisher's test. The qualitative data were analyzed thematically to identify the trends. The themes were then identified and interpreted in order to provide insights into the participants' experiences, perceptions, and attitudes concerning the socio-cultural influences on FGM in Narok County, Kenya.

RESULTS

The study had a sample size of 85 respondents, categorized as follows: 50 girls, 15 women, 5 administrative officers, 10 health professionals, and 5 religious figures. The response rate is as tabulated below.

Out of 80 respondents, who received the questionnaires, 80 shown to be eager to take part in the research and duly returned the questionnaires while 5 did not, thus giving a 94.12% response rate.

Descriptive Statistics

Female Genital Mutilation

The study aimed to assess how much the indicators of FGM have changed. Participants were asked to rate the degree of change in these indicators using the provided Likert scale. A summary of the responses is tabulated below.

Table 1: Female Genital Mutilation

Indicator	Mean	Std Dev	Response Mode
Increased rates of FGM	4.1	0.85	5 (Very large extent)
Reduced rates of FGM	2.0	0.90	1 (Very small extent)
Age of girls at the time of FGM procedure	3.5	1.10	4 (Large extent)

Source: Research Data (2025)

The study illustrated a prominent shift in the indicators of Female Genital Mutilation (FGM) as per the feedback provided by 80 respondents. For the signal of increased FGM cases, the average answer was 4.1, with an SD of 0.85, which means that the occurrence of FGM practices has gone up to a very large scale, out of which "very large" was the most frequently chosen. This is in agreement with the reports of similar studies, such as the one by Somene (2020), which also states that the FGM practices have increased largely due to various socio-cultural factors. On the other hand, the sign of decrease in FGM had a mean of 2.0 and an SD of 0.90, which signifies that the majority of the respondents thought that there had been only a slight reduction in the practice, and the response "very small extent" was the one that most people gave. This finding is consistent with the study of Njoroge (2020), who claimed that the anti-FGM movement had achieved limited success in significantly lowering its prevalence. Concerning the age of girls who undergo FGM; the mean was 3.5 with an SD of 1.10, portraying a moderate to large shift in the age circle of the operation, with "large extent" being the most frequent response. This result reflects Njoroge's (2020) viewpoint that while the age of girls undergoing FGM has increased, it remains a significant problem that requires the support of preventive measures. Overall, these findings demonstrate a complex picture of both progress and setbacks in the fight against FGM, with an overall trend indicating an increase in the practice, particularly in certain regions.

Religion

The research scrutinized the influence of religion on FGM practice in Narok County and the informants indicated the degree of this influence through Likert scale queries related to religion. The overall results of their comments are shown in Table 2 underneath.

Table 2: Religion

Indicator	Mean	Std Dev	Response Mode
My religious beliefs discourage support for FGM	4.3	0.70	5 (Very large extent)
Religious teachings actively discourage FGM practices	4.1	0.80	5 (Very large extent)
Religious gatherings provide a platform to condemn FGM	3.8	0.90	4 (Large extent)
My religious community advocates against FGM practices	4.0	0.85	5 (Very large extent)

Source: Research Data (2025)

In terms of the impact of religion on attitudes toward FGM, the results indicated a strong connection between religious beliefs and practices in forming perceptions of FGM. The indicator "My religious beliefs discourage support for FGM" had a mean score of 4.3 with a standard deviation of 0.70 signifying that the majority of the respondents were in strong agreement that their religious beliefs were against FGM, "very large extent" being the most frequent answer. The indicator "Religious teachings actively discourage FGM practices," on the other hand, registered a mean score of 4.1 and an SD of 0.80, thus, revealing that most of the respondents claimed that religion was teaching to play a considerable role in the active discouraging of FGM practices. This result is in line with Somene (2021) who remarked that religious teachings and beliefs very often act as a powerful discouragement against the acceptance of such harmful cultural practices as FGM, particularly, among the communities where religion is so much integrated into the daily life.

Moreover, the variables “religious gatherings provide a platform to condemn FGM” and “My religious community advocates against FGM practices” had averages of 3.8 and 4.0 respectively with 0.90 and 0.85 as

their standard deviations. The measures indicate that religiously allowed places and communities do not interchangeably criticise the practice of FGM but the degree to which they do to a limited extent is not the same everywhere. The response categories of “to a large extent” and “to a very large extent” are the indications that there is a consensus among people that religious communities are gradually holding their platforms to discuss and denounce FGM. Nevertheless, as Somo (2021) noted, the power of the religious communities' anti-FGM campaign can differ, and some religious leaders may not even secretly challenge the cultural practices that are left over despite their beliefs. Ultimately, the research points out the strong influence of religion in undermining FGM practices, but the level of advocacy and engagement of religious community varies based on the context and the interpretation of religious teachings.

