Master's Thesis of International Studies

Gender Differences in the Impact of Marital Status and Type on Life Satisfaction and Self-Rated Health in Tanzania

탄자니아의 젠더에 따른 결혼의 유무 및 유형이
삶의 만족도와 주관적 건강상태에 미치는 영향에 관한 연구

August 2023

Graduate School of International Studies
Seoul National University
International Cooperation Major

Haeun Choi

Gender Differences in the Impact of Marital Status and Type on Life Satisfaction and Self-Rated Health in Tanzania

Examiner Chong-Sup Kim

Submitting a master's thesis of
International Studies

August 2023

Graduate School of International Studies
Seoul National University
International Cooperation Major

Haeun Choi

Confirming the master's thesis written by
Haeun Choi

August 2023

Chair	Kim, Taekyoon (Seal)
Vice Chair	Kim, Bokyung (Seal)
Examiner	Kim, Chong-Sup (Seal)

Abstract

This study examines gender differences in the impact of marital status and type on life satisfaction (LS) and self-rated health (SRH) in Tanzania. Utilizing data from the 2008-2015 National Panel Survey Uniform Panel Dataset of Tanzania (TNPS UPD), this research investigates several key aspects; (1) the disparities in LS and SRH between married and unmarried men and women, (2) the variations in these measures based on marital types (monogamous and polygamous marriages), (3) the influence of satisfaction with availability of social support (healthcare and educational services) on LS and SRH, and (4) the potential socio-cultural factors that affect the observed outcomes. The study employs a quantitative approach through multiple regression modeling. The empirical analysis reveals that both married women and men report higher levels of LS compared to their single counterparts. However, concerning health, married men rate their health more favorably than single men, while married women do not exhibit the same advantage over single women. Regarding marital type, polygamous males report higher LS and SRH than monogamous males, but polygamous females have a more negative SRH status compared to monogamous women, with no significant difference in LS between the two groups of women. Furthermore, satisfaction with healthcare and educational services is positively associated with higher levels of LS and SRH. Based on the literature reviews and the in-depth interview of Tanzanian civil servants, these empirical findings imply that marriage is significant factor in enhancing LS for both men and women in Tanzania with the sense of community. However, further results imply that androcentric culture of marriage in Tanzania can lead to negative health status in married women and especially polygamous women in Tanzania. In order to improve life satisfaction and health of women in Tanzania, it is essential to ensure that significant social services, such as healthcare and educational services, should be readily available to the public in Tanzania and discriminative gender norms in culture of the marriage should be sublated. By identifying gender differences in the impact of marital status and types on life satisfaction and health, this study holds significance for Tanzanian policymakers aiming to develop appropriate policies to achieve the enhanced quality of life and best well-being community and it also provides guidance for development practitioners on how to address when implementing gender-based development projects and working towards achieving sustainable goals in Africa.

Keywords: self-rated health, life satisfaction, gender difference, marriage, social support, polygamy, Tanzania

Student Number: 2021-23136

Table of Contents

List of Tables and Figures

I. Introduction

Human development revolves around the pursuit of well-being, which includes subjective well-being (SWB) and health. Within this context, life satisfaction (LS) and self-rated health (SRH) have emerged as reliable measurements of SWB and health, serving as interconnected indicators of overall well-being. These two dimensions, SWB and health, are significantly influenced by social factors, with existing research shedding light on the impact of societal norms, values, and structures on individuals' overall well-being and formation of perception on the quality of life and health status (Kelishadi et al. 2016, Marmot & UCL Institute of Health Equity, 2014). Among various socio-demographic determinants, gender and marriage are two major factors in Africa. Gender refers to "the socially constructed characteristics, norms, behaviors, and roles associated with being a woman or a man" (WHO, n.d.). Different gender norms and roles within societies continue to have a significant impact on establishing living standards and social structures and resulting in different levels of health status and LS (Sen & Östlin, 2008; Manandhar et al., 2018). Moreover, gender also plays a substantial role in shaping families, which are fundamental units of social communities and have a profound impact on human welfare (Marks et al.,2009). Another key social factor, marriage is a significant life stage in family formation, reflecting and reinforcing unique gender norms. It has long been recognized as a powerful catalyst for enhancing the quality of life and health by providing emotional and social stability and reducing mortality risk (Rajabi Gilan et al., 2021; Waite, 1995; Han et al., 2014). However, depending on perspectives on gender dynamics within societies, the impact of marriage on SWB and health can vary.

One of the regions that gender difference and marriage culture stands out is Africa, where traditional gender norms prevail in overall lifestyle (Azuh et al., 2015) and marriage is considered as an essential and fundamental social relationship in life as a whole (Assimeng, 2007). Gender norms influenced by cultural customs and religious beliefs in Africa are reflected in unbalanced division of roles in households and can trigger marriage cultures that can violate human rights, such as polygamy, prevalent in various African regions within the 'polygyny belt' from Senegal to Tanzania. (Petroni et al., 2017; Mtenga et al., 2015). Polygamous marriage has been associated with female health challenges, including an increased risk of HIV/AIDS infection (Gazimbi et al., 2020; WHO, 2022). Despite the criticism polygamy have received from international societies, they remain widely practiced, seen as cultural and religious norms that can impact quality of life especially in Sub-Saharan Africa (Diggos, 2007; Meekers & Franklin, 1995). Therefore, understanding the interplay of gender norms with the effects of marital status and type on well-being is imperative for promoting African human development. in this context. However, most studies on well-being are conducted in developed societies and the existing literature in Africa neglect significant socio-cultural factors such as gender and marriage but focus on economic factors (Lawrence et al., 2019; Botha & Snowball, 2015; Botha & Booysen, 2013). Furthermore, existing research in Africa is predominantly centered in South Africa, led by Valerie Møller under the South African Quality of Life Trends Project (Rustin & Florence, 2021).

Thus, this study addresses this gap by analyzing gender differences in the impact of marital status and type on subjective well-being and health in Tanzania, characterized by low human development and high gender inequality. Tanzania's low

rankings in the World Happiness Report and worse results of health indicators (maternal mortality rates, new HIV infections rates, child marriage rates and adolescent fertility rates) rather than other African countries highlight the need to improve well-being, particularly for women facing significant health challenges (UNICEF, 2022; WHO, 2022). Considering the concerning indicators and the country's location in the polygyny belt, Tanzania exhibits significant female health issues strongly associated with marriage, necessitating extensive gender-specific research to understand the potential causes of heightened risk in female health and well-being. However, despite increasing interest, research in this field remains limited in Tanzania (Adesanya et al., 2017).

Therefore, this study aims to investigate gender differences in the impact of marital status and type on SWB and health in Tanzania where represents gender-based marriage culture and outstanding female health challenges related to marital traits in Africa. This study adopts quantitative approach by using 2008-2015 National Panel Survey in Tanzania. Additionally, to bring integrated approach, in-depth interviews with Tanzanian public officers are also conducted to provide contextual insights. This study also considers the influence of social supports such as healthcare and educational services, since utilization of social services has been considered a significant factor in enhancing SWB (Cheng et al., 2022; Pecha & Beuermann, 2016). This study sheds light on the necessity of integrated research using social factors such as gender and marriage in the field of SWB and health in Africa where represents low quality of life with high gender inequality rate. The findings provide insights for policy implications to improve quality of life for Tanzania and developing social supports for women's empowerment and sustainable development.

II. Literature Review

2.1. Life Satisfaction and Self-Rated Health

Life satisfaction (LS) and self-rated health (SRH) serve as prominent indicators of human well-being intimately intertwined with each other. LS refers to a socially constructed concept wherein individuals subjectively evaluate their overall well-being, including satisfaction with diverse facets of life (Erdogan et al., 2012; Rajabi Gilan et al., 2021; Krause, 2004). LS involves the subjective evaluation of one's well-being, encompassing satisfaction with various life domains, and has been widely utilized as the key measure of SWB in numerous research studies (Rajabi Gilan et al., 2021). Health, being another critical dimension of human well-being, has garnered significant attention in various human development studies and among the measures of health, self-rated health (SRH) stands out as a robust assessment of overall health status, encompassing both physical and psychological well-being (Hodačová et al., 2017). SRH has been recognized as a robust measure of overall health status that captures an individual's evaluation of their physical and mental well-being and it has demonstrated reliability in predicting morbidity and mortality, thus serving as a crucial tool for assessing health outcomes (Wuorela et al., 2020). Recognizing the significance of LS and SRH, researchers have increasingly recognized the importance of studying LS and SRH within the context of sustainable development and the pursuit of improved quality of life (De Neve & Sachs, 2020). However, compared to international studies, the number of research endeavors examining SWB in Africa remains relatively limited. Despite the presence of multiple determinants influencing African well-being, existing studies predominantly emphasize the role of economic status as the primary driver of SWB

under the umbrella of happiness economics (Chamlou, 2014; Adesanya et al., 2017). However, one of the significant determinants that researchers should also give due attention to in Africa is socio-cultural factors which encompasses various socio-demographic measures and cultural values. Sunday Idemudia & Adedeji (2023) highlight that "the notion of well-being from an African perspective is usually defined within the framework of group norms, values, kinship relationships and ties entrenched in cultural values which are presumed to affect mental health and treatment" (Sunday Idemudia & Adedeji, 2023) Understanding the socio-cultural context, particularly focusing on group and family culture, is crucial in comprehending how Africans perceive their well-being. Furthermore, Kasenda et al. (2022) underscore the close association between socio-demographic factors, contextual background, and self-rated health, as evidenced by the indication of poor SRH in women, increasing age, and lower education levels in Malawi. Therefore, conducting integrated analyses of cultural contexts and socio-demographic factors is pivotal for enhancing well-being in Africa.

2.2 Gender Differences in Life Satisfaction and Self-Rated Health

Gender, as a key socio-demographic factor, can influence the manifestation of LS and SRH in different ways. In terms of health, common evidence from previous research represents that the self-rated health status of women is more negative than men (Crimmins, E. et al., 2011; Case & Paxson, 2005). A study by Boerma et al. (2016), which analyzed World Health Surveys from 59 countries, found that female respondents were more likely to rate their health as poorer than male respondents across all regions. The study suggests that the potential causes of the consistent large

female-male gap in SRH as different type of biological chronic diseases and sociocultural characteristics on gender of each society. Regarding LS, while there have been varying findings indicating that women may have higher, lower, or no significant difference in LS compared to men, the majority of studies support the notion that women tend to report higher levels of LS (Jovanović, 2019; Tay et al., 2014; Esteban-Gonzalo et al., 2020; Helliwell & Putnam, 2004; Glaesmer et al., 2011) However, interestingly, some studies disclosed that only in Sub-Saharan African countries across global regions, men demonstrate higher levels of LS than women, suggesting possible reasons such as pervasive gender inequality and discriminatory cultural traits in these societies (Joshanloo & Jovanović, 2020; Blackden, 2007). Additionally, findings by Moghani Lankarani et al. (2017) indicate that poor SRH only stands out among female respondents in African countries such as Ghana, South Africa, and Uruguay, among 15 countries studied. In African countries, the gender gap in LS and health is influenced by multidimensional factors including biological disparities, socioeconomic features, and cultural traits. Prevailing traditional patriarchal gender norms contribute to unequal distribution of socio-economic status and discriminatory cultural practices in Africa. Significant findings from South Africa highlight that achieving gender equality in social rights is closely linked to positive SWB among women (Rustin & Florence, 2021). Existing literature suggests that women may perceive happiness and health differently than men based on socio-cultural contexts and this is highly associated with gender differences in well-being of Africans. Therefore, gender-based research on SWB and health status is needed in Africa to explore these potential mechanisms and implement appropriate interventions.

2.3. The Impact of Marriage on Life Satisfaction and Self- Rated Health

Marriage is often considered as a significant milestone in an individual's life, providing social and emotional support and stability. Studies have shown that married individuals experience higher levels of LS, overall happiness, and emotional well-being than their unmarried counterparts (Hills & Argyle, 2001; Waite & Gallagher, 2000). For instance, according to Dickason (2019), the South African investors who are married also confirmed a positive LS compared to those who never married investors. Furthermore, in the study of Mwinnyaa et.al, (2018), African American men who are more satisfied with their lives and happier tend to be married and report better physical health rather than the men who checked their LS lower. Some study argues that due to the sense of comfort and stability of marriage, individuals who are married experience more positive LS than the others in the opposite (Campbell et al., 1976), and this positive relationship is linked to the healthier life both in physically and mentally. According to Lawrence, E. et.al (2019), the marriage is highly correlated with the health and longevity in a positive way and revealed that "general happiness" is much based on the satisfaction with the marriage. It is buffered by the increased access of health insurances and social support (Wood et al. 2007). While marriage is generally associated with higher levels of happiness and better health outcomes as above, there have been differences in the impact of marriage on LS and SRH by different demographic factors. For instance, according to Glenn (1975), married males are more satisfied with their lives compared to married females, suggesting that men may derive more health benefits from marriage due to the social and emotional support provided by their spouse or partner. However, the impact of marriage on well-being status depends on the different sociocultural

factors, since some study suggests that the impact of marriage tends to increase the extent to LS for women rather than men as a whole (Tao, 2019). In Africa, the well-being is significantly related to marriage life reflected by socio-cultural gender roles. According to Ferrari (2022), based on South African data analysis, the well-being of female respondents is mostly derived from gender norms which adopt as daughters, wives, and mothers caring and supporting for family members. Hence, how marriage is contextualized in each society and differences are represented by gender in the effect of marriage on SWB and health status should be explored in further research with various regions in Africa for promoting well-being.

