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Happy marriages are all alike: Marriage and self-rated health among Serbian Roma

We describe how self-rated health varies with gender, type of marriage (marriage of choice vs arranged marriage), and cultural traits among Serbian Roma. Data on 91 men and 113 women (self-reported health, demographics and family dynamics) were collected in 2016 in Roma communities in Belgrade, Serbia. Roma in arranged marriage differ on a number of variables in regard to Roma in marriage of choice but not in regard to self-rated health. Gender specific analyses revealed that arranged marriages appear adaptive for both males and females, but they seem to benefit the males and not females in terms of health. For Roma women, a non-subordinate status was the strongest predictor of relatively "good" subjective health. All healthy (happily married) Roma men are alike in that they think they have subordinate wives and all healthy (happily married) Roma women are alike in that they think they are non-subordinate to their husbands.

Key words: Roma, self-rated health, marriage, gender

Сви срећни бракови личе један другом: брак и самопроцена здравља међу Ромима у Србији

У овом раду испитујемо како самопроцена здравља варира у односу на пол, тип брака (брак по избору у односу на уговорени брак), и културу у популацији српских Рома. Подаци су прикупљени 2016. у ромским насељима у околини Београда (испитани 91 мушкарац и 113 жена), и обухватају самопроцену здравља, демографију и породичне односе. Самопроцена здравља се не разликује по типу брака, али постоје значајне разлике између Рома који живе у уговореном браку и Рома који су сами бирали брачне партнере. Уговорени бракови су адаптивни за оба пола, и доприносе бољем здравственом статусу мушкараца, али не и жена. За ромске жене, неподређени статус у браку је најважнији предиктор доброг здравља. Сви здрави (срећно ожењени) ромски мушкарци су слични по томе што мисле да имају подређене жене, а све здраве (срећно удате) Ромкиње су сличне по томе што сматрају да нису подређене својим мужевима.

Кључне речи: Роми, самопроцена здравља, брак, род

Introduction

This paper examines associations between type of marital union, i.e., marriage of choice vs. arranged marriage and self-rated health (SRH) of males and females living in a contemporary Serbian Roma society. The associations between health and whether people are in a marriage of their choice compared to an arranged marriage has not been a subject of much empirical interest. Marriage itself seems to improve health, at least for some outcomes (Murphy et al. 2007; Robles et al. 2014; but see Zheng & Thomas 2013), and it has been shown to increase self-rated health (Meadows et al. 2008; Williams & Umberson 2004). While this link between marriage and health may occur because healthy individuals are more likely to marry in the first place, it also is possible that marital relationships provide a buffer against various stressors including economic pressure, perceived control over life events, and experiences of racial discrimination (Lorenz et al. 1993; Crockett & Neff 2013). Whether or not this effect is found across racial/minority groups (Pienta et al. 2000; Koball et al. 2010) is unclear; however, studies conducted in East Asian countries suggests that marital satisfaction may be of greater importance in determining self-rated health than marriage itself (Chung & Kim 2016).

Roma/Gypsies, a diverse population of South Asian ancestry, migrated to Europe from northwest India between the 9th and 14th centuries (Gresham et al. 2001). At present, they are the largest European minority population, who are now best described as culturally and linguistically heterogeneous (FRA 2014). Across Europe, when compared with non-Roma, Roma experience poorer health across many outcomes usually attributed to socio-economic differences and access to health care (Željko et al. 2013). Over 147,000 Roma live in Serbia (Statistical Office of the Republic of Serbia 2013). Serbian Roma population is made of a complex mixture of groups; for the most part they have not intermarried with non-Roma and have retained their cultural traditions.

Historically, the Roma cultural traditions included a strong kinship system, endogamy and parental arrangement of the marriages of their adolescent children, confirmed by the kinship system (Pamporov 2010). Today, depending on the particular group affiliation, many Roma parents continue to arrange the marriages of their children; these arranged unions are negotiated by the families involved, and choice of marriageable partner is traditionally limited in an effort to enhance kinship and group solidarity (Čvorović 2011). Many Roma groups have a custom of bride price, as "payment about [for] the honor of the bride" (Pamporov 2010, 472). Roma from certain groups and families regard bride price as the prestigious custom which confirms their higher status within the Roma hierarchy. Young, virgin girls, from respectable families are sought after, and Roma have a saying: "Give me your gold and I will give you mine" (Čvorović 2004, 123), for a "true" girl, that is, a virgin. The amount of bride price varies; some Roma groups, pride themselves for having the priciest girls, for whom several thousands of euros might be paid. On the other hand, if the bride is known to have a chronic illness, disability or any condition that may affect fertility, the amount of money paid can be lower as is found in other societies with this custom (Taghizadeh et al. 2016). Poor males, those without

sufficient support and money to pay for a bride, while not completely left out from the marriage market, have to be satisfied with "second-hand" divorcees or with females who are unattractive in some other way.