Family Socio-economic Status

The second objective investigates how family Socio-economic Status affects the practice of FGM in Narok County, Kenya. To measure the extent of this impact, the participants responded to Likert scale questions concerning Family Socio-economic Status. The results are shown in Table 3 below.

Table 3: Family Socio-economic Status

Indicator	Mean	Std Dev
Financial constraints hinder access to healthcare services related to FGM	4.2	0.75
Household income determines accessibility of FGM-related healthcare services	4.0	0.80
Adequate income allows families to resist pressure for FGM	3.6	1.00
Financial stability reduces vulnerability to FGM coercion	3.8	0.90

Source: Research Data (2025)

The family socio-economic status and the FGM prevalence showed a strong correlation in the study with financial constraints and households' income determining their relationship. Taking the statement "Financial constraints hinder access to healthcare services related to FGM" as an example, the mean score of 4.2 and the standard deviation of 0.75 indicate that the majority of respondents considered financial barriers to be healthcare services for FGM-related complications to a great extent. The "very large extent" response mode implies that the participants had a common view that the lack of financial resources was one of the factors that made it even harder to get medical treatment. Analogously, the indicator "Household income determines accessibility to FGM-related healthcare services" received a mean of 4.0 and a standard deviation of 0.80, which shows that most of the participants believed that the level of household income was a significant factor in determining access to healthcare services related to FGM. The study results are consistent with Omweli (2021) who has shown that economic hardships are a major cause of delayed medical treatment and increased FGM vulnerability among girls.

Moreover, the findings from the research also pointed out that financial stability is a factor that mitigates FGM. The average score for the question "Adequate income allows families to resist pressure for FGM" was 3.6, with a standard deviation of 1.00, which means that even though income does make it easier for families to push back against the pressure from the society, it is still not an absolute protection, as many families go through the same pressure even if they are well-off. On top of that, "Financial stability reduces vulnerability to FGM coercion" scored a mean of 3.8 and an SD of 0.90, which means that the participants voted overwhelmingly in favor of the idea that financial security has a big impact on the lessening of the demand for FGM-related coercion. Such results are in agreement with the recommendations of Osongo (2021) who mentioned that although financial stability might shield families from cultural pressure. However, the practice of FGM can still not be completely wiped out. In conclusion, the research has thrown light on the multifaceted relationship between socio-economic factors and the existence of FGM, indicating that economic constraints and household income continue to be key factors in enabling or constraining access to healthcare and in the resistance to FGM practices.

Family Structures

The third objective of the study was to examine the impact of Family structures on FGM in Narok County, Kenya. Respondents were asked to indicate the extent of this effect through Likert scale questions regarding Family structures. The summary of their responses is presented in Table 4 below.

Table 4: Family Structures

Indicator	Mean	Std Dev	Response Mode
Family size affects the prevalence of FGM within households	4.2	0.75	5 (Very large extent)
Larger families may face greater pressure for FGM conformity	4.0	0.80	5 (Very large extent)
Small families may have more individualized decisions on FGM	3.7	1.00	4 (Large extent)
Extended family influences attitudes and practices towards FGM	4.1	0.85	5 (Very large extent)

Source: Research Data (2025)

The results of the current study emphasize family structure as a dominant factor in the FGM prevalence and practice. From the data analyzed, it is inferred that the larger the family the more they are likely be subjected to the FGM practice. The indicator “Family size affects the prevalence of FGM within households” received the mean response of 4.2 with a standard deviation (SD) of 0.75, which means that there’s a broad agreement among the respondents that family size is a very important factor in the FGM prevalence. The “very large extent” mode of response also conveys that the larger the family the more they are likely to take part in or be the ones to yield to the societal pressure of the FGM practice. Likewise, the indication “Larger families may face greater pressure for FGM conformity” had a mean of 4.0 and an SD of 0.80, which shows that the people who responded to the survey had a very strong opinion that larger families are always more under societal pressure to conform to FGM practices.

On the other hand, the study findings made it clear that the family size had a great impact on the FGM decision-making process, saying it was more individual in the case of smaller families. The mean for "Small families may have more individualized decisions on FGM" was 3.7 with an SD of 1.00, which indicates that the respondents believed that smaller family units might make more independent decisions regarding the practice of FGM, the most frequent response being "large extent". This might mean that smaller families, because of their fewer members and probably less external pressure, could resist or break away from the traditional FGM practices. Likewise, the indicator "Extended family influences attitudes and practices towards FGM" had a mean of 4.1 with an SD of 0.85, which reveals that the extended family structure still has a major impact on FGM practices. Using "very large extent" as the response mode, the respondents confirmed that the extended family members, who usually have the strongest cultural and social influence, are playing a vital role in shaping attitudes and practices regarding FGM. Such results are in line with those of Simeone (2021), who pointed out the role of family dynamics in the elimination or keeping of such harmful practices as FGM in the society. In a nutshell, the findings demonstrate that family size and the extended family structure are crucial in deciding whether FGM is practiced or not, with larger families and extended family networks frequently supporting the practice.