2.4. The impact of Social Support on Life Satisfaction and Self-Rated Health

Social support is a crucial factor in promoting both LS and health outcomes. Previous research has consistently shown that individuals with strong social support networks tend to report better mental and physical health outcomes compared to those with weaker social connections (Matud et al., 2019). For instance, Dai et al. (2016) has demonstrated that the elderly who have higher income level, maintain healthier marital status, and achieve higher education are apt to utilize better social support and it is closely connected to the quality of life and LS (Moeini et al., 2018). Although there are various types of social support, two significant social services that are significantly associated with LS and health are healthcare service and educational service. The positive correlation between health outcomes and availability or utilization of healthcare services has been constantly studied. (Cheng et al., 2022; Pecha & Beuermann, 2016). The availability of social support can bolster happiness and positive mental health outcomes, which in turn can contribute

to improved physical health outcomes and “self-rated health acts as a predictor of hospital services use” (Tamayo-Fonseca et al., 2015). Furthermore, studies have proved that educational services have a close relationship with LS and SWB, showing that individuals with higher education are more likely to have stable sources of income, participate in social activities and support systems, and promote health-related services (Ross & Wu, 1995; Zajacova & Lawrence, 2018). Therefore, healthcare and educational services can be included as meaningful factors that have possibility to be linked to LS and health status positively.

III. Study Site: Tanzania

This section will discuss the rationale for selecting Tanzania as the target country for case study by outlining the reasons why Tanzania is an appropriate context to examine gender difference in the effect of marital status and type on life satisfaction (LS) and self-rated health (SRH).

3.1. Subjective Well-Being in Tanzania

According to the World Happiness Report's three-year average ranking for the years 2020-2022 (Helliwell et al., 2022) Tanzania was ranked 129th out of 137 countries in terms of happiness. Furthermore, Tanzania's ranking for the happiness gap between the top and bottom halves of the population was 128, indicating a very low value. This ranking is determined by various indicators such as GDP per capita, healthy life expectancy at birth, social support, freedom to make life choices, generosity, perception of corruption, and positive and negative effect. While it is challenging to assert that the majority of Tanzanians are unhappy, as SWB is influenced by multidimensional factors, the results suggest that these indicators are significant contributors to LS, and Tanzania scored poorly in these areas. In the context of Tanzania, several studies have explored significant factors related to SWB. In rural areas of Tanzania, young people are more likely to report higher LS if they experience a high level of household consumption and live with their family members (Chamberlin, 2021). Additionally, individuals who have their primary needs met, such as access to food, water, technology, and information, are more likely to experience happiness and social support. Household income also plays a significant role in driving SWB in Tanzania (Allegretti et al., 2022). However, there

is still a lack of sufficient research on exploring potential socio-demographic determinants of SWB and health, highlighting the need for further studies in this field in Tanzania.

3.2. Gender-Based Health Challenges in Tanzania

Tanzania is a low-income country in East Africa that faces significant gender-based health challenges. The country has made progress in improving health outcomes in recent years, but still lags far behind many other countries in the region (World Health Organization, 2022). One of the major health challenges facing Tanzania is a high burden of infectious disease, HIV/AIDS. According to the World Health Statistics by WHO (2022), in terms of new HIV infections rate (per 1000 uninfected population) in 2020, the value is 1.26 which is much higher than the average of African countries (0.82) and the average of the whole countries in the world (0.19). Possible causes have explored by several research, suggesting that it is transmitted by the group of people who have multiple sexual partners, and the risk of HIV/AIDS infection is higher against the vulnerable groups including women with low educational level and young age (Mpondo et al., 2017; Geis et al., 2011). The vulnerability is also found "among married and cohabiting individuals who are remarried, have unbalanced gender norms and a number of sexual partners in lifetime." (Mtenga et al., 2015). Hence, the social drivers based on gender norm in Tanzania affect the transmission of HIV/AIDS infection.

Another priority of the health issues in Tanzania are maternal mortality. According to World Bank (2023), "maternal mortality ratio (MMR) is the number of women who die from pregnancy-related causes while pregnant or within 42 days of

pregnancy termination per 100,000 live births". Statistics show that in Tanzania, 524 women die per 100,000 live births due to pregnancy-related causes. Although it has decreased from 854 in 2000 to 524 in 2017, "the current high MMR is still far from the targeted Sustainable Development Goals of less than 140 maternal deaths per 100,000 live births by 2030" (Bintabara et al., 2018; Moran et al., 2016). Although lack of skilled birth attendants and limited access to quality health care services are included in the major causes, a lack of autonomy in decision-making for women and traditional beliefs surrounding pregnancy and childbirth has revealed as a significant factor that hinder decreasing the danger of maternal mortality. According to the study of Danforth et al. (2009), by interviewing 826 male-female pairs in Kasulu district of Tanzania, it demonstrated that "agreement of partners regarding the importance of delivery in the facility was associated with a higher likelihood of women delivering in a health facility". As a male-dominated society, women in Tanzania are usually not the major decision maker in the household and autonomous individual even regarding childbirth and hence the male partner's influences on women's reproductive health are considerable (Dudgeon & Inhorn 2004). Predominant health challenges in Tanzania are considerably correlated to gender norms which uphold power and rights of men rather than of women.

3.3. Socio-Cultural Background of Gender and Marriage in Tanzania

Tanzania is a low-human development country, ranked 160th out of 191 countries in the Human Development Index, and 146th out of 170 countries in the Gender Inequality Index (UNDP, 2022). The low level of gender equality in Tanzania is due to traditional gender norms that consider women to be of lower status than men. This

deeply ingrained socio-cultural norm, based on male preferences, results in imbalanced power dynamics between men and women, leading to physical and/or sexual violence against women According to the World Health Organization (2022), nearly 38% of ever-partnered women and girls aged 15-49 have experienced physical and/or sexual violence by a current or former intimate partner in their lifetime, which is higher than the average in African countries and globally. While the legal framework of Tanzania, as stated in the Constitution of the United Republic of Tanzania (1977), ensures equal protection of women's human rights, there have been criticisms from the Committee on the Elimination of Discrimination against Women (CEDAW) regarding other laws in Tanzania. These laws, such as Customary and Religious Law, have been identified as recognizing discrimination against women by failing to criminalize marital rape and by remaining silent on issues of domestic violence and corporal punishment (Christine, 2017).

The long-standing gender norms under the socio-cultural notion in Tanzania have influenced the quality of life differently for women and men. Women in Tanzania are expected to fulfill the roles of "mother" and "wife" by performing unpaid household work and childcare, and supporting their families, rather than working in the formal sector. As a result, women face economic exclusion and gender-based discrimination in terms of income, with men earning 1.5 times more than women (NBS, 2014; Idris, 2018). The gender gap also affects educational achievement, with only 0.8% of women completing secondary education in 2010 (GCE, 2012) Traditional values lead to the perception that girls' educational achievement is an obstacle to marriage (Silas Mollel & Chong, 2017). traditional values lead to the perception that girls' educational achievement is an obstacle to

marriage. Consequently, women are often expected to depend on their husband or male head of household, leading them to get married earlier pursuing self-development by living on their own.

However, it does not mean that unequal gender norms induce women to get married by force. In Tanzania, marriage is considered as an essential stage of life and a desirable behavior for having a stable family, which is viewed as a cornerstone of life for both men and women. According to the research by Schaffnit et al. (2019). which investigated the local attitudes towards marriage in northern Tanzania, there are largely three major reasons for marrying which are "childbearing, partnership and respect and status". Based on the result of the focus group discussion and survey analysis of the study, most of the female respondents agreed that giving birth and raising children is a big pleasure and happiness for them and the inability to conceive babies is significant ordeal of their lives. Additionally, both male and female respondents universally recognized that marriage is regarded as a key partnership relationship of having mutual responsibility and solidarity and gaining social status with respect from community. In terms of women, "86% of female married respondents reported that their status within their community improved after marriage" (Schaffnit et al., 2019). Therefore, marriage seems to be significant factor meeting the LS in Tanzania.

There are largely three methods of marriage in Tanzania which are legal marriage recognized by courts, or religious authorities (Muslim and Christianity) and customary marriage (Stark, 2018). According to the Tanzania Demographic and Health Survey (TDHS) 2015-16, "62 percent of women and 52 percent of men are in a marital union" (Christine, 2017; MoHCDGEC et al., 2016). However, it is

estimated that there are more people in married status than official government records indicate, as many cases of marriage go unreported due to the payment of bride price or adherence to customary marriage practices (Schaffnit et al., 2019). Marriage culture in Tanzania is closely linked to the gender norms that has had foothold by sociocultural and religious notion. However, it entails gender inequality and may result in human rights violations against women. One of common marriage practices that negatively impact health and happiness of women in Tanzania is polygamous marriage.

Polygamous marriage is a widespread practice in Tanzania, with 18% of married women and 9% of married men having more than one spouse (MoHCDGEC et al., 2016). As one of the country in the 'polygyny belt', the practice of polygamy in Tanzania is a multifaceted and delicate matter, given its endorsement by religious institutions and cultural norms, as well as its recognition as a legally acceptable marital arrangement in certain communities (Diggos, 2007; Christine, 2017). This phenomenon is particularly prevalent in rural areas and among individuals with lower levels of education and income.

Polygamous marriage has been criticized by international societies due to the violation of female human rights and dignity. A number of studies have highlighted the potential risks associated with polygamous marriage, including increased risk of HIV transmission and other sexually transmitted diseases for women and higher rates of violence against wives by polygamous husbands (McCloskey, 2005). According to Diggos (2007), Women who are in polygamous marriages are at a greater risk of contracting HIV and other sexually transmitted infections compared to women in monogamous marriages, with the risk being three

times higher in polygamous marriages (Christine, 2017). Women's rights advocates also argue that polygamy perpetuates gender inequality and is emotionally damaging for women, with negative psychological effects including isolation, abandonment, jealousy, and loneliness.

Despite the controversy surrounding polygamous marriage, it is recognized under the Law of Marriage Act of 1971 as a legal union in which the husband may marry multiple women, assumimng that customary and Islamic marriages are polygamous, while other marriages are monogamous unless otherwise specified in a contract (Christine, 2017). However, the perspective that the practice of polygamy violates international human rights standards and call for its prohibition is prevalent in the international society.

Furthermore, some researchers have argued that it may have positive effects on women's lives, including greater access to wealth, improved food security, and better physical health for their children (Mubangizi, 2016). The study which title is “no evidence that polygynous marriage is a harmful cultural practice in northern Tanzania” argued that polygamous marriages may be advantageous for women, providing them with increased access to resources such as land and livestock, improved food security, and children with better physical health as indicated by their higher weight scores (Lawson et al., 2015). Additionally, proponents of polygamy argue that it can serve as a form of household cooperative, with the workload shared among multiple spouses. These findings suggest that polygamy may be in women's strategic interests and may not have negative group-level consequences on well-being.

Another marital practice which entails potential female health issues is child

marriage (early marriage). According to World Bank (2023), the rate of adolescent fertility in Tanzania has increased since 2012 and the rate in 2020 was higher than the average rate of Sub-Saharan Africa, indicating that 124 of every 1,000 girls ages 15-19 gave birth. According to the National Population Policy Commission, the determinants of high fertility are early marriage and low contraceptive use" (Mturi & Hinde, 1995). Child marriage, which is called as early marriage, a marriage before 18 years old, brings about the pregnancy and birth at early age which is possible to be led to negative consequences for their health, and education and to contribute to perpetuating cycles of poverty and inequality (Walker, 2012; Silas Mollel & Chong, 2017).

One of the culturally entrenched practices that set off the child marriage is female genital mutilation (FGM) and initiation rites. They are regarded as rite of passage into adulthood and particularly for girls, which is often associated with readiness for marriage. In terms of FGM, although Tanzania has prohibited it legally through the *Sexual Offences Special Provisions Act, 1998* (SOSPA) since it has been notably accepted as the human rights violation of women and girls in the world, still 10% of women aged 15-49 in Tanzania have experienced the FGM (Canada: Immigration and Refugee Board of Canada, 2008; MoHCDGEC et al., 2016). According to Rehema et al. (2014), the initiation rite of girls, which is called, *'unyago',* teaches "male physiology, sexual intercourse, pregnancy, childbirth and responsibilities of a good wife and mother' while boy's rite, *jando,* deliver the "bravery, the responsibilities as man has to carry, marriage and so son". Most of the rites provide the basic attitude based on sex and transmits the traditional gender norms, aiming to maintain the superiority of men and the inferiority of women in

both the community and marriage (Kapungwe ,2003).

However, despite the possible danger in female health, the early marriage has been accepted as great opportunity to get higher social status and guarantee of security. Schaffnit et al. (2021) stated that despite the overweighed risk, early marriage regarded as desirable option under the structural barriers such as poverty. Moreover, as Stark (2018) demonstrated in the study that some Muslim girls voluntarily wish to marry early to escape poverty and get independence as audult, the perspective of considering early marriage in a positive practice is intensified in the religious culture of Muslim.