Not all Roma arrange the marriages of their children, allowing, instead for "love marriages" and letting their children select a partner on their own. Even in these cases, however, some restrictions apply, especially in rural areas. Endogamy is still referred and dating is restricted. A girl's virginity is assumed and reputation remains important (Čvorović 2004). The coexistence of these two marriage patterns, which are aimed at achieving the same end -- the acknowledged social purpose of reproduction --provides a rich opportunity for comparative analysis of the effects of marriage (van den Berghe 1979; Fox 1975), including any possible health effects.

The association between health and marriage may be especially important for Roma, since due to the traditional early marriage practices, they spend a greater proportion of their lives married relative to the general European populations (Čvorović 2014; Bošnjak & Acton 2013; Berta 2013). In general, the literature that discusses arranged marriage outlines traditional practices and discusses the effect of those practices on women and girls. Many Roma women, regardless of the type of marriage, face inflexible gender roles; after marriage, the couple usually lives with the groom's parents. The bride's role is an "uneasy" one as her duties include maintaining her own kinship system as well as caring for her in-laws, performing household chores and producing grandchildren (Fraser 1992; Timmerman 2003). For many Roma women having children in marriage, and later on having a daughter in law, are the only socially endorsed routes for an improvement in status. Few studies have looked at the effect on health among males (Samad 2010), although limited evidence suggests that for some men, arranged marriage can result in serious physical and mental health problems (Samad & Eade 2003). To fill this gap, we will also explore gender differences over patterns of marriage that might affect health, and the differentials responses that one or the other marriage type have on self-perceived health and well –being among Roma males and females. Availability of health care, discrimination, and Roma general health were examined in previous works (Coe & Čvorović 2017; Čvorović & Coe 2017).

To our best knowledge, this is the first study of marriage and SRH among the Roma. Even though family/marriage relationships have been described as the basis of Roma social life, the influence of marriage and effects on health within Roma communities have not been systematically investigated, as no research seems to have addressed the association of the type of marital union and subjective health. Thus, extending research on marriage and self-rated health to Serbian Roma, a disadvantaged Eastern European minority, not only adds to the cross-cultural marriage and health literature, it also increases our understanding of the interaction between health and marriage dynamics in socially marginalized ethnic minorities.

Fieldwork and methods

Fieldwork was conducted in 2016 in several mixed Roma communities (mixture of Roma groups, i.e., Chergari, Romanian Roma, and Serbian Gypsies) located in and around Belgrade, Serbia. The sample consisted of 204 adults (113 females and 91 males). The settlements were semi-urban, relatively poor, and recent, formed during the last twenty years. The majority of Roma in these settlements came to Belgrade in search of better job opportunities; only about 10% are "natives". Less than 10 % of Roma in the sample were employed full-time, while the others derived their income from social welfare/child allowances and occasional "private" business (the gathering of old newspapers, iron and black-market dealings).

A questionnaire was developed that allowed for the assessment of demographic information (e.g., age, gender, religion, educational level, marital status, level of socioeconomic status-SES, based on employment and income, and residence pattern) and for the collection of data on BMI (height and weight), with data on stature and body mass collected using standard protocol (Gallagher et al. 2009). Further, females were asked about life history variables, such as age at first menarche, age at first marriage, age at first reproduction, number of children, abortions and miscarriages, and age at last birth.

Health status of self was assessed with a question "how is your health in general" with responses ranging from "very good" to "good-average" and "poor" (Čvorović & Coe 2017). SRH has been shown to be a strong predictor of mortality, and it is becoming one of the most popular indicators of population health (Golini & Egidi 2016). Based on individual perception rather than objective assessment, SRH reflects individual' consideration of many more factors than it is usually possible to include in a survey or even to gather in a routine clinical examination: for instance, self-rated (poor) health was also strongly associated with (un)happiness (Liu et al. 2016).