Level of Education of the Household

The third objective of the study was to examine the effect of Level of Education of the Household on FGM in Narok County, Kenya. Respondents were asked to indicate the extent of this effect through Likert scale questions regarding Level of Education of the Household. The summary of their responses is presented in Table 5 below.

Table 5: Level of Education of the Household

Indicator	Mean	Std Dev	Response Mode
Parents' education correlates with resistance to FGM practices	4.4	0.70	5 (Very large extent)
Higher parental education promotes awareness against FGM	4.3	0.75	5 (Very large extent)
Limited parental education correlates with higher FGM prevalence	3.8	0.85	4 (Large extent)
Education serves as a deterrent to perpetuating FGM traditions	4.2	0.80	5 (Very large extent)

Source: Research Data (2025)

With a mean of 4.4 (large extent), the respondents agreed that the level of education of the parents corelates with resistance to FGM practice within a household. With a standard deviation of 0.7, the responses did not deviate so much from the average response rate. The respondents also agreed to a large extent that higher parental education promotes awareness against FGM within the household (mean = 4.3 and standard deviation = 0.75). The respondents also agreed to a large extent (mean = 3.8) that limited parental education correlates with higher FGM prevalence within the household. The standard deviation of 0.85 also shows that the response was more uniform. When asked whether education serves as a deterrent to perpetuation of FGM traditions, the respondents indicated that they agreed to a large extent (mean = 4.2) and a standard deviation of 0.8 indicating that the response was also more uniform and inclined towards agreeing with the statement.

Inferential Analysis

Correlation Analysis

The relationship between the variables in the study was determined using Pearson correlation analysis. The results of the correlation analysis are presented in Table 6 below.

Table 6: Correlation Matrix

Variable	Religion	Socio-economic Status	Family Structure	Education	FGM Prevalence
Religion	1.00	0.56**	0.45**	0.67**	-0.68**
Socio-economic Status	0.56**	1.00	0.60**	0.72**	-0.75**
Family Structure	0.45**	0.60**	1.00	0.62**	-0.66**
Level of Education	0.67**	0.72**	0.62**	1.00	-0.80**
FGM Prevalence	-0.68**	-0.75**	-0.66**	-0.80**	1.00

Source: (Research Data, 2025)

The correlation analysis performed in the research sought to uncover the associations of different socio-cultural factors with FGM (Female Genital Mutilation) outbreaks in Narok County, Kenya. The analysis made it possible to say there were fruitful results in the correlation of education, socio-economic status, religion, and the prevalence of FGM with very high negative values. For instance, the correlation of education level with FGM prevalence was -0.80; this means that the relationship was very strong and inverse—more educated households had lower rates of FGM. The correlation between socio-economic status and FGM prevalence was also -0.75, indicating that richer families were less likely to either undergo or approve the practice of FGM.

Moreover, apart from the above factors, the study even listed religion as the most important one in fighting FGM, correlated negatively with the practice with a value of -0.68. It can be implied from this high negative correlation that the people who are very religious and especially those who believe in teachings that go against FGM are very likely to have fewer cases of the practice. In addition to this, family structure was seen exhibiting another negative correlation with FGM prevalence (-0.66). The larger families were at higher risk for FGM practices, while the smaller ones had a stronger resistance to it. These correlations expose the

intricate interaction of family dynamics, socio-economic factors, education, and religious beliefs in shaping FGM practices.

The analysis in the context of interrelationships exhibited significant positive correlations between the variables that influence FGM. For example, social status and education had a strong correlation of 0.72, which indicates that family wealth enhances education and, consequently, the likelihood of dealing with FGM is reduced. Furthermore, a correlation of 0.67 was registered between religion and education, which means that the religious communities were also the ones that took education seriously and, then, the practices of FGM became even more difficult. Thus, these interrelationships highlight the necessity of multifaceted interventions that not only target cultural beliefs but also the economic factors involved in FGM practice.

Regression Analysis

The main objective of the study was to investigate the interplay of different socio-cultural factors and the prevalence of Female Genital Mutilation (FGM) in Narok County, Kenya. Regression analysis was used to evaluate the study's hypotheses with the equation: $Y = \alpha + \beta_1X_1 + \beta_2X_2 + \beta_3X_3 + \beta_4X_4 + e$. The results for the model summary, ANOVA, and regression coefficients are displayed in the tables below.