IV. Conceptual Framework

Considering the previous literature review and national context of Tanzania, this study references two frameworks derived from previous relevant studies to explain and analyze the selection of the variables and their relationships comprehensively. The first framework is a revised version developed by Rishworth et al. (2020), based on the World Health Organization (WHO) Commission on Social Determinants of Health (CSDH). This framework illustrates the influence of social factors on health and well-being in Uganda. Considering the contextual background, including culture and social values, socioeconomic positions such as marital status, gender, and ethnicity are established, thereby impacting health and well-being equity through intermediary social factors. The authors substituted social class in the original version with marital status to reflect the socio-cultural characteristics of Africa. The framework suggests that the underlying cause of the unequal distribution of subjective well-being and health stems from varying socioeconomic and political contexts. It provides a conceptual space for exploring how major socioeconomic positions, such as marital status and gender, affect subjective well-being and health status in diverse socio-cultural contexts. Furthermore, the framework proposes that subjective well-being and health status among different socioeconomic positions are associated with intermediary determinants, including the provision of social support, healthcare systems, material circumstances, behavioral and biological factors, and psychological factors. This implies that expanding the availability of social support and diverse healthcare services can positively contribute to equity in subjective well-being and health status. Consequently, this naturally leads to further research on the correlation between individuals' satisfaction with the availability of social services

and their subjective well-being and health status.

Another framework is the framework for Gender-Transformative Health Promotion for Women created by Pederson et al. (2015). As the framework elucidates, gendered social structures and systems influenced by socio-cultural contextual factors result in imbalanced power dynamics and discriminatory values and practices. As these unequal gendered health determinants can impact gender and health equity, Pederson et al. (2015) emphasize the importance of implementing gender-transformative health promotion interventions. These interventions involve changing asymmetric gender norms, ensuring equal access to resources regardless of gender, and enhancing women's empowerment in health behaviors. This framework offers insights for African countries characterized by significant gender inequality in social structures, traditional norms, and cultural gender expectations. It emphasizes the need for appropriate political, social, and legal interventions to challenge and rectify discriminatory gender norms, thereby enhancing quality of life and health status.

These two frameworks consistently suggest that socio-cultural contexts serve as fundamental underpinnings that significantly influence subjective well-being and health. Based on societal cultural values, socio-demographic factors such as gender and marriage shape and impact equity in subjective well-being and health status. These ideas provide a research space for exploring how gender and marriage affect well-being status within specific socio-cultural contexts. In Tanzania, where traditional and religious gender norms are reflected in marriage practices, such as polygamous and child marriages, studying the impact of marital status and type on subjective well-being and health across different genders would be a valuable

investigation. Furthermore, as both frameworks highlight the importance of expanding appropriate social support to promote subjective well-being and health status based on socio-cultural contexts, identifying the significance of social services in enhancing well-being in Tanzania is essential for informing appropriate policy implications and striving for a high quality of life in the country.

Based on these two frameworks for integrated analysis and prior literature reviews, this study aims to explore gender differences in the impact of marital status and type on SWB and health of individuals in Tanzania, where exhibits a gender-based marriage culture and faces significant female health challenges associated with marital traits in the African context. Additionally, to identify the significance of availability of social supports in improving quality of life and health, this study also examines the effect of the satisfaction of availability of two major social services, educational and healthcare services on human well-being. To address objective of this study, the study seeks to answer the following research questions: 1) Are there gender differences in the effect of marital status on life satisfaction and self-rated health?; 2) Are there gender differences in the effect of marital type on life satisfaction and self-rated health?; and 3) Does satisfaction on the availability of social support affect life satisfaction and self-rated health in Tanzania?

To investigate these research questions, this study established a framework determining two major dependent variables and six independent variables presented in figure 4. Two major dependent variables are measurements of SWB and health which are life satisfaction (LS) and self-rated health (SRH). LS and SRH have been acknowledged its significance as a SWB and health indicator respectively in the aforementioned studies. As LS reflects overall perception on life, it has been utilized

in many studies to evaluate SWB rather than happiness. As for SRH, although its assessment can be vague and subjective so as to precisely seize the objective health status, many studies demonstrated that SRH is a statistically robust biological indicator, effectively predicting mortality and morbidity (Idler & Benyamini, 1997; Singh-Manoux et.al 2007; Latham & Peek, 2013).

In examining socio-demographic determinants of LS and SRH, this study addresses six independent variables which are gender, marriage, the satisfaction with availability on healthcare and educational services, age, and education level. One of the major variables is gender which has also been found to play a role in LS and SRH, with women generally reporting worse health and higher levels of LS compared to men (Jerdén et al., 2011; Goldbeck et al., 2007). Moreover, marriage has been found to have a significant effect on health and LS outcomes, with married individuals reporting higher levels of well-being and lower rates of mortality than unmarried individuals (Rajabi Gilan et al., 2021; Lawrence et al., 2019). However, as these tendencies can vary by sociocultural, political, economic, and historical factors in each country, multidisciplinary studies are continuously needed. Furthermore, considering African cultural and religious custom in marriage, not only the marital status, but also marital type such as monogamous and polygamous marriage should be analyzed. Therefore, in this study, gender and marriage are adopted in the form of interaction term to represent gender difference in each marital status and type.

Variables related to satisfaction with the availability of public services, such as healthcare and education, are also included in the study to examine the impact of accessibility to social support on LS and SRH outcomes. Previous research has

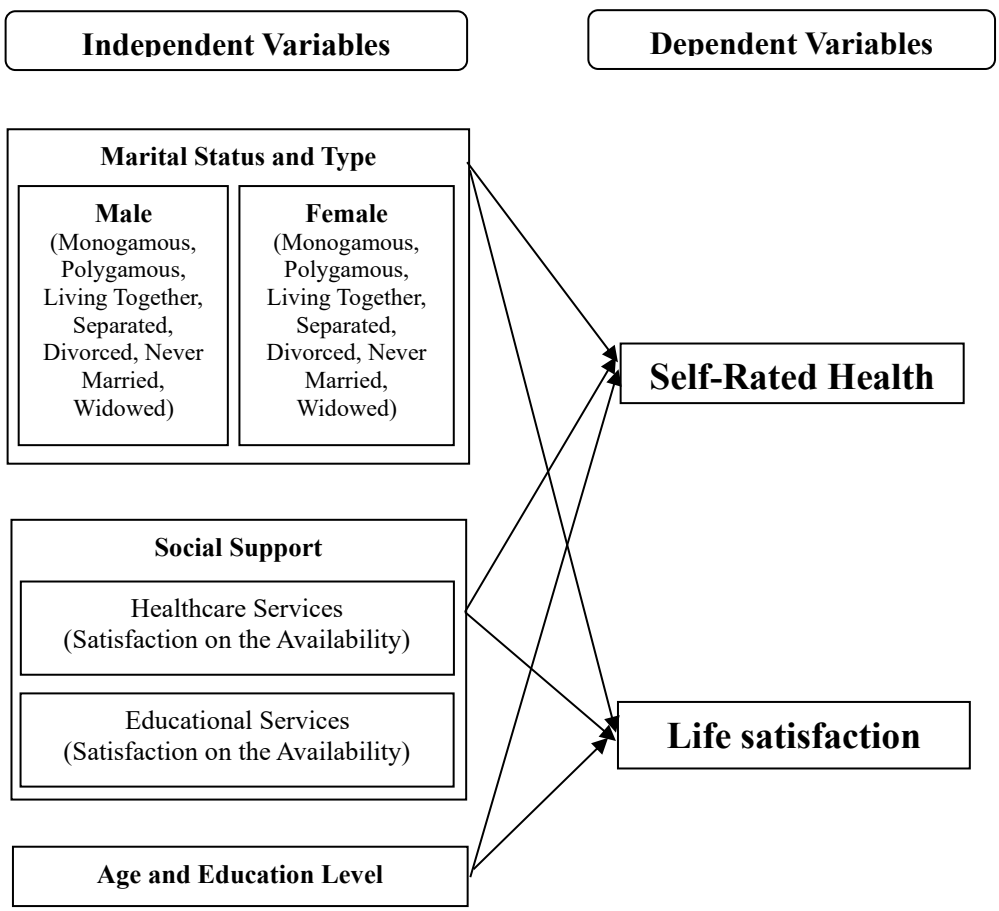
shown that social support is closely connected with better health outcomes and better values of LS, and people's perception and satisfaction with their access to public services can significantly affect their SRH status and LS. (Cummings & Cockerham, 2004). Therefore, including these variables allows for a better understanding of how individuals' satisfaction with public services may be related to their LS and SRH outcomes.

Additionally, age, as a significant demographic feature, is included. Research has shown that older individuals with reduced self-care capacity tend to experience chronic illnesses and have poor value of SWB than younger individuals (Borg et al., 2006; Angelini et al., 2012). Lastly, another key social factor, education level is included as well. According to Matud et al. (2019), the education level can be a significant factor that affects SRH and subjective happiness, and especially for the female group, there were statistically significant correlations. However, depending on different sociocultural factors, it can be revealed differently. For instance, in Ghana and Burkina Faso (Udofia et al., 2014; Onadja et al., 2013), SRH and education level are not significantly associated, but in South Africa, those who obtained secondary and tertiary education tended to report their health more positively (Chola & Alaba, 2013; Duboz et al., 2017). Hence, multifaceted studies in various countries conditions should be implemented in succession.

As you can see in figure 1, to reply to the first research question, marital status and type are distinguished by gender and placed as major independent variables affecting LS and SRH. By comparing never-married people with married group, which is merged by monogamous and polygamous marriage, this study explore how marriage affects LS and SRH and can be varied by gender. Furthermore,

to analyze the second research question, among married men and women, monogamous group and polygamous group are compared in terms of LS and SRH. Lastly, this study also includes the possible independent variables that are potentially correlated to LS and health which are the availability of social support (healthcare and educational services), age and education level. The detailed explanation for measurements for each dependent and independent variable is elaborated in the following section.

Figure 1. The Relation Diagram for the Impact of Socio-Demographic Factors on Life Satisfaction and Self-Rated Health



Source: Author

V. Methodology

The Data

This study aims to examine how Tanzanian males and females perceive their health status and subjective life satisfaction, and how marital status can impact these perceptions. To achieve this, the study analyzed the 2008-2015 National Panel Survey Uniform Panel Dataset of Tanzania (TNPS UPD) obtained from the World Bank, using multiple regression analysis. The TNPS UPD is a multi-topic household survey that collects data through four rounds of national panel surveys in Tanzania: 2008-09 (R1), 2010-11 (R2), 2012-13 (R3), and 2014-2015 (R4). While a 2020-2021 panel data also exists, this study concluded that the 2008-2015 survey data is more reliable for analysis as some key variables, such as polygamy, do not have robust data in the 2020-2021 data. This research merged the datasets with individual household members' observations, resulting in a total of 83,706 observations. The TNPS UPD collected data on various socioeconomic factors through a diverse range of questionnaires. This study used some of the questions from the survey as a foundation for the variables used in this study.

Dependent Variables

Dependent variables are crucial to understanding the gender difference in LS and SRH by marital status and type in Tanzania. This study employs two major dependent variables: LIFESAT and HEALTH. HEALTH in this study refers to self-rated health (SRH), which is widely recognized as a significant health indicator for measuring an individual's physical and psychological health status. SRH is usually measured by questionnaire, asking a single question like, “In general, how would

you rate your health?" which is the first question of the Short Form Health Survey (SF-36), or "Overall, would you say that your health is excellent, very good, good, fair or poor?" which is used by World Health Organization (WHO) (Duboz et al., 2017; Wuorela et al., 2020; Subramanian et al., 2010; Ware & Gandek, 1998). SRH is commonly measured using a single item questionnaire and the simplicity and ease of use of this approach make it a practical choice for large-scale surveys or studies with large sample sizes such as national panel data, reducing the burden on participants who may be unwilling or unable to complete more time-consuming health assessments. Research has also demonstrated that the responses to a single-item questionnaire on SRH are significantly associated with other health measures, such as mortality, morbidity, and health care utilization by capturing the individual's own perception of their health, rather than relying solely on objective measures of health status that may not fully capture the individual's experience (Franks et al., 2003). Therefore, in this study, the value of the variable, HEALTH is established based on the responses of the single question, "How satisfied or dissatisfied would you say you are with your health?" which is a Likert-type scale.

Similarly, the variable, LIFESAT focuses on how people perceive their lives as a whole and how they rate the quality of life positively. This study places LIFESAT not as the self-evaluation based on temporary feeling about present life status, but as the long-term reflection on the well-being of whole life. Hence, to observe the perception disparities of Tanzanian on overall quality of life, LIFESAT is semanticized as an individual's aggregate satisfaction with life and is referred from the responses of single question, "How satisfied or dissatisfied would you say you are with your life as a whole?" As the SRH measurement does, this approach is

consistent with global reports of LS, which have good internal consistency, moderate stability, and are sensitive to changing life circumstances (Siahpush et al., 2008).

Independent Variables

This study selected six demographic and social indicators of the respondents as independent variables known to be closely related to health and happiness outcomes. As a significant demographic features, age, gender and marital status are included in independent variables. Based on the sociocultural background of Tanzania, this research distinguished sex, focusing on the female group, by setting the value of the variable as '1' for female and '0' for male and establishing the name of the variable as FEMALE. Regarding marital status, the variable MARITAL includes all statuses and types, such as monogamous and polygamous marriages, living together, separated, divorced, never married, and widowed. In respect of social factors, this research includes the educational level. The variable EDUCATION reveals the highest grade that respondents completed, indicating the level of education. Tanzania has 13 years of formal schooling including primary and secondary education and people are available to enroll the university after completing diploma course. For convenience of analysis, this study divided range into 4 different levels which are Primary, Secondary, Diploma and University and coded from 0 to 3 respectively. In this study, the primary group will be regarded as the reference group in the regression model. For measuring the self-rated satisfaction on the possibility to utilize public services, the variable HEALTHCARE is established based on the question, "How satisfied or dissatisfied would you say you are with the health care availability?" and the variable, EDUSERVICE is also set

based on the question, “How satisfied or dissatisfied would you say you are with the education availability?” Details of the variables are listed in Table 1.