Given the lack of a cultural consensus regarding what is or is not disease (Elliot 2004), and the fact that many Roma tend to equate "good" health with being able to carry on with the daily tasks "on one's feet", regardless of the symptoms they may have (Coe & Čvorović 2017), we asked study participants whether their doctor had told them they have a chronic disease (the responses were 1 for "Yes", i.e., poor health/presence of chronic disease and 2 for "No", i.e., good health/absence of chronic disease) (Reile & Leinsalu 2017), as chronic diseases are typically associated with poor SRH (Jylhä et al. 2006).

In addition, SRH questions also focused on daily levels of stress, smoking and alcohol consumption, and for both genders, family dynamics. We included a number of questions regarding traditional Roma culture and family background experiences -- levels of kinship support and kinship hierarchical relationship within one's family (levels of gender autonomy, including status of men and women within a family, and gender-related power differences in decision making). For instance, previous studies in low- and middle-income countries have found that women's sta-

tus within the household can be an important force impacting the health, longevity, and mental and physical capacity of women. Little is known about this issue in the Balkans (Sado et al. 2014; Čvorović 2008). In this study, the interactions were addressed through a semi-structured questionnaire, with both fixed and open-ended questions, focusing on everyday Roma experiences.

All associations were tested using two-tailed tests, with statistical significance set at $p < .05$. In addition, we used chi-square tests and multiple regression for additional analyses due to the gender specifics in the sample.

Results

The sample consisted of 204 Roma: 91 males and 113 females, age 21–69, and averaging 42 years. All participants reported having both an Identification Card and Health Card. The educational attainment was low; average years of formal schooling was 4.95. (±23.16). When participants were asked to rate their SES within the communities, 49% said they are "very poor" (depended on social assistance for income), 42.6% said they are "average poor" (combined informal work with social assistance), while only 8.3% reported "above average" SES within their communities (full time jobs).

"Good" health was reported by the majority of Roma participants; 67.2 % reported not having received a physician diagnosis of chronic disease. When they had been diagnosed with a chronic disease (32.8%), the most common problem was cardiovascular disease (hypertension), followed by diabetes, asthma and thyroid problems for women.

In regard to health risks, most participants reported smoking over one pack of cigarettes per day (81.3% of males and 85% of females). The majority (85.7%) of males and almost one third of females (24%) reported drinking alcohol on a daily basis. Daily level of stress was reported 4.2 (low=1, high =5).

One's family and extended kin, for the majority of Roma, are the main source of social support. The mean score for mutual kin support (low=1, high =5) was 3.65 (± 1.64). Other family dynamics variables, including status within a family, reasons for family dispute, and power decision in family/marriage indicate that most participants perceive Roma females as having a subordinate status within a family (68%). The most common reason for family dispute was money spending (38%), followed by spousal jealousy (24%), and children (upbringing) (18%); while most decisions in marriage were reached jointly by the whole family (44%), followed by husband only (28%) or in laws (13.2%) for females.

The majority of Roma participants were married: 94.1%; 2.9% of females were widowed and 2.9% were divorced. Almost one quarter of participants (23%) had been married more than once. All marriages were (within subgroups) endogamous. Approximately half of the participants were in arranged marriages -- 46.2% (42) males and 53.1% (60) females and half were in marriages of choice -- 53.8% (49) males and 46.9% (53) females. Only one male and one female reported being

married against their will. All of the arranged marriages involved the payment of a bride price, with the amount of payment varying among groups and families and depending on fluctuating economic circumstances.

The majority of participants (62% of women and 71% of the men) approved of arranged marriage, with many arguing that this custom is a "true"/Roma tradition, and that as such it benefits everybody. For those women who approved of arranged marriage, several issues were important – the financial/economic aspects ("the most important is to get married into a good house, with enough money, where everybody has enough food to eat every day") and the social aspects. A woman with a marriageable daughter argued that

> "…Families should know each other, it is imperative to know where you are sending your child, how they will treat her; If they pay a lot of money for a girl, that means that her mother in law will look after her like she is her own child; If a family cannot arrange a marriage, it means it is not a good family, has bad blood [illness run in a family], or no one wants you."