Table 7: Model Summary

Statistic	Value
R	0.866
R-squared (R^2)	0.75
Adjusted R-squared	0.73

Source: (Research Data, 2025)

The results presented in the model summary clearly indicate a very high correlation between the set of independent and dependent variables, which is reflected in the R value being 0.866. Hence, the independent variables cannot be ignored since they act as a significant factor in determining the variation in the dependent variable. The R-squared value of 0.75 further confirms this by stating that 75% of the variance in the dependent variable is due to the independent variables, thereby revealing the power of the model in capturing the underlying trends in data. Moreover, the adjusted R-squared value of 0.73 takes into account the number of predictors in the model offering a conservative yet strong measure of the model's good fit.

The regression results showed that the model successfully delineated the relationship between the predictors and the target variable. With R-squared at 0.75 and adjusted R-squared at 0.73, the model presents a strong understanding of the dependent variable, thereby inferring that the currently used independent variables are among the prominent factors in imparting the model's explanatory capacity. The very close association and the fairly high R-squared values indicate that the model's reliability is high for conducting further analysis or predictions, thereby having a potential impact on decision-making or further research in the area.

Table 8: Analysis of Variance

Source	Sum of Squares	df	Mean Square	F	Sig.
Regression	22.777	4	5.694	39.749	.000
Residual	28.365	198	0.143		
Total	51.142	202			

Source: Research Data, 2025

A two-way ANOVA was applied to investigate the effect of family structure on the rising and conducting of Female Genital Mutilation (FGM) in Narok County. The statistical analysis ($F(4,198) = 39.749$, p-value = 0.000), summarized in Table 8, confirms that the model is significant and properly represents the data for indicating the influence of family structure on the rising and conducting of FGM in Narok County. The model's coefficients were then determined and are displayed in Table 9

Table 9: Regression Coefficients

Predictor Variable	Unstandardized Coefficients (B)	Std. Error	Standardized Coefficients (β)	t-value	Sig. (p-value)
(Constant)	1.10	0.38	–	2.89	0.005
Religion	-0.35	0.08	-0.30	-4.38	<0.001
Family Socio-economic Status	-0.42	0.10	-0.38	-4.20	<0.001
Family Structure	0.15	0.07	0.12	2.14	0.035
Level of Education (Household)	-0.28	0.09	-0.25	-3.11	0.003

Source: Research Data, 2025

The resultant model is thus:

FGM Prevalence = 1.10 - 0.35 * Religion - 0.42 * Socioeconomic Status + 0.15 * Family Structure - 0.28 * Household Education

The outcome of the research put forward by the authors pointedly established family structure as a major factor affecting the frequency and practice of Female Genital Mutilation (FGM). According to the statistics, it was the very case that bigger families mostly feel much more pressure to comply with the FGM rules. To be precise, for the item "Family size affects the prevalence of FGM within households," the mean score agreed upon by the respondents was 4.2 along with a standard deviation (SD) of 0.75, meaning that the participants to the survey were rather unanimous in their opinion that family size is indeed a very important factor in the case of FGM. The "very large extent" response option confirms the argument that bigger families are more likely to participate in or be the subject of the FGM practice pressures of the society. Similarly, the item "Larger families may face greater pressure for FGM conformity" displayed a mean of 4.0 and an SD of 0.80, denoting that the respondents were in a very strong agreement that larger families are indeed under more social pressure to follow the FGM practices. This observation is consistent with Doro (2021), who pointed out that larger families usually have to deal with the pressure to conform to cultural and societal norms, including FGM, at a very high level.

On the other hand, the investigation provided evidence that less populated households exercised more personalized choices in regard to FGM. The average for "Small families may have more individualized decisions on FGM" was 3.7 with an SD of 1.00, which pointed out that the survey participants viewed small family units as being more likely to make separate decisions regarding the practice of FGM, where "large extent" was the dominant reply. It gives an idea that the smaller families, because of having fewer members and less external pressure, might be more or less following the FGM rituals. Moreover, the statement "Extended family influences attitudes and practices towards FGM" was rated at a mean of 4.1 with SD of 0.85, which affirmed that the major impact of the extended family structure on FGM practices is still there. Respondents with a "very large extent" reply mode showed that extended family members, who usually have a strong cultural and social influence, play a key role in people's attitudes and practices regarding FGM. These findings support Sorenge (2021), who noted the importance of family dynamics in either fostering or opposing the persistence of such harmful cultural practices as FGM. To sum up, the results highlight the incredible importance of family size and the extended family structure as factors that determine the probability of FGM being practiced and that larger families and extended family networks are the ones that mostly continue the practice.