Table 1. Details of the Dependent and Independent Variables

Variables	Question
DEPENDENT VARIABLES	
HEALTH	How satisfied or dissatisfied would you say you are with your health? (1-8, 8: Very satisfied)
LIFESAT	How satisfied or dissatisfied would you say you are with your life as a whole? (1-8, 8: Very satisfied)
INDEPENDENT VARIABLES	
AGE	How old is respondent's age?
FEMALE	Respondent’s sex (0: Male, 1: Female)
MARITAL	What is marital status of the respondent? (1: Monogamous, 2: Polygamous, 3: Living Together, 4: Separated, 5: Divorced, 6: Never Married, 7: Widow(er))
EDUCATION	What is the highest grade completed by the respondent? (0-3, 0: Primary, 1: Secondary, 2: Diploma, 3: University / Primary: the reference group)
HEALTHCARE	How satisfied or dissatisfied would you say you are with the healthcare availability? (1-8, 8: Very satisfied)
EDUSERVICE	How satisfied or dissatisfied would you say you are with the education availability? (1-8, 8: Very satisfied)

Descriptive Statistics

Table 2 presents the descriptive statistics of the dependent variables. Among the total of 83,706 observations, there are 26,127 observations (or cases) for the "HEALTH" variable and the "LIFESAT" variable. In case of HEALTH variable, the mean is 6.45, which indicates that, on average, people reported relatively high levels of health. The standard deviation is 1.75, which suggests that there is some variability in the reported levels of health, with some people reporting lower levels of health than

others. The minimum value of the "HEALTH" variable is 1, which is the lowest possible value, while the maximum value is 8, which is the highest possible value. The mean of the "LIFESAT" variable is 4.68, which indicates that, on average, people reported moderate levels of LS. The minimum value is 1 and the maximum value is 8 with higher values indicating higher levels of LS.

Table 2. Descriptive Statistics for Dependent Variables

Independent Variables	Obs	Mean	Std. Dev.	Min	Max
HEALTH	26,127	6.45	1.75	1	8
LIFESAT	26,127	4.68	2.07	1	8

The descriptive statistics of independent variables are shown in Table 3 . The average age of the sample is 35.32. As for gender, female accounts for about 53% and male accounts for about 47%. In terms of marital status, approximately 21% are never married, and approximately 55% are married, including both monogamous and polygamous marital types. Regarding educational level, over 50% of valid respondents fall into the Secondary category, and there are a very few people who have University level education. The descriptive statistics of the variable, HEALTHCARE which measures self-reported satisfaction with the availability of healthcare services, suggests that there is no significant difference in the ratio of satisfied and dissatisfied people. However, regarding the availability of educational services, the data indicates that the ratio of dissatisfied individuals is significantly higher than the ratio of satisfied individuals.

Table 3. Descriptive Statistics for Independent Variables

Independent Variables	Obs	Mean	Std. Dev.	Min	Max
AGE	26,127	35.32	14.08	3	93
FEMALE	26,127	.53	.50	0	1
Independent Variables	**Category**		**Freq.**	**Percent**	
MARITAL	Never Married		5,509	21.09	
	Monogamous Married		12,400	47.46	
	Polygamous Married		1,938	7.42	
	Living Together		3,030	11.60	
	Separated		1,341	5.13	
	Divorced		692	2.65	
	Widow(er)		1,217	4.66	
			26,127	100.00	
EDUCATION	Primary		5,196	19.89	
	Secondary		15,035	57.55	
	Diploma		5,630	21.55	
	University		266	1.02	
			26,127	100.00	
HEALTHCARE	Very Satisfied		1,460	6.98	
	Satisfied		5,587	26.71	
	Somewhat Satisfied		3,243	15.50	
	Neither Satisfied nor Dissatisfied		716	3.42	
	Somewhat Dissatisfied		1,091	5.22	
	Dissatisfied		5,344	25.55	
	Very Dissatisfied		3,294	15.75	
	Not Applicable		183	0.87	
			20,918	100.00	
EDUSERVICE	Very Satisfied		1,002	4.79	
	Satisfied		4,092	19.56	
	Somewhat Satisfied		2,505	11.98	
	Neither Satisfied nor Dissatisfied		617	2.95	
	Somewhat Dissatisfied		1,038	4.96	
	Dissatisfied		7,277	34.79	
	Very Dissatisfied		3,644	17.42	
	Not Applicable		743	3.55	
			20,918	100.00	

The Empirical Model

Establishing the major dependent variables as HEALTH (self-rated health) and LIFESAT (life satisfaction), the variables, AGE, FEMALE (1 for female and 0 for male), EDUCATION (education level) HEALTHCARE (healthcare availability satisfaction), EDUSERVICE (education availability satisfaction) were input as independent variables. EDUCATION is a categorical variable, and primary education is used as a reference category. Subsequently, the multiple regression model was derived by including dependent, independent variables and an interaction term by multiplying the MARITAL (marital status and type) and FEMALE (whether or not a woman). Based on this setting, this study constructed four empirical models to observe how SRH and LS can vary by gender and marital status and type and how its difference can be related to the self-contentment on public services availability.

To answer the first research question, the first model examines the gender difference in the impact of marital status on LS and health by applying each dependent variable of HEALTH and LIFESAT and independent variables of AGE, EDUCATION, FEMALE and MARITAL into the functional formula for multiple regression. To compare the married and never-married group, this study forms new category, *married male and female* representing married group of each gender by merging the data of monogamous and polygamous marriage. By including the interaction term FEMALE*MARITAL, we can analyze the effects of marital status on HEALTH and LIFESAT by gender.

To explore the second research question, the model 3 examines the gender difference in the impact of marital type on LS and health. While in Model 1, to compare the married and never-married group, the variable MARITAL was divided

into married, living together, separated, divorced, and widow(er), as the third model examines the gender difference in the impact of marital type on LS and SRH, the variable, MARITAL was further divided into monogamous and polygamous in model 3. The first and third model equation are as follows:

(Model 1 and 3)

$$LIFESAT_i = a_0 + a_1 AGE_i + a_2 AGE^2{}_i + a_3 EDUCATION_i + a_4 FEMALE_i + a_5 MARITAL_i + a_6 FEMALE_i \times MARITAL_i + \varepsilon_i$$

$$HEALTH_i = c_0 + c_1 AGE_i + c_2 AGE^2{}_i + c_3 EDUCATION_i + c_4 FEMALE_i + c_5 MARITAL_i + c_6 FEMALE_i \times MARITAL_i + \varepsilon_i$$

To confirm whether there is any association between the perception on the availability of healthcare and educational services and the SRH and LS, which is the point of the third research question, the model 2 and 4 adds the two independent variables of HEALTHCARE and EDUSERVICE on the regression formula of model 1 and 3 respectively. As the variables are not the objective measurement of service availability, but the individual subjective satisfaction on the possibility to use the services, this researcher implemented a separated model, concerning simultaneity issue and endogenous effect. The model 2 and 4 are as follows:

(Model 2 and 4)

$$LIFESAT_i = b_0 + b_1 AGE_i + b_2 AGE^2{}_i + b_3 HELATHCARE_i + b_4 EDUSERVICE_i + b_5 EDUCATION_i + b_6 FEMALE_i + b_7 MARITAL_i + b_8 FEMALE_i \times MARITAL_i + \varepsilon_i$$

$$HEALTH_i = d_0 + d_1 AGE_i + d_2 AGE^2{}_i + d_3 HELATHCARE_i + d_4 EDUSERVICE_i + d_5 EDUCATION_i + d_6 FEMALE_i + d_7 MARITAL_i + d_8 FEMALE_i \times MARRITAL_i + \varepsilon_i$$

VI. Empirical Results

The empirical results of the multiple regression models are presented in Tables 4 and 5. In Table 4, models 1 and 2 examine the relationship between marital status and self-rated health (SRH) and life satisfaction (LS), considering the impact of the availability of public services in Tanzania. Similarly, Table 5 presents models 3 and 4, which explore the association between marital type and SRH and LS, while also accounting for the effect of the availability of public services. The study comprises a robust dataset of 26,127 observations in models 1 and 3, and 20,918 observations in models 2 and 4. The major dependent variables in these models are HEALTH (self-rated health) and LIFESAT (life satisfaction), while the main independent variables are FEMALE (gender) and MARITAL (marital status and type). In addition to the core independent variables, the models also incorporate other demographic factors, including AGE and EDUCATION. Moreover, HELTHCARE and EDUSERVICE are introduced as additional independent variables in models 2 and 4 to further analyze their impact on SRH and LS.

In table 4, the findings reveal significant relationships between age and the dependent variables HEALTH and LIFESAT. In model 1, age exhibits a negative and significant coefficient value of -0.0086 ($p<0.05$) in HEALTH, while the age squared (AGE^2) exhibits -0.0002 ($p<0.001$). Similarly, in LIFESAT, age has a negative coefficient value of -0.0552 ($p<0.001$), and the age squared (AGE^2) has a positive coefficient value of 0.0006 ($p<0.001$). These results indicate that the relationship between age and the dependent variables is not linear. Specifically, with increasing age, HEALTH decreases at an increasing rate, while LIFESAT first decreases and then increases, forming a U-shaped curve. This implies that, in terms of health,

individuals experience a subsequent decline with age, whereas LS declines until the late 40s (566/12) and then shows signs of improvement. These patterns are consistent in model 2 as well. The findings align with previous studies and social conventions that suggest natural aging has a negative impact on SRH and LS, but after a certain age, LS improves due to life stability (Phaswana-Mafuya et al., 2013).

Regarding educational level, the study finds that the coefficient values of most levels of education is positive and statistically significant in both HEALTH and LIFESAT of both models. Notably, individuals with a university-level education (University) exhibit the highest positive significance compared to the reference group (Primary) in both variables. These findings suggest that higher levels of education are associated with better SRH among Tanzanian individuals, which aligns with existing research demonstrating a positive relationship between educational attainment and improved health outcomes (Ross & Wu, 1995, Zajacova & Lawrence, 2018). Hamad et al. (2018), in a meta-analysis on the association between education and health based on the impact of compulsory schooling laws, found that those with higher educational attainment had lower mortality rates, reduced smoking prevalence, and lower obesity rates. Similarly, Kouladoum (2023) observed a positive effect of inclusive education on the health performance of both male and female individuals in Sub-Saharan African countries. Additionally, educational achievement strongly correlates with an individual's LS. Individuals with higher levels of education are often better equipped to find fulfilling employment, maintain positive relationships, and make informed decisions about their health and well-being, all of which can contribute to greater LS (Cheung & Chan, 2009, Hassan et al., 2021).

Regarding gender, the study finds that the coefficient for FEMALE in the variable HEALTH is -0.0108 and -0.0904 in model 1 and 2, respectively. This indicates that females tend to have slightly lower levels of SRH compared to males. However, the difference is not statistically significant, and a similar trend is observed in the variable LIFESAT, reflecting no substantial disparity in LS between single males and single females.

However, in terms of marital status, the coefficient values of *Married Male* remain statistically significant in LIFESAT of both models, with 0.292 ($p<0.001$) and 0.281 ($p<0.001$) in model 1 and 2, respectively. Similarly, *Married Female* also displays statistically significant coefficient values of 0.344 ($p<0.001$) and 0.215 ($p<0.001$) in both models. These findings suggest that married individuals, both male and female, tend to report higher levels of LS compared to their single counterparts.

Furthermore, in terms of female group, the variable, *Female-Living Together* represents significant and positive coefficients of 0.447 ($p<0.001$) and 0.322 ($p<0.001$) in LIFESAT. This indicates that for women, living together with someone under one roof and sharing one's life with a partner significantly enhances LS, even without being officially married. However, in terms of HEALTH, only married men show statistically significant and positive coefficients of 0.171 ($p<0.001$) and 0.144 ($p<0.001$) in both models, compared to single men. On the other hand, married women display a slightly lower coefficient value (-0.102) than single women, but it is not statistically significant. This suggests that, in comparison to women, men are more likely to experience better SRH status when they get married. Additionally, it is observed that individuals who are separated, divorced, or widowed display a negative association with both SRH (HEALTH) and LS (LIFESAT);

nevertheless, it is important to note that these associations do not achieve statistical significance.

In Model 2, two additional independent variables, HEALTHCARE and EDUSERVICE, were introduced to investigate the impact of self-satisfaction with the availability of social support on SRH (HEALTH) and LS (LIFESAT). The overall trend in Model 2 is consistent with that of Model 1, but the R-squared values for both HEALTH and LIFESAT increased, indicating enhanced explanatory power.

The study reveals that the coefficients related to self-satisfaction with the accessibility of healthcare and educational services demonstrate positive and statistically significant effects on both HEALTH and LIFESAT. This suggests that Tanzanian individuals who express satisfaction with the availability of healthcare and educational services are more likely to report higher levels of LS and SRH. Specifically, in the case of HEALTH, the coefficient for HEALTHCARE is 0.119 ($p<0.001$), slightly higher than that of EDUSERVICE, which is 0.0510 ($p<0.001$). Conversely, in terms of LIFESAT, the effect is opposite. LS appears to be more influenced by satisfaction with the availability of educational services than healthcare. However, the study notes that these variables represent subjective values rather than objective measures, and thus may have concurrency problems.

Overall, the study finds that married individuals are more likely to rate their life positively compared to single individuals. However, in terms of SRH, married men have better health status than single men, while married women have slightly lower health status than single women, although the difference is not statistically significant. Regarding age, the research highlights a gradual decline in SRH with the aging process. In contrast, LS tends to decrease until a certain age and then begins

to improve. Furthermore, the study identifies a positive association between education level and both SRH and LS among Tanzanian individuals. Higher levels of education are linked to better SRH and LS in this population.

Table 4. Multiple Regression Results of (Model 1 and 2)

Model	Model 1		Model 2	
Variable	HEALTH	LIFESAT	HEALTH	LIFESAT
AGE	-0.00857*	-0.0552***	0.00200	-0.0336***
	(-2.19)	(-11.86)	(0.47)	(-7.29)
AGE^2	-0.000215***	0.000589***	-0.000349***	0.000319***
	(-4.80)	(11.08)	(-7.19)	(6.03)
EDUCATION				
Secondary	0.0821**	-0.150***	0.109***	-0.109**
	(2.91)	(-4.46)	(3.53)	(-3.24)
Diploma	0.288***	0.0714	0.287***	0.0925*
	(8.60)	(1.79)	(7.89)	(2.33)
University	0.766***	0.699***	0.750***	0.218
	(7.24)	(5.57)	(6.82)	(1.82)
FEMALE	-0.0108	0.0485	-0.0904	-0.0192
	(-0.24)	(0.90)	(-1.84)	(-0.36)
MARITAL				
Married Male	**0.171*** **	**0.292*** **	**0.144****	**0.281*** **
	(4.07)	**(5.87)**	**(3.17)**	**(5.69)**
Male-Living Together	-0.00574	-0.0685	-0.0444	-0.0165
	(-0.10)	(-1.05)	(-0.76)	(-0.26)
Male-Separated	-0.169	-0.00424	-0.224*	0.0339
	(-1.77)	(-0.04)	(-2.17)	(0.30)
Male-Divorced	-0.292	0.121	-0.231	0.0544
	(-1.90)	(0.66)	(-1.46)	(0.31)
Male-Widow(er)	-0.0716	-0.141	0.0436	-0.0295
	(-0.54)	(-0.90)	(0.30)	(-0.19)

Married Female	-0.102 (-1.90)	**0.344***** **(5.39)**	-0.0830 (-1.42)	**0.215***** **(3.39)**
Female-Living Together	0.0567 (0.75)	0.447*** (4.94)	0.0505 (0.63)	0.322*** (3.67)
Female-Separated	0.185 (1.64)	0.0652 (0.49)	0.223 (1.83)	0.0188 (0.14)
Female-Divorced	0.164 (0.96)	-0.365 (-1.80)	0.0954 (0.54)	-0.285 (-1.48)
Female-Widow(er)	-0.134 (-0.94)	0.210 (1.24)	-0.253 (-1.61)	0.0682 (0.40)
HEALTHCARE			**0.119***** **(21.30)**	**0.193***** **(31.76)**
EDUSERVICE			**0.0510***** **(8.99)**	**0.319***** **(51.68)**
Constant	6.936*** (95.57)	5.380*** (62.37)	6.014*** (70.11)	2.777*** (29.73)
N	26127	26127	20918	20918
R-Sqaured	0.057	0.026	0.094	0.217

t statistics in parentheses

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

The Table 5 presents the regression results of model 3 and 4 that investigate the relationship between several independent variables and two dependent variables, namely HEALTH and LIFESAT. The independent variables include AGE, AGE^2 (age squared), EDUCATION (with multiple subcategories), FEMALE (gender), MARITAL (with divisions into Male-Monogamous, Male-Polygamous, Female-Monogamous, and Female-Polygamous categories), HEALTHCARE, and EDUSERVICE.

The findings related to age and education in models 3 and 4 align with the results observed in models 1 and 2. Individuals with higher levels of education

continue to demonstrate better SRH and SWB compared to those with lower educational attainment. Similarly, the coefficient results for FEMALE in models 3 and 4 mirror the outcomes of models 1 and 2, indicating negative coefficients (-0.0109 and -0.0904) for HEALTH and both positive and negative coefficients (0.0474 and -0.0197) for LIFESAT. However, these coefficients remain statistically insignificant.

Regarding the MARITAL variable, the coefficients for *Male-Monogamous, Male-Polygamous*, and *Female-Polygamous* display statistical significance in relation to HEALTH. In model 3, polygamous men exhibit a more positively rated health status with a higher coefficient of 0.258 ($p<0.001$) compared to monogamous men with a coefficient of 0.160 ($p<0.001$). Conversely, women in polygamous marriages show a lower negative coefficient of -0.189 ($p<0.05$) compared to monogamous women with a coefficient of -0.0890. This indicates that polygamous men tend to report better health status than monogamous men, while polygamous women tend to have poorer health status than monogamous women. Similar patterns are observed in model 4.

In terms of LIFESAT, the coefficients for *Male-Monogamous, Male-Polygamous*, *Female-Monogamous, Female-Polygamous* and *Female-Living Together* are all positive and statistically significant. Monogamous men have a lower coefficient of 0.269 ($p<0.001$) compared to polygamous men with a coefficient of 0.574 ($p<0.001$), and polygamous women with a coefficient of 0.385 ($p<0.001$) have slightly higher LS than monogamous women with a coefficient of 0.337 ($p<0.001$). Additionally, women living together with men without formal marriage demonstrate a positive and significant coefficient of 0.441 ($p<0.001$). These results indicate that

the gap in LS between polygamous and never-married individuals is larger than that of monogamous individuals. Furthermore, being divorced or widowed is negatively associated with both health and LS, but they are not statistically significant. Finally, HEALTHCARE and EDUSERVICE also show positive and highly significant coefficients ($p<0.001$) in both HEALTH and LIFESAT, indicating that improved access to healthcare and educational services is associated with better SRH and LS. These results align with the findings from model 2.

Table 5. Multiple Regression Results (Model 3 and 4)

Model	Model 3		Model 4	
Variables	HEALTH	LIFESAT	HEALTH	LIFESAT
AGE	-0.00882*	-0.0577***	0.00170	-0.0358***
	(-2.25)	(-12.36)	(0.40)	(-7.75)
AGE^2	-0.000213***	0.000609***	-0.000347***	0.000338***
	(-4.76)	(11.46)	(-7.15)	(6.39)
EDUCATION				
Secondary	0.0829**	-0.144***	0.110***	-0.105**
	(2.93)	(-4.29)	(3.54)	(-3.11)
Diploma	0.290***	0.0821*	0.288***	0.101*
	(8.62)	(2.06)	(7.90)	(2.55)
University	0.771***	0.731***	0.757***	0.244*
	(7.29)	(5.82)	(6.87)	(2.04)
FEMALE	-0.0109	0.0474	-0.0904	-0.0197
	(-0.24)	(0.88)	(-1.84)	(-0.37)
MARITAL				
Male-Monogamous	**0.160*** **	**0.269*** **	**0.129****	**0.264*** **
	(3.78)	**(5.34)**	**(2.81)**	**(5.30)**
Male-Polygamous	**0.258*** **	**0.574*** **	**0.268*** **	**0.501*** **
	(3.90)	**(7.31)**	**(3.70)**	**(6.36)**
Male-Living Together	-0.00345	-0.0527	-0.0414	-0.00332
	(-0.06)	(-0.81)	(-0.71)	(-0.05)

Male-Separated	-0.166 (-1.74)	0.0158 (0.14)	-0.219* (-2.13)	0.0507 (0.45)
Male-Divorced	-0.288 (-1.88)	0.142 (0.78)	-0.226 (-1.43)	0.0716 (0.41)
Male-Widow(er)	-0.0666 (-0.51)	-0.115 (-0.74)	0.0503 (0.35)	-0.00853 (-0.05)
Female-Monogamous	-0.0890 (-1.62)	**0.337***** **(5.17)**	-0.0627 (-1.05)	**0.204**** **(3.15)**
Female-Polygamous	**-0.189*** **(-2.12)**	**0.385***** **(3.64)**	**-0.221*** **(-2.28)**	**0.277**** **(2.62)**
Female-Living Together	0.0557 (0.73)	**0.441***** **(4.88)**	0.0491 (0.61)	**0.317***** **(3.62)**
Female-Separated	0.184 (1.64)	0.0629 (0.47)	0.222 (1.82)	0.0169 (0.13)
Female-Divorced	0.164 (0.96)	-0.367 (-1.81)	0.0946 (0.54)	-0.287 (-1.49)
Female-Widow(er)	-0.134 (-0.94)	0.210 (1.24)	-0.254 (-1.61)	0.0690 (0.40)
HEALTHCARE			0.119*** (21.30)	0.192*** (31.67)
EDUSERVICE			0.0508*** (8.96)	0.319*** (51.60)
Constant	6.941*** (95.41)	5.419*** (62.73)	6.020*** (69.98)	2.818*** (30.09)
N	26127	26127	20918	20918
R-Sqaured	0.057	0.027	0.094	0.218

t statistics in parentheses

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

VII. Discussion

The preceding findings offer valuable insights into gender differences in the impact of marital status and type on individual well-being measures, namely self-rated health (SRH) and life satisfaction (LS) in Tanzania. The inclusion of public service availability as a covariate enables us to assess its potential influence on the relationship between marital status or type and well-being outcomes. Based on the empirical results, this study draws upon in-depth interviews with select Tanzanian public officers, conducted to gain a comprehensive understanding of the subject matter. By analyzing the findings in conjunction with prior research and insights from the in-depth interviews (see Appendix A), several noteworthy discoveries have been identified.

At first, as shown in the regression results, findings suggest that regardless of gender, marriage is an important factor in promoting LS in Tanzania. This is consistent with previous studies that have found a positive relationship between marriage and LS (Hills & Argyle, 2001; Waite & Gallagher, 2000; Campbell et al., 1976). As participants also stated in the interview, marriage is a vital stage of life in Tanzania which provides stability, financial security, and sense of belonging under the umbrella of family. As Sunday Idemudia & Adedeji (2023) stated, the perspective towards well-being in Africa is built on culture of collectivism, highlighting the family ties and group norms. As Schaffnit et al. (2019) demonstrated, the potential reasons that Tanzanian pursue to marry are because having and raising a child is major joy for both men and women and thereby, they can get higher LS. Also, marital status is usually associated with social status in the community and hence, marriage can enhance the self-esteem as the participant A also highlighted in the in-depth

interview. Since marriage is regarded as indispensable and beneficial partnership in Tanzania, this socio-cultural norm for marriage can be a cornerstone of the positive impact of marriage on LS. However, in terms of health status, only men evidenced the significant positive association while women indicated insignificant negative value. One possible cause can be the unbalanced gender norm which treat women as a supporter of husband and children by handling all unpaid domestic work and doing additional informal work. Glenn (1975) also stated that married men tend to receive greater health benefits from their marital status, possibly because of the emotional and social support provided by their female partners. Additionally, as high maternal mortality in Tanzania verifies, there is a danger that jeopardizes women's health during childbirth, where the husband's opinion on delivering in a healthcare facility can have an impact on women's reproductive health (Danforth et al., 2009; Dudgeon & Inhorn, 2004). Therefore, this study implies that these possible socio-cultural causes can affect the gender difference in the impact of marriage on SRH.

Secondly, in terms of marital type, the regression results represent that both monogamous and polygamous men and women demonstrated its positive satisfaction level of life, while the potential negative effects of polygamous marital status on women's health was found. This negative relationship in polygamous women is possible to be attributed to increased competition and conflict among co-wives, which can lead to psychological distress and poor health outcomes (Shepard 2013). Additionally, as participant C highlighted in the interview, one of the critical possible health challenges of polygamous women is HIV/AIDS. A study by Diggos, (2007) demonstrated that “HIV transmission in Tanzania showed that polygamous married women had a three times higher risk of getting HIV and are more likely of

getting other sexually transmitted diseases than monogamous married women" (Christine, 2017). Besides, there are lots of child marriage in polygamous women, but pregnancy and birth at early age is led to poor health status of girls, which is commonly promoted by traditional initiation rites and FGM (Walker, 2012; Silas Mollel & Chong, 2017; Kapungwe, 2003). However, despite the factors that have a bad effect on health of women, the fact that polygamous women have significant and positive value in LS implies that polygamous marriage is agreed as just one of the marriage cultures and even great opportunity to get an access to better wealth and social status, not as a human rights violation of women (Lawson et al., 2015). All the interviewees who responded to question 2 stated that individuals in polygamous marriages do not perceive polygamy as a severe issue. Rather, it is seen as a socio-cultural norm, particularly within the Muslim community. Therefore, this study suggests that the compound of such social factors, including cultural and religious perspectives, contributed to the aforementioned results. However, this study implies that recognizing polygamous marriage as a cultural practice can have significant detrimental effects on the health status of women, potentially contributing to a decrease in overall quality of life in African countries.