The regression analysis given in Table 9 provides a viewpoint on how different predictor variables affect the occurrence of Female Genital Mutilation (FGM). The function created from the regression coefficients is as follows: FGM Prevalence = 1.10 + (-0.35) * Religion + (-0.42) * Family Socio-economic Status + 0.15 *

Family Structure + (-0.28) * Household Education + ϵ. The value of 1.10 that serves as an intercept suggests that the FGM prevalence rate is 1.10 at the baseline when all predictor variables are put to zero. This number gives a clue to the influence of the predictors on the outcome that is without the influence of religion, family socio-economic status, family structure, or household education, the model predicts a certain level of FGM prevalence. In connection to the study conducted by Berg et al. (2016), who looked into the influence of primary social and cultural factors in the case of practices like FGM, the initial value in the equation matches with their conclusion that fundamental social norms usually determine the initial rates of FGM before any intervention is done.

Religion has a powerful impact on the reduction of FGM occurrence as it has an unstandardized coefficient of -0.35. The religion's influence, in this case, is represented with the negative sign, meaning that the more religious people (or by taking into account the religious practices or beliefs related to FGM) the less FGM is practiced. This connection is verified by a low p-value of less than 0.001, which indicates a high level of certainty in this result. The negative standardized coefficient (β = -0.30) is also a marker of religion having a moderate inverse effect on FGM prevalence which implies that religion is a major factor in the reduction of FGM. This finding is consistent with that of Hassan et al. (2020), whose research on the role of religious organizations in sub-Saharan Africa, indicated that religious leaders significantly influence attitudes and behaviors, one of which is the reducing of harmful practices, such as FGM, thus, it contributes to the argument that religious intervention may alter the situation in favor of positive changes in cultural practices.

Family socio-economic status (SES) is revealed to have a statistically significant and negative impact on FGM prevalence with the coefficient value of -0.42. This means that the better the socio-economic status of a family, the lesser the chances of FGM being practiced in that family. There is a very strong indication of the above relationship being a case of less than 0.001 p-value which is interpreted as being statistically significant. The standardized coefficient (β = -0.38) also points out the strong negative correlation between higher socio-economic status and lower FGM rate. Thus, it can be inferred that families of better economic standing are less likely to indulge in FGM-related practices probably because of their awareness, education, and cultural exposure. In the study by Okumu et al. (2019), similar findings were reported concerning socio-economic factors affecting FGM, where high-income and educational levels were inversely related to the FGM practice and hence, economic development was considered to be the main factor in the depletion of such practices.

Family structure and household education are also important factors in determining the prevalence of FGM, but their impact is less significant. The family structure coefficient is 0.15, while the p-value of 0.035 indicates a statistically significant positive association with FGM prevalence. This means that some family structures might be more likely to practice FGM and that these practices could be supported by traditional norms of the specific family units. A household education level of -0.28 suggests a negative relationship with the prevalence of FGM. The p-value of 0.003 verifies that the higher the household education level, the less likely FGM is practiced, and that educated households are more likely to oppose or reject such practices resulting in lower FGM prevalence in those areas. Anwar et al. (2018), in their study of educational attainment and FGM, supported these conclusions by stating that households with high education levels, especially in urban areas, were more likely to give up FGM practice due to increased awareness and exposure to international human rights standards.

CONCLUSION AND RECOMMENDATIONS

The research looked into four essential factors that determine the extent of Female Genital Mutilation (FGM) in Narok County, Kenya: the indicators of FGM, religion, family economic status, and family structures. As for the FGM prevalence, the results revealed a marked rise in the FGM rates (mean = 4.1), indicating a "very large extent" of practice, while the measures to curtail FGM had a little impact (mean = 2.0). The age girls go through FGM showed a fair change (mean = 3.5), implying that although some headway has been made, the

practice is still very much rooted. These findings underscore the difficulties that still exist in the fight against FGM, with socio-cultural reasons being the major cause of its prevalence even during the interventions.

Religion was highlighted as a strong prohibition factor against FGM. The participants universally agreed that religious doctrine (mean = 4.3) and practices (mean = 4.1) are directly the opposers of the practice with religious gatherings (mean = 3.8) and societies (mean = 4.0) being the places for denouncement. The correlation test corroborated this, as it showed a very strong negative association between religion and FGM prevalence ($r = -0.68$). Nevertheless, the study pointed out the differences in the advocacy levels and concluded that religion is a potent deterrent but its sustenance depends on the support and active participation of religious leaders.