Lastly, a positive association was observed between satisfaction regarding the accessibility of social services, specifically healthcare and educational services, and SRH as well as LS. This finding aligns with the research conducted by Matud et al. (2019), which concluded that social support, encompassing the perception of available and reliable assistance from society, is linked to improved health outcomes and elevated levels of LS (Matud et al., 2019). Aforementioned studies have consistently proved positive impact of access to utilize healthcare services on better

health outcomes and higher LS (Cheng et al., 2022; Pecha & Beuermann, 2016; Cummings & Cockerham, 2004). In terms of educational services, better educational achievement is closely connected to get a quality of life and good health. This association can be attributed to the fact that individuals with higher levels of education are more prone to possess stable sources of income, engage in social activities and support systems, and advocate for health-related services. (Ross & Wu, 1995; Zajacova & Lawrence 2018). Expanding the availability of educational service is strongly associated with an individual's LS. Individuals with higher levels of education are often better equipped to find fulfilling employment, maintain positive relationships, and make informed decisions about their health and well-being, all of which can contribute to greater LS (Cheung & Chan, 2009; Hassan et al., 2021). This relationship is also reinforced by the common responses of all participants in the interview, acknowledging the benefits of social supports. Based on the conceptual frameworks, these findings also emphasize that gender-specific social support and health promotion initiatives can serve as significant avenues for promoting gender equity in SWB and health status in Tanzania.

These findings contribute to a deeper understanding of the complex factors influencing individuals' SRH and LS in Tanzania. By examining the role of both marital status and marital type, along with the impact of public service accessibility, this study provides a comprehensive perspective on the determinants of well-being in the Tanzanian population.

VIII. Conclusion

Under the purpose of exploring the impact of marital status and type on gender-specific life satisfaction (LS) and self-rated health (SRH) in Tanzania, this study obtained significant results through quantitative analysis of the Tanzanian National Panel Survey Uniform Panel Dataset (TNPS UPD) and additional integrated analysis based on in-depth interviews with Tanzanian public officers.

The results of this study indicate that marriage plays a crucial role in promoting LS in Tanzania, irrespective of gender. The positive effect of marriage can be attributed to various factors with a sense of belonging, including the joy of childbearing, improved social status, and financial security. In a society like Tanzania, where social networks and community ties hold great value, marriage assumes an even more significant role in fostering good health and quality of life. However, there is only positive effect of marriage on health for men, not for women. Based on the cultural gender norms, this implies that the physical and psychological burdens placed on women as wives and mothers encompassing domestic responsibilities and additional economic activities, can impact women's overall health status. Additionally, the risks associated with the childbirth process, such as inadequate infrastructure and partner's involvement in deciding facility-based deliveries, can further contribute to this disparity.

Furthermore, our results highlight the potential adverse effects of polygamous marital status on female health in Tanzania. Specifically, compared to women in monogamous marriages, women in polygamous marriages reported significantly lower levels of SRH. It may be attributed to both physical and mental health challenges such as higher risk of HIV/AIDS infection, child marriage, potential conflict among co-wives, which can lead to psychological distress and poor

health outcomes. However, it is worth noting that despite the negative impact on health, polygamous women still express LS, suggesting that polygamy is widely accepted as a cultural and religious norm among them, and the social benefits of marriage outweigh the dissatisfaction with health status. Nonetheless, the positive LS observed among polygamous married women underscores the potential risks to female health and consistent declines in overall well-being.

Moreover, our findings demonstrate a positive association between the satisfaction on the availability of healthcare and educational services and SRH and LS in Tanzania. This underscores the importance of enhancing access to quality healthcare and education in the country, particularly in resource-limited areas. By investing in these domains, policymakers and stakeholders can promote health and well-being in Tanzania and contribute to the country's overall development. Despite the insights provided by this study, the fundamental data of this study is 2008-2015 version due to some missing values of key components in 2020-2021 version. Therefore, future research should utilize recent and robust data to capture any changes and trends.

In conclusion, this study holds great significance in advancing the field of well-being research in Africa, offering valuable insights that transcend the boundaries of Tanzania. By meticulously considering the intricate interplay of gender dynamics, marital status, and access to social services in shaping well-being outcomes, this research contributes to a profound comprehension of the determinants that influence individual and societal well-being. The integration of empirical data and in-depth interviews further strengthens the robustness of the findings, making it a valuable resource for policymakers, researchers, and stakeholders seeking to

improve the well-being and health of individuals in the region.

As Tanzania continues its journey of rapid development in the Sub-Saharan African region, the empirical implications of this study resonate not only within Tanzania but also extend to other African countries facing similar challenges. Policymakers can draw upon the recommendations and policy implications derived from this research to craft targeted interventions that promote gender equality, safeguard women's health, and enhance access to essential social services. By addressing the complexities of marriage culture and its impact on well-being, policymakers can design initiatives that support the positive aspects of marriage while mitigating potential risks associated with certain marital types, such as polygamous marriages. The positive association between satisfaction with healthcare and educational services and well-being outcomes underscores the importance of investing in these critical domains. By improving the accessibility and quality of healthcare and education, policymakers can empower individuals, promote healthier lifestyles, and bolster overall well-being. Such investments contribute to human capital development and pave the way for sustainable social and economic progress. Furthermore, the gender-transformative health promotion interventions proposed in this study offer a pathway towards fostering a more inclusive and equitable society. Addressing gender inequalities in social structures and cultural norms can empower women and enable them to make informed decisions about their health and well-being. By challenging discriminatory gender norms and providing equal opportunities for both genders, policymakers can create an environment that supports the well-being and advancement of all citizens.

In essence, this study serves as a cornerstone in the pursuit of well-being

enhancement in Africa, providing evidence-based insights and policy recommendations for the betterment of societies. By acknowledging and addressing the complex interconnections of socio-cultural factors, Tanzania and other African countries can lay the groundwork for a brighter and more prosperous future for their citizens. This research invites stakeholders to collaboratively strive towards building a more equitable, healthy, and prosperous continent, where the well-being of every individual is nurtured, and societal progress is firmly grounded in the principles of inclusivity and sustainability.

Bibliography

Adesanya A, O., Rojas, B., Darboe, A., & Beogo, I. (2017). Socioeconomic differential in self-assessment of health and happiness in 5 African countries: Finding from World Value Survey. *PloS One, 12*(11), E0188281.

Allegretti, A., Mutalemwa, G., & Ngonzi, T. (2022). Analyzing rural livelihoods in Sub-Saharan Africa through the concept of life satisfaction: The case of Tanzania. *Journal of Sociology and Development*, *5*(1).

Angelini, V., Cavapozzi, D., Corazzini, L., & Paccagnella, O. (2012). Age, Health and Life Satisfaction Among Older Europeans. *Social Indicators Research, 105*(2), 293-308.

Assimeng, M. (2007). Social structure of Ghana, second edition, *Ghana Publishing Corporation, Accra*.

Azuh, D., Fayomi, O., & Ajayi, Lady. (2015). Socio-cultural factors of gender roles in women's Healthcare Utilization in Southwest Nigeria. *Open Journal of Social Sciences*, *03*(04), 105–117. https://doi.org/10.4236/jss.2015.34013

Bintabara, D., Nakamura, K., & Seino, K. (2018). Improving access to healthcare for women in Tanzania by addressing socioeconomic determinants and health insurance: A population-based cross-sectional survey. *BMJ Open, 8*(9), E023013.)

Blackden, M. (2007). Gender and growth in sub-Saharan Africa: Issues and evidence. In *Advancing development: Core themes in global economics* (p. Advancing development: core themes in global economics, 2007).

Boerma, T., Hosseinpoor, A., Verdes, E. and Chatterji, S. (2016). A global assessment of the gender gap in self-reported health with survey data from 59 countries. *BMC Public Health*, 16(1), 675.

Borg, C., Hallberg, I., & Blomqvist, K. (2006). Life satisfaction among older people (65) with reduced self-care capacity: The relationship to social, health and financial aspects. *Journal of Clinical Nursing*, 15(5), 607-618.

Botha, F., & Booysen, F. (2013). The relationship between marital status and life satisfaction among South African adults. *Acta Academica*, *45*(2), 150-178.

Botha, F., & Snowball, J. (2015). Subjective well-being in Africa: Editorial. *African Review of Economics and Finance, 7*(1), 1-5.

Campbell, A. (1976). Subjective measures of well-being. *American Psychologist, 31*(2), 117–124.

Canada: Immigration and Refugee Board of Canada. (2008). Tanzania: The practice of female genital mutilation (FGM); state protection available to victims. TZA102863.E, available at: https://www.refworld.org/docid/48d2237c28.html

Case, A., & Paxson, C. (2005). Sex Differences in Morbidity and Mortality. *Demography, 42*(2), 189-214.

Chamberlin, J. (2021). Life satisfaction of rural young people in Tanzania. *Integrated Development Program Discussion Paper. CIMMYT.*

Chamlou, N. (2014) The Economics of Happiness and Anger in North Africa. WIDER Working Paper 2014/060. Helsinki: *UNU-WIDER*. https://doi.org/10.35188/UNU-WIDER/2014/781-3

Cheng, J., Kuang, X., & Zeng, L. (2022). The impact of human resources for health on the health outcomes of Chinese people. *BMC Health Services Research, 22*(1), 1-1213.

Cheung, H., & Chan, A. (2009). The effect of education on life satisfaction across countries. *Alberta Journal of Educational Research, 55*(1), 124-136.

Chola, L., & Alaba, O. (2013). Association of neighbourhood and individual social capital, neighbourhood economic deprivation and self-rated health in South Africa--a multi-level analysis. *PloS One, 8*(7), E71085

Christine, L. N. (2017). Are polygamous marriages to be considered a human rights violation or a human rights realization in the contexts of Sweden and Tanzania? Retrieved from http://hdl.handle.net/2077/52775

Crimmins, E., Kim, J., & Solé-Auró, A. (2011). Gender differences in health: Results from SHARE, ELSA and HRS. *European Journal of Public Health, 21*(1), 81-91

Cummings, S., & Cockerham, C. (2004). Depression and Life Satisfaction in Assisted Living Residents. *Clinical Gerontologist, 27*(1-2), 25-42

Dai, Y., Zhang, C., Zhang, B., Li, Z., Jiang, C., & Huang, H. (2016). Social support and the self-rated health of older people: A comparative study in Tainan Taiwan and Fuzhou Fujian province. *Medicine (Baltimore), 95*(24), E3881.

Danforth, E., Kruk, M., Rockers, P., Mbaruku, G., & Galea, S. (2009). Household Decision-making about Delivery in Health Facilities: Evidence from Tanzania. *Journal of Health, Population and Nutrition, 27*(5), 696-703.

De Neve, J. & Sachs, J. (2020). The SDGs and human well-being: A global analysis of synergies, trade-offs, and regional differences. *Scientific Reports, 10*(1), 15113.

Dickason, Z. (2019). LIFE SATISFACTION: THE INFLUENCE OF MARITAL STATUS AND GENDER. Gender & Behaviour, 17(2), 13308-13313. Retrieved from https://www.proquest.com/scholarly-journals/life-satisfaction-influence-marital-status-gender/docview/2325238297/se-2

Diggos, H. A. (2007). HIV transmission within marriage: findings from Tanzania. *Master of Public Health Thesis. Amsterdam: Royal Tropical Institute, Vrije Universiteit Amsterdam*

Duboz, P., Boëtsch, G., Gueye, L., & Macia, E. (2017). Self-rated health in Senegal: A comparison between urban and rural areas. *PloS One, 12*(9), E0184416.

Dudgeon, M., & Inhorn, M. (2004). Men's influences on women's reproductive health: Medical anthropological perspectives. *Social Science & Medicine (1982), 59*(7), 1379-1395.

Esteban-Gonzalo, S., Esteban-Gonzalo, L., Cabanas-Sánchez, V., Miret, M., & Veiga, O. (2020). The Investigation of Gender Differences in Subjective Wellbeing in Children and Adolescents: The UP&DOWN Study. *International Journal of Environmental Research and Public Health, 17*(8), 2732.

Erdogan, B., Bauer, T., Truxillo, D., & Mansfield, L. (2012). Whistle While You Work. *Journal of Management, 38*(4), 1038-1083.

Ferrari, G. (2022). What is wellbeing for rural South African women? Textual analysis of focus group discussion transcripts and implications for programme design and evaluation. *Humanities & Social Sciences Communications, 9*(1), 1-15.

Franks P, Gold MR, Fiscella K (2003). Sociodemographics, self-rated health, and mortality in the US. *Social Science & Medicine*. 56 (12): 2505–14. doi:10.1016/s0277-9536(02)00281-2

Gazimbi, M., Magadi, M., Onyango-Ouma, W., Walker, E., Cresswell, R., Kaseje, M. and Wafula, C. (2020). Is polygyny a risk factor in the transmission of HIV in sub-Saharan Africa? A systematic review. *African Journal of Reproductive Health, 24*(4), 198-212.

GCE. (2012). "Gender Discrimination in Education: The violation of rights of women and girls." Global Campaign for Education. Johannesburg

Geis, S., Maboko, L., Saathoff, E., Hoffmann, O., Geldmacher, C., Mmbando, D., . . . Hoelscher, M. (2011). Risk Factors for HIV-1 Infection in a Longitudinal, Prospective Cohort of Adults From the Mbeya Region,

Tanzania. *Journal of Acquired Immune Deficiency Syndromes (1999), 56*(5), 453-459.).

Glaesmer, H., Grande, G., Braehler, E., & Roth, M. (2011). The German Version of the Satisfaction With Life Scale (SWLS): Psychometric Properties, Validity, and Population-Based Norms. *European Journal of Psychological Assessment : Official Organ of the European Association of Psychological Assessment, 27*(2), 127-132.

Glenn, N. D. (1975). The contribution of marriage to the psychological well-being of males and females. Journal of marriage and family, 37(3), 594-600.

Goldbeck, L., Schmitz, T., Besier, T., Herschbach, P., & Henrich, G. (2007). Life satisfaction decreases during adolescence. Quality of Life Research, 16, 969–979.

Hamad, R., Elser, H., Tran, D., Rehkopf, D., & Goodman, S. (2018). How and why studies disagree about the effects of education on health: A systematic review and meta-analysis of studies of compulsory schooling laws. *Social Science & Medicine (1982), 212*, 168-178.

Han, K., Park, E., Kim, J., Kim, S., & Park, S. (2014). Is marital status associated with quality of life? *Health and Quality of Life Outcomes, 12*(1), 109.

Hassan, F., Hina, H., & Qayyum, A. (2021). Education and life satisfaction: A marginal mediation analysis. *Business Review (Karachi, Pakistan), 15*(2), 1-26.

Helliwell, J. F., Layard, R., Sachs, J., De Neve, J. E., Aknin, L. B., Haushofer, J., ... and Huang, H. (Eds.). (2022). World Happiness Report 2022. New York, NY: Sustainable Development Solutions Network.

Helliwell JF, Putnam RD (2004) The social context of well-being. PhiloTrans R Soc B Biol Sci 359(1449):1435–1446. https://doi.org/10.1098/rstb.2004.1522

Hills, P., & Argyle, M. (2001). Emotional stability as a major dimension of happiness. *Personality and Individual Differences, 31*(8), 1357–1364. https://doi.org/10.1016/ S0191-8869(00)00229-4

Hodačová, L., Hlaváčková, E., Sigmundová, D., Kalman, M., & Kopčáková, J. (2017). Trends in Life Satisfaction and Self-rated Health in Czech School-aged Children: HBSC Study. *Central European Journal of Public Health, 25 Suppl 1*(Supplement 1), S51-S56.

Idler EL, Benyamini Y. (1997). "Self-rated health and mortality: a review of twenty-seven community studies". *Journal of Health and Social Behavior*. 38 (1): 21–37. doi:10.2307/2955359

Idris, I. (2018). *Mapping women's economic exclusion in Tanzania.* K4D Helpdesk Report. Brighton, UK: Institute of Development Studies

Jerdén, L., Burell, G., Stenlund, Hans, Ph.L, Weinehall, Lars, M.D., & Bergström, Erik, M.D. (2011). Gender Differences and Predictors of Self-Rated Health Development Among Swedish Adolescents. *Journal of Adolescent Health, 48*(2), 143-150

Joshanloo, M., & Jovanović, V. (2020). The relationship between gender and life satisfaction: Analysis across demographic groups and global regions. *Archives of Women's Mental Health, 23*(3), 331-338.

Jovanović, V. (2019). Measurement Invariance of the Serbian Version of the Satisfaction With Life Scale Across Age, Gender, and Time. *European Journal of Psychological Assessment : Official Organ of the European Association of Psychological Assessment, 35*(4), 555-563.

Kapungwe, A. (2003). Traditional cultural practices of imparting sex education and the fight against HIV/AIDS: The case of initiation ceremonies for girls in Zambia. African Sociological Review 7(1): 35-52.

Kasenda, S., Meland, E., Hetlevik, &., Mildestvedt, T., & Dullie, L. (2022). Factors associated with self-rated health in primary care in the South-Western health zone of Malawi. *BMC Family Practice, 23*(1), 1-88.

Kelishadi, R., Djalalinia, S., Qorbani, M., Mansourian, M., Motlagh, M., Ardalan, G., . . . Heshmat, R. (2016). Self-Rated Health and Life Satisfaction in Iranian Children and Adolescents at the National and Provincial Level: The CASPIAN-IV Study. *Iranian Red Crescent Medical Journal, 18*(12).

Kouladoum, J. (2023). Inclusive Education and Health Performance in Sub Saharan Africa. *Social Indicators Research, 165*(3), 879-900.

Krause, N. (2004). Lifetime Trauma, Emotional Support, and Life Satisfaction Among Older Adults. *The Gerontologist, 44*(5), 615-623.

Latham K, Peek CW (2013). "Self-rated health and morbidity onset among late midlife U.S. adults". *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*. 68 (1): 107–16. doi:10.1093/geronb/gbs104

Lawrence, E., Rogers, R., Zajacova, A., & Wadsworth, T. (2019). Marital Happiness, Marital Status, Health, and Longevity. *Journal of Happiness Studies, 20*(5), 1539-1561.

Lawson, D. W., James, S., Ngadaya, E., Ngowi, B., Mfinanga, S. G., & Borgerhoff Mulder, M. (2015). No evidence that polygynous marriage is a harmful cultural practice in northern Tanzania. *Proceedings of the National*

Academy of Sciences, *112*(45), 13827-13832.

Manandhar, M., Hawkes, S., Buse, K., Nosrati, E., & Magar, V. (2018). Gender, health and the 2030 agenda for sustainable development. *Bulletin of the World Health Organization, 96*(9), 644-653.

Marks, J., Bun, L. C., & McHale, S. M. (2009). Family Patterns of Gender Role Attitudes. *Sex roles*, *61*(3-4), 221–234. https://doi.org/10.1007/s11199-009-9619-3

Marmot, M. & UCL Institute of Health Equity. (2014). Review of social determinants and the health divide in the WHO European Region: final report, Updated reprint 2014. *World Health Organization. Regional Office for Europe.* https://apps.who.int/iris/handle/10665/108636

Moghani Lankarani, M., Shah, S., & Assari, S. (2017). Gender differences in vulnerability to socioeconomic status on self-rated health in 15 countries. *Women's Health Bulletin*, *4*(3). https://doi.org/10.5812/whb.45280

Matud, M., García, M., & Fortes, D. (2019). Relevance of Gender and Social Support in Self-Rated Health and Life Satisfaction in Elderly Spanish People. *International Journal of Environmental Research and Public Health, 16*(15), 2725.,

McCloskey, L. A., Williams, C., & Larsen, U. (2005). Gender inequality and intimate partner violence among women in Moshi, Tanzania. *International family planning perspectives*, 124-130.

Meekers, D., & Franklin, N. (1995). Women's Perceptions of Polygyny among the Kaguru of Tanzania. *Ethnology*, *34*(4), 315–329. https://doi.org/10.2307/3773944

Moeini, B., Barati, M., Farhadian, M., & Ara, M. (2018). The Association between Social Support and Happiness among Elderly in Iran. *Korean Journal of Family Medicine, 39*(4), 260-265.

Moran, A., Jolivet, R., Chou, D., Dalglish, S., Hill, K., Ramsey, K., . . . Say, L. (2016). A common monitoring framework for ending preventable maternal mortality, 2015-2030: Phase I of a multi-step process. *BMC Pregnancy and Childbirth, 16*(1), 250.

MoHCDGEC (Ministry of Health, Community Development, Gender, Elderly and Children) /Tanzania Mainland, Ministry of Health - MoH/Zanzibar, National Bureau of Statistics - NBS/Tanzania, Office of Chief Government Statistician-OCGS/Zanzibar, & ICF. (2016). Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS- MIS) 2015-16. Dar es Salaam/Tanzania: MoHCDGEC, MoH, NBS,OCGS, and ICF.

Mpondo, B., Gunda, D., & Kilonzo, S. (2017). HIV Epidemic in Tanzania: The Possible Role of the Key Populations. *AIDS Research and Treatment, 2017*, 7089150-7.

Mtenga, S., Pfeiffer, C., Merten, S., Mamdani, M., Exavery, A., Haafkens, J., . . . Geubbels, E. (2015). Prevalence and social drivers of HIV among married and cohabitating heterosexual adults in south-eastern Tanzania: Analysis of adult health community cohort data. *Global Health Action, 8*(1), 28941-10

Mturi, A., & Hinde, P. (1995). Recent demographic change in Tanzania: Causes, consequences and future prospects. *Journal of International Development, 7*(1), 117-134.

Mubangizi, J. C. (2016). An African perspective on some gender-related cultural practices that violate human rights and perpetuate women's poverty. *Journal of Social Sciences*, *47*(1), 68-78.

Mwinnyaa G, Porch T, Bowie J, Thorpe RJ Jr. (2018). The Association Between Happiness and Self-Rated Physical Health of African American Men: A Population-Based Cross-Sectional Study. Am J Mens Health. 2018 Sep;12(5):1615-1620. doi: 10.1177/1557988318780844. Epub 2018 Jun 27. PMID: 29947566; PMCID: PMC6142117.

NBS (2014). Tanzania, United Republic of – Integrated Labour Force Survey 2014: Analytical Report. National Bureau of Statistics, Tanzania. http://www.nbs.go.tz/nbstz/index.php/english/statistics-by-subject/labour-statistics/614-the-2014- integrated-labour-force-survey-ilfs

Onadja, Y., Bignami, S., Rossier, C., & Zunzunegui, M. (2013). The components of self-rated health among adults in Ouagadougou, Burkina Faso. *Population Health Metrics, 11*(1), 15.

Pecha, C., & Beuermann, D. (2016). Healthy to Work: The Impact of Free Public Healthcare on Health Status and Labor Supply in Jamaica

Pederson, A., Greaves, L., & Poole, N. (2015). Gender-transformative health promotion for women. *Health Promotion International, 30*(1), 140-150.

Petroni, S., Steinhaus, M., Fenn, N., Stoebenau, K., & Gregowski, A. (2017). New Findings on Child Marriage in Sub-Saharan Africa. *Annals of Global Health, 83*(5-6), 781-790

Phaswana-Mafuya, N., Peltzer, K., Chirinda, W., Kose, Z., Hoosain, E., Ramlagan, S., . . . Davids, A. (2013). Self-rated health and associated factors among older South Africans: Evidence from the study on global ageing and adult health. *Global Health Action, 6*(1), 19880

Rajabi Gilan, N., Khezeli, M., & Zardoshtian, S. (2021). The effect of self-rated health, subjective socioeconomic status, social capital, and physical activity on life satisfaction: A cross-sectional study in urban western Iran. *BMC Public Health, 21*(1), 233.

Rehema, M., Verhan, B., Emmanuel, M., & Douglas, M. (2014). Effects of Initiation Rituals to Primary and Secondary School Girls in Morogoro Rural District. *International Journal of Innovation and Scientific Research*, *6*(1). http://www.ijisr.issr-journals.org/

Rishworth, A., Elliott, S., & Kangmennaang, J. (2020). Getting Old Well in Sub Saharan Africa: Exploring the Social and Structural Drivers of Subjective Wellbeing among Elderly Men and Women in Uganda. *International Journal of Environmental Research and Public Health, 17*(7), 2347

Ross, C. E., & Wu, C. (1995). The Links Between Education and Health. *American Sociological Review*, *60*(5), 719–745. https://doi.org/10.2307/2096319

Rustin, C., & Florence, M. (2021). Gender equality and women's happiness in post-apartheid South Africa. *Agenda (Durban), 35*(2), 146-156.

Schaffnit, S. B., Hassan, A., Urassa, M., & Lawson, D. W. (2019). Parent–offspring conflict unlikely to explain 'child marriage' in northwestern Tanzania. Nature Human Behaviour. https://doi.org/10.1038/s41562-019-0535-4.

Schaffnit, S., Urassa, M., & Lawson, D. (2019). "Child marriage" in context: Exploring local attitudes towards early marriage in rural Tanzania. *Sexual and Reproductive Health Matters, 27*(1), 93-105.

Schaffnit, S., Wamoyi, J., Urassa, M., Dardoumpa, M., & Lawson, D. (2021). When marriage is the best available option: Perceptions of opportunity and risk in female adolescence in Tanzania. *Global Public Health, 16*(12), 1820-1833

Sen, G., & Östlin, P. (2008). Gender inequity in health: Why it exists and how we can change it. *Global Public Health*, 3(1), 1-12.

Shepard, L. (2013). The impact of polygamy on women's mental health: A systematic review. *Epidemiology and Psychiatric Sciences, 22*(1), 47-62.

Siahpush, M., Spittal, M., & Singh, G. (2008). Happiness and Life Satisfaction Prospectively Predict Self-Rated Health, Physical Health, and the Presence of Limiting, Long-Term Health Conditions. *American Journal of Health Promotion, 23*(1), 18-26.

Silas Mollel, N., & Chong, R. (2017). Socio-cultural Constraints of Girls' Access to Education in Mtwara District, Tanzania. *Khazar Journal of Humanities*

and Social Sciences, 20(3), 108-125.

Singh-Manoux A, Dugravot A, Shipley MJ, Ferrie JE, Martikainen P, Goldberg M, Zins M. (2007). The association between self-rated health and mortality in different socioeconomic groups in the GAZEL cohort study. *International Journal of Epidemiology.* 36 (6): 1222–8. doi:10.1093/ije/dym170

Stark, L. (2018). Poverty, Consent, and Choice in Early Marriage: Ethnographic Perspectives from Urban Tanzania. *Marriage & Family Review, 54*(6), 565-581.