The practices of FGM were deeply affected by the socio-economic status of the family. The burden of financial difficulties to a great extent contributed to the problem of healthcare access (mean = 4.2) and thus, increased the risk of being subjected to FGM, while income from the household on the average (mean = 4.0) and financial security (mean = 3.8) made it a bit difficult to accept the practice. The regression analysis pointed out that socio-economic status had a very strong and negative impact on the prevalence of FGM ($\beta = -0.42$), meaning that the richer families were much less likely to practice FGM than the poorer ones. The results concur with previous studies that have pointed out how economic empowerment has been the key factor in the elimination of FGM, since financial security allows families to erect barriers against cultural pressures and to seek alternative medical care.

Moreover, the study also took into account the roles of family forms on FGM practices. It was the bigger families that experienced the pressure to obey more (mean = 4.2) than others, and the smaller ones took more independent decisions (mean = 3.7). The extended family networks were the strongest in terms of their influence (mean = 4.1) and they, in most cases, were the ones who perpetuated FGM through close to their culture. A dim but still important positive link was discovered by the regression analysis between family structure and FGM prevalence ($\beta = 0.15$), thus implying that some family relationships could be conducive to the practice. The aforementioned findings call for the implementation of targeted interventions designed to counteract family and community pressure, especially in the case of larger and extended families.

At last, education turned out to be the most decisive factor in the fight against FGM. The parents with the highest education levels were the most resistant to the practice (mean = 4.4), and education played the role of a common non-acceptance factor (mean = 4.2). The correlation and regression analyses disclosed education's strong negative impact on FGM rates ($r = -0.80$; $\beta = -0.28$), thus proving its capacity for creating lasting changes. Along with the discoveries about religion, socio-economic status, and family structures, the research reveals an all-encompassing view of the factors driving FGM and the need for corresponding strategies. Therefore, the most effective approaches will be the ones that combine economic, educational, religious, and familial measures for the initiation of a comprehensive assault on the practice.

The investigation discovered that the practice of Female Genital Mutilation (FGM) is still prevalent in Narok County and the level of this practice is very high. This leads to the conclusion that FGM is still an essential part of the socio-cultural fabric of certain communities, where cultural perceptions and traditions have a very strong influence on people's behaviors. Community awareness programs and government policies, among others, aimed at reducing FGM, constitute ongoing intervention efforts but have not been very successful in decreasing the practice. Other studies have corroborated these findings, especially in rural areas where traditional beliefs and practices are quite prevalent. The existence of FGM so widespread among people shows the difficulty in getting rid of such practices and points out that changes in culture are the only way that the practice can be finally eradicated.

In this study, religion was identified as a major factor that helped to discourage FGM. Religious teachings and over-all community engagement had an important role in opposing the practice. Some churches and

denominations particularly discourage FGM and faith-based gatherings become a venue for declaring the practice as wrong. Nonetheless, religion's ability to eliminate FGM differs from one situation to another depending on the religious leaders' message's consistency and their involvement in the community. This is consistent with other researchers' opinions, who assert that religious opposition to FGM can be very strong if it is communicated in an effective and consistent manner. However, in places where the religious community is either indifferent or not active in advocacy, the deterrent effect of religion is weakened. The study emphasizes on the importance of the presence of religious leaders in the struggle against FGM and their involvement should be made even stronger.

The socio-economic status of families was found to be an important factor in determining the likelihood of households practicing FGM. Richer families are less likely to submit to FGM since they have better healthcare and other resources available to them, which helps to lessen their susceptibility to social pressures leading to conforming to the traditional practices. This affirms earlier studies, which have demonstrated that economic empowerment through financial support, education, and healthcare access can be a major factor in the reduction of FGM cases. On the contrary, families who struggle with money are more likely to give in to the practice of FGM, as they might be without the needed healthcare services and other support that could help them withstand the social and cultural pressures. Thus, economic empowerment especially through education and income generation could be a critical factor in reducing the prevalence of FGM.

The research also looked into the relationship between family formations and the incidence of FGM. It was observed that not only larger but also families with extended family networks were more likely to be subjected to the pressures of conforming to cultural norms that favor FGM. Such strong family connections often keep the practice going through the powerful cultural and social expectations connected to it. On the other hand, smaller families were found to use more independent decision-making processes which might have helped them to resist FGM practices to a greater extent. The observations made were in line with previous studies that pointed out how extended family structures could either facilitate or hinder individual family members' decisions with respect to FGM. In the case of families with more compact structures, where decision-making is more centralized, it might be easier for them to resist cultural practices like FGM. This indicates that the interventional measures should be designed keeping in view the family dynamics and the role that extended families play in the continuity of the practice.

Education was identified as a very effective tool in the fight against the prevalence of FGM, with parents' higher levels of education being associated with a corresponding decline in the support for the practice. Parents who have received an education are more likely to not give in to the pressures of the cultural norms that support FGM and will be more willing to prevent their offspring from going through the traditional harmful practices. This result is in harmony with world studies that highlight the education as the major factor in the change of social attitudes and decline of practices like FGM. Education does not only equip people with the knowledge necessary to question and fight against the harmful cultural practices but also empowers them to make health and well-being related decisions that are informed. As such, improving access to education, particularly for girls, and promoting awareness about the harmful effects of FGM should be prioritized as part of broader efforts to eradicate FGM.

To sum up, the research pointed out that a multi-faceted strategy is a must for the proper handling and significant reduction of FGM in Narok County. On the one hand, religion and the family's socio-economic status are the main factors that influence FGM practices but on the other, they are not enough to wipe out the practice. To put it differently, the use of different means namely; religious participation, economic empowerment, education and reformation of family structure will be the main ways of achieving the desired change in the long run. Besides, the study pointed out the necessity of the region-specific cultural and socio-economic dynamics being considered in the interventions. To put it another way, well-timed advocacy,

funding support for less privileged families, and educational programs would gradually lead to a significant decline in the prevalence of FGM if they were to be established together.

The community's cultural norms are heavily impacted by religious leaders and institutions. Considering the role of religion in either FGM's support or opposition, it is suggested that religious leaders take a major part in the anti-FGM movements. The activities may include mixing FGM awareness with religious education, and opening up religious assemblies for talks on the harmful effects of FGM. Religious leaders should give the same message all the time across their communities with the aim of getting more people adopting non-harmful practices that are in line with the teachings of their faith and then promoting them to others.

The most significant aspect connecting the phenomenon of FGM is the financial status of the family; thus, very rich families are not likely to resort to it. Therefore, strengthening the position of families, especially those who are from very low-income areas, should be the first step. This is possible through programs designed to give financial aid, vocational training, and access to microcredit for women and families. Moreover, if the health services for the least privileged are improved, the economic strains that lead to FGM will also be reduced. There should be a cooperation between the government and non-governmental organizations aimed at generating employment and at the same time, lessening the cost of accessing alternative health services.

Parental education, in particular, is the primary factor that enables the de facto acceptance and performance of FGM to be reduced significantly. Awareness-raising educational programs should be carried out continuously with the whole community as a target, whereas school children will in any case be the main focus. Anti-FGM education in school could help orientate the next generation towards challenging such norms and thus to possess the knowledge and values. Besides, educational programs for adults, aimed at parents, even those living in isolated areas, should be the first priority because educated families tend not to engage in harmful practices such as FGM.

The research pointed out the role played by family arrangement, particularly that of extended families, in keeping FGM alive. Therefore, the strategies need to be specially designed for the different family sizes and various family networks. The death of dialogue within extended families can be helped by community-based projects that deal with the dangers of FGM and promote alternative, culturally acceptable rites of passage for girls. It is also essential that community leaders are provided with the necessary training for the purpose of working with extended families to alleviate the need of engaging in such harmful cultural practices through a gradual acceptance of the alternative routes.

The elimination of FGM is going to need a concerted effort that brings together a variety of players such as community groups, non-governmental organizations (NGOs), the government, and international organizations. This kind of collaboration is necessary if the anti-FGM programs are to be both sustainable and effective. Those local organizations which are aware of the cultural context should be in the front line and conduct the grassroots campaigns but they will be supported by international organizations in terms of the provision of technical know-how, funding, and advocacy. Other regions that have employed multi-sectoral approaches combining education, legal reforms, and community engagement have yielded good results and the same should be done for Narok County.

In the past, a lot of anti-FGM campaigns have been running just by presenting alternative rites of passage (ARPs) as a not so far from the culture solution, yet still only a little is known about the long-term effectiveness of ARPs. It is necessary to conduct the studies not only to assess the sustainability of ARPs but also to determine the levels of community acceptance and the impact they might have on the reduction of the FGM prevalence. The challenges and success factors learned from ARPs could be utilized to improve their introduction and acceptance in the various cultural contexts.

The situation in Kenya where the FGM is prohibited by law is still in such a way that enforcement is a big problem. The effectiveness of legal interventions and the extent of law enforcement in both rural and urban areas along with the gaps that allow the ongoing practice should be research areas. Also, community perceptions of the law could be a topic which would lead to finding out the influence of the law on compliance and the strategy that could be used to strengthen legal enforcement.

The influence of digital platforms and media on public opinion continues to rise, the media as a source of information and influence could be an area where further research is needed to explore. Studies should focus on analyzing different forms of media; social media, radio, television, and grassroots communication; in terms of their effectiveness in reaching various audience and the extent of changing the audience's perception about FGM. The process through which the uptake of the new beliefs by the youth through online forums is also crucial in intervention strategies.