Subramanian SV, Huijts T, Avendano M (2010). "Self-reported health assessments in the 2002 World Health Survey: how do they correlate with education?". *Bulletin of the World Health Organization*. 88 (2): 131–8. doi:10.2471/BLT.09.067058. PMC 2814481

Sunday Idemudia, E., & Adedeji, A. (2023). Well-Being and Culture: An African Perspective. IntechOpen. doi: 10.5772/intechopen.109842

World Bank. (2023). Tanzania. World Bank Open Data. https://data.worldbank.org/country/tanzania

Tamayo-Fonseca, N., Nolasco, A., Quesada, J., Pereyra-Zamora, P., Melchor, I., Moncho, J., . . . Barona, C. (2015). Self-rated health and hospital services use in the Spanish National Health System: A longitudinal study. *BMC Health Services Research, 15*(493), 492.

Tao, H. (2019). Marriage and Happiness: Evidence from Taiwan. *Journal of Happiness Studies, 20*(6), 1843-1861.

Tay L, Ng V, Kuykendall L, Diener E (2014) Demographic factors and worker well-being: an empirical review using representative data from the United States and across the world. In: Perrewé PL, Rosen CC, Halbesleben JRB (eds) The role of demographics in occupational stress and well-being. Emerald Group Publishing Limited, Bingley, pp 235–283

Udofia, E., Yawson, A., Aduful, K., & Bwambale, F. (2014). Residential characteristics as correlates of occupants' health in the greater Accra region, Ghana. *BMC Public Health, 14*(1), 244.

UNDP (United Nations Development Programme). (2022). Human Development Report 2021-22: Uncertain Times, Unsettled Lives: Shaping our Future in a Transforming World. New York.

UNICEF. (2022). United Nations Children's Fund, Child Marriage in Eastern and Southern Africa: A statistical overview and reflections on ending the practice, UNICEF, New York.

United Republic of Tanzania. (1977). Constitution of the United Republic of Tanzania. Retrieved from https://oagmis.agctz.go.tz/public

Waite, L. (1995). Does Marriage Matter? *Demography, 32*(4), 483-507.

Waite, L. J., & Gallagher, M. (2000). *The case for marriage: Why married people are happier, healthier and better off financially*. New York: Doubleday.

Walker, J. (2012). Early Marriage in Africa - Trends, Harmful Effects and Interventions. *African Journal of Reproductive Health, 16*(2), 231-240.)

Ware JE & Gandek B (1998). "Overview of the SF-36 Health Survey and the International Quality of Life Assessment (IQOLA) Project". *Journal of Clinical Epidemiology.* 51 (11): 903–12. doi:10.1016/s0895-4356(98)00081-x

Wood, R., Goesling, B., & Avellar, S. (2007). The Effects of Marriage on Health: A Synthesis of Recent Research Evidence. *Mathematica Policy Research Published Reports,* Mathematica Policy Research Published Reports, 2007

World Health Organization (WHO). (2022). *World Health Statistics 2022: monitoring health for the SDGs, sustainable development goals*.

World Health Organization (WHO). (n.d.). *Gender and health*. World Health Organization. https://www.who.int/health-topics/gender#tab=tab_1

Wuorela, M., Lavonius, S., Salminen, M., Vahlberg, T., Viitanen, M., & Viikari, L. (2020). Self-rated health and objective health status as predictors of all-cause mortality among older people: A prospective study with a 5-, 10-, and 27-year follow-up. *BMC Geriatrics, 20*(1), 120.

Zajacova, A., & Lawrence, E. (2018). The Relationship Between Education and Health: Reducing Disparities Through a Contextual Approach. *Annual Review of Public Health, 39*(1), 273-289.

Appendix A. In-Depth Interview

This section presents the results of brief in-depth interviews conducted as part of the research aimed at gaining a comprehensive understanding of the socio-cultural context of Tanzania. The focus of these interviews was to explore the experiences and viewpoints of Tanzanian public officers engaged in the field of gender and development. Through these interviews, valuable insights were sought to illuminate the influence of various factors, including gender, marital status, type of marriage, and social services, on life satisfaction and health outcomes within Tanzania.

A total of three male participants were carefully selected to be part of this interview process. The selection criteria were based on their qualifications and backgrounds, particularly their expertise in the fields of public policy and development, and their academic background, with all participants coming from the same master's degree course. Additionally, the participants were limited to individuals in monogamous marriages. The interviews were conducted through both email communication and offline meetings. It should be acknowledged that while efforts were made to ensure a balanced representation of gender, marital status, professional, and academic backgrounds among the interviewees, this was not guaranteed due to time constraints and the nature of email interviews. Nevertheless, this rigorous selection process aimed to ensure that the interviewees possessed relevant knowledge and experiences, contributing to the richness and depth of insights gained from the interviews.

The primary purpose of conducting these interviews was to contextualize and delve into the cultural practices, thereby exploring and anticipating potential

factors that may influence the regression results. The following sections present a comprehensive analysis of the valuable insights gathered through these interviews, shedding light on the intricate socio-cultural fabric of Tanzania and its intricate relationship with gender and development issues. The outcomes of these interviews contribute to a broader understanding of how gender dynamics, marital status, and access to social services intertwine to impact the well-being of Tanzanian society.

The interviews focused on three main themes: 1) the role of marriage in shaping life satisfaction and health outcomes by gender; 2) the impact of marital type on these outcomes by gender; and 3) the relationship between availability of social services and life satisfaction and self-rated health and added some responses regarding socio-cultural features on gender in Tanzania. The major interview questions and responses of each theme are presented below:

Theme 1: The role of marriage in shaping life satisfaction and health outcomes by gender

Q1. What does marriage mean in Tanzania? Do you think marriage is a significant factor for enhancing self-rated health and life satisfaction for men and women in Tanzania? If so, why do you think like that?

Participant A: "As marriage is considered as self-esteem for an individual in the society, married men or women are considered to be more satisfied than unmarried individuals. This is according to the socio-cultural perspective within the society of Tanzania."

Participant B: "I think marriage is a significant factor for enhancing self-rated health and life satisfaction for men and women in Tanzania because of the following reasons.

1. Life in a country like Tanzania requires strong cooperation between men and women to succeed in any aspect, including the economic sphere.
2. Married people have a greater chance of experiencing peace of mind and having a supportive partner.
3. Marriage provides a channel for sexual relationship. As for men, having sexual relationship is considered as critical desire; therefore, the more he has access to it, the more satisfied he will feel with his life."

Participant C: "Marriage is a key factor that strengthens family ties and adds a sense of stability in Tanzania. Additionally, having a family can bring great happiness and therefore, marriage can enhance life satisfaction. However, in Tanzanian culture, there may be some kind of pressure on individuals who do not get married until their late 20s or 30s, with people often asking whether they have any issues that are preventing them from marrying."

Theme 2: The impact of marital type on these outcomes by gender

Q2. what do you think about polygamous marriage? What do you think about the impact of polygamous marriage on the health and life satisfaction of men and women?

Participant A: "Polygamous marriage it is just a social –cultural issue, in my personal perspective it has nothing to do on health and life- satisfaction for both men

and women.”

Participant B: "My view on polygamous marriage is that it is, to a large extent, a source of problems in society and can negatively impact the health of the society, especially children. However, for a better understanding of polygamy in Tanzania, it is important to note that some who practice it do not see it as a problem because it is a part of their culture and norms. Polygamy can result from three factors: culture, religion, and fashion."

Participant C: “Polygamous usually enacts under the cultural and religious custom of Muslim and often occurred in rural areas. Especially, for women, most of polygamous women are less educated and in a severe poverty. In terms of self-rated health, as a husband have sexual relationship with all co-wives, there can be a significant danger of HIV/AIDS issues among polygamous women and the tension or jealousy worse the women’s mental health as well. Therefore, it threatens polygamous health and can make life satisfaction lower.

Theme 3: The relationship between availability of social services and life satisfaction and self-rated health

Q3. Do you think the availability of social support such as healthcare and educational services is significant to enhance life satisfaction and health status? If so, do you think that men and women have equal access to healthcare services and educational services in Tanzania?

Participant A: “Yes. In a legal perspective, in Tanzania, both women and men have equal access to healthcare services and education services, but due to social –cultural set up some of the society tend to give more opportunity and preference to school a boy than a girl -children.”

Participant B: “Social service are important factor in one’s well-being. Both men and women have equal access healthcare services and educational services in Tanzania. However, to some extent women where larging behind in education sector due to some other factors which is not related with the equal access to education.”

Participant C: “Healthcare and educational services are important and there is no gender inequality to access healthcare services. However, in case of education, girls tend to get less education than boys due to cultural features.”

Additional Response regarding Socio-Cultural Features on Gender in Tanzania

Q4. Do you think societal expectations and cultural norms and practices in Tanzania impact the self-rated health and life satisfaction of men and women differently?

Participant C: "In Tanzania, a male-dominated culture prevailed, and the reproductive ability of women is highly valued, and there is a severe preference for having sons over daughters. As a result, women face gender stereotypes that prioritize motherhood over education and in rural areas, there are issues with child marriage. I think the major issue is that Tanzanian cultural practices and policies are

more focused on making girls to be a good mother and less interested in making boys to be a good men and father as an equal member of family and society with women."

Overall, the in-depth interviews provided valuable insights into the socio-cultural background of Tanzania on gender difference in the impact of marital status and type, and social services on life satisfaction and health outcomes in Tanzania. The findings suggest that gender inequalities persist in Tanzania, particularly in relation to education and employment opportunities for women. However, marriage was found to be an important factor in promoting positive health outcomes and greater life satisfaction, regardless of gender. The results also highlighted the importance of access to quality healthcare and educational opportunities in promoting positive health and life outcomes in Tanzania.

국문초록

본 연구는 탄자니아의 젠더에 따른 결혼의 유무 및 유형이 삶의 만족도와 주관적 건강상태에 미치는 영향에 관해 탐구한다. 탄자니아의 2008-2015 국가 패널 조사(TNPS UPD)의 결과를 바탕으로, 본 논문은 (1) 결혼한 그룹과 미혼 그룹에서 각각 삶의 만족과 주관적 건강상태 (Self-Rated Health; SRH)가 젠더에 따라 어떻게 나타나는지, (2) 일부일처제 및 일부다처제 결혼 등의 결혼 유형에서 삶의 만족도와 주관적 건강상태가 젠더에 따라 어떻게 달라질 수 있는지, (3) 의료 및 교육 서비스와 같은 사회적 지원의 이용가능성에 대한 만족도가 삶의 만족도와 주관적 건강상태에 미치는 영향이 있는지, 마지막으로 (4) 위 연구질문의 결과에 영향을 미칠 수 있는 사회 문화적 원인이 무엇인지를 탐구한다. 본 연구는 혼합방법론을 사용하였으며, 다중회귀모형을 패널데이터를 분석하고, 통합적인 분석을 위해 탄자니아의 관련분야 공무원과의 심층인터뷰를 진행했다.

회귀분석 결과, 미혼남녀보다 기혼남녀가 삶에 더 만족하는 것으로 나타났으나, 주관적 건강상태와 관련하여, 기혼 남성은 미혼 남성보다 자신의 건강 상태를 호의적으로 평가한 반면, 기혼 여성은 미혼 여성보다 그렇지 않은 것으로 나타났다. 결과는 나아가 일부다처제 남성이 일부일처제 남성보다 자신의 삶을 긍정적으로 평가하는 반면 여성 집단에서는 그 차이가 크지 않음을 보여주고 있으며, 일부다처제 남성과 일부일처제 남성의 주관적 건강상태는 큰 차이가 없지만, 여성의 경우, 일부다처제 여성들이 일부일처제 여성들보다 그들의 건강 상태에 훨씬 덜 만족하는 것으로 나타났다. 더불어, 사회적 지원 측면에서는 의료서비스와 교육서비스의 이용가능성에 만족하는 사람들은 더 높은 삶의 만족도와 더 나은 주관적 건강상태를 가질 가능성이 높은 것으로 나타났다.

관련 참고문헌 검토와 심층 인터뷰를 바탕으로, 이러한 결과는 탄자니아의 남성 중심의 사회 문화적 맥락 속에서 여성에게는 결혼이 건강 자체에는 부정적인 영향을 미칠 확률이 높으나, 전반적인 삶의 질을 향상시키는 중요한 요소임을 시사한다. 그러나, 본 논문은 일부다처제와 같은 남성 중심의 결혼 문화가 잠정적으로 탄자니아 여성의 건강과 행복 모두의 큰 감소로 이어질 수 있다는 것을 조명한다. 더불어, 삶의 만족도와 건강 수준을 향상시키기 위해, 의료 및 교육 서비스와 같은 중요한 사회 서비스를 탄자니아의 대중 모두가 쉽게 이용할 수 있어야 함을 제안한다.

본 논문은 탄자니아의 젠더에 따른 결혼유무와 결혼유형이 삶의 만족도와 건강에 미치는 영향을 실증분석과 심층 인터뷰를 통해 통합적으로 탐구함으로써 탄자니아의 젠더 기반의 사회문화적 맥락을 이해하고, 이를 바탕으로 정책입안자들이 적합한 정책을 개발함으로써 탄자니아의 삶의 질 개선목표를 효과적으로 달성하는 데에 시사점을 제공한다는 것에 의의가 있다. 더불어, 국제개발협력실무자들이 탄자니아를 넘어 아프리카 국가들의 젠더 기반 개발사업을 효과적으로 수행하고, 관련 지속가능한 목표를 달성할 수 있도록 유의미한 정보를 제공한다는 것에 의의가 있다.

키워드: 삶의 만족도, 주관적 건강 상태, 젠더 차이, 결혼, 사회적 지원, 일부다처제, 탄자니아