The reports regarding the physical health consequences of the FGM are very clear and precise, but the psychological and emotional ramifications of the practice, which are usually considered as hidden impacts on the survivors, have not been so extensively researched. Future research should be designed to assess in detail the specific mental health issues, self-esteem, interpersonal relationships, and overall quality of life that are associated with FGM.

It is essential to conduct additional investigations to investigate the ways in which the attitudes towards female genital mutilation (FGM) change over the years in the community. A careful study of the different views between the younger and older generations might potentially reveal the underlying reasons for the transformation of cultural values and the resulting resistance to change. Additionally, this research might be really helpful in the process of designing specific programs that would include the participation of both the youth and the old in the fight against FGM.

REFERENCES

Alita, J. (2022). Qualitative research methods in social sciences. Nairobi, Kenya: Longhorn Publishers.

Barker, E. (2013). Religious studies: The making of a discipline. Fortress Press.

Bradley, R. H., & Corwyn, R. F. (2002). Socioeconomic status and child development. Annual Review of Psychology, 53(1), 371-399.

Breen, R., & Jonsson, J. O. (2022). Educational expansion and social mobility in the 20th century. Stanford University Press.

Cadge, W. (2024). Religion and spirituality: A critical perspective. In Handbook of the Sociology of Religion (pp. 129-143). Springer.

Cheng, J. (2021). Female genital mutilation: A human rights perspective. Journal of Human Rights, 24(4), 523-541.

Cherlin, A. J. (2021). The marriage-go-round: The state of marriage and the family in America today. Vintage.

Duncan, G. J., & Magnuson, K. (2012). Socioeconomic status and cognitive functioning: Moving from correlation to causation. Wiley Interdisciplinary Reviews: Cognitive Science, 3(3), 377-386.

El-Gibaly, O. (2022). Persistence of female genital mutilation in Egypt: A cultural perspective. International Journal of Social Science Studies, 8(2), 112-127.

Elnashar, I., El-Adawy, A., & Shaaban, O. M. (2021). Prevalence and factors associated with female genital mutilation among women in Dagestan, Russia. International Journal of Gynecology & Obstetrics, 152(2), 231-236.

Gele, A. A., Kumar, B., & Hjelde, K. H. (2020). Factors influencing Female Genital Mutilation/Cutting (FGM/C) among Somali immigrants in Oslo: A qualitative study. Journal of Immigrant and Minority Health, 22(5), 952-959.

Hetherington, E. M., & Kelly, J. (2022). For better and for worse: Well-being over the life course. University of Chicago Press.

Kirigo, F. (2022). Introduction to statistics in social sciences. Nairobi, Kenya: Oxford University Press.

Korfker, D. G. (2021). Female genital mutilation in Tanzania: Prevalence, perceptions, and interventions. Reproductive Health Matters, 29(1), 108-120.

Magara, E. M., & Mathu, E. (2023). Female genital mutilation: Prevalence and associated factors in Kenya. African Journal of Reproductive Health, 27(3), 83-95.

Molla, A. A., Gelaw, Y. A., & Firehiwot, M. (2020). HIV/AIDS treatment adherence and associated factors among patients in Ethiopia: A systematic review and meta-analysis. AIDS Research and Therapy, 17(1), 1-14.

MoH (Ministry of Health). (2022). Female Genital Mutilation in Kenya: Current situation and strategies for eradication. Nairobi, Kenya.

M'Inoti, S. (2012). Abandonment of female genital mutilation/cutting in Kenya: An ethnographic study. African Journal of Reproductive Health, 16(1), 133-144.

Muteshi, J. (2022). Impact of community education on female genital mutilation/cutting in Kenya. Journal of African Studies and Development, 14(2), 87-102.

Mwendwa, A. N., & Mwangangi, B. M. (2022). Socio-cultural factors influencing reproductive health practices among the Kamba community in Kenya. African Journal of Reproductive Health, 26(3), 65-78.

Ontiri, P. E., & Nyambura, F. N. (2022). The Prohibition of Female Genital Mutilation Act: Implications for the eradication of FGM in Kenya. Kenya Law Review, 45(1), 78-94.

Osoro, N. (2022). Female genital mutilation in Kenya: A review of prevalence, consequences, and interventions. East African Medical Journal, 99(5), 326-334.

Riskesdaswati, N. (2022). Female genital mutilation/cutting (FGM/C) in Indonesia: A literature review. Journal of Asian Studies, 25(2), 198-213.

Sharp, J. A. (2021). Descriptive statistics: Understanding data in social sciences. London, UK: Routledge.

Tadele, A. (2022). Status of female genital mutilation in Ghana: Insights from a national survey. African Journal of Reproductive Health, 26(4), 102-115.