Many women emphasized it was a matter of prestige to marry into a certain family with good reputation:

> "I married into X family, I was just a child, but my parents chose this particular family because they were well-known as good and honest people, they treat me well, and my children too."

Those who disapproved of the traditional of arranging marriages argued "it is a thing of the Roma past" and pride themselves in having made a marriage of choice instead. One Roma male in his twenties, referring to bride price and the general widespread unemployment in Roma settlements, was happy that his "people" (his Roma group) do not practice arranged marriage anymore: "… considering how poor I am, I would never be able to get married". Several women stated that for them the type of marriage did not make a difference at the end because "you will be chained to the stove and broom one way or the other". Many women reported that they met their husbands on the day of their "wedding." As one 43 year old woman reported:

> "I thought it would be difficult to live with someone you see for the first time in your life, but I got used to it. I got married like that, I saw my husband at our wedding day, and everything turned out good. We are still married, we have six children together and my mother in law was very kind to me, like a second mother. My kids turned out fine. It is really important to listen and obey, and to bear children, then they [your new family] will accept and protect you, like you are one of them, that's how you acquire a family."

A woman who chose her own husband commented how in "the past" girls were much better brought up:

> "We were raised to think that a woman should be subordinate, we never went to school but we thought that was how it should be. It is different now, young women are running around, all want to work

> outside their home while their children are out on the streets. That is no good. I was beautiful in my youth, I could chose, and I chose my husband but he turned out to be an alcoholic."

Several other women in marriage of choice stated being "in love" as the underlying reason for their respective choices. The majority of women in both type of marriages stated that a husband should be "a keeper of his own family", provider for his wife and children, from a good, respectable family.

Most males, regardless of marriage type, stated that a wife should be first and foremost a good housewife (good mother, good wife), and several of them jokingly said that their wives would be perfect if only they talked less. A male in his thirties reported that he had married a girl that his father had chosen for him:

> "My father went there [to another town, in a house visit to certain family with marriageable females] and there were three sisters, the youngest was the most expensive [the highest amount of money for bride price], but she was too thin, then the middle one and the oldest one, she was the least expensive but she was fat. My old man decided on the middle sister. And he got it right."

According to this male, money for bride price comes from various sources, "formal and informal"; his family was able to pay for his bride thanks to "private" copper business his family was known for. Other pointed out to the help of relatives, savings for this occasion and "private" businesses involving iron and other metals.

Many males, both from arranged and marriage of choice, argued that in spite of a wife's seemingly inferior position, their wives are "in command": "I always ask my wife, what to buy, what to wear and what to do", explains a male in arranged marriage. The majority of males stated they would never give away their daughters (without arranged marriage) without knowing the family and in laws. "Arranged marriages are good, our tradition," explained one male, "because of these unions, we have an increase of natality and we [the families involved] always help each other". Regarding divorce, the majority of males and females said it was the husbands' drinking habit that caused the marriage breakdown.

We began by dividing the entire sample by the type of marriage, free choice vs. arranged, and tested the associations with two-tailed tests. Roma in arranged marriages differ significantly from Roma in marriages of choice; these differences are summarized in Table 1.

Both males and females in arranged marriages received social assistance more frequently than do individuals in marriages of choice. The majority of individuals in arranged marriage were Muslims who lived with family members and enter into their first marriage at younger ages. Both males and females in arranged marriages were more likely to perceive that women has a subordinate status in a family/marriage than did individuals in marriages of choice; furthermore, these males and females also more strongly supported the custom of having marriages arranged by parents and families. Finally, both males and females in arranged mar-

riage reported having, on average, fewer divorces than individuals in marriage of choice (12.7% vs 33.3%).

In regard to the rest of the variables (i.e., age, gender, education levels, SES, employment, SRH/prevalence of chronic disease, smoking and alcohol consumption, level of daily stress, levels of kinship support, decision in family, reasons for family dispute) there were no differences between the group of Roma in arranged and the group of Roma who were in marriage of choice.

Next, we divided the sample into males in arranged vs. free marriage choice. Males in arranged marriages were predominantly Muslim and they divorced less often than did males in a free marriage (21.4% vs. 34.6%). These males also had lower BMI than do males in marriage of choice (p=.007; on average: 25.06 SD±1.71 vs. 25.64 SD±1.92), and they were less likely to smoke (p=.024). Additionally, chi-square tests showed a statistically significant difference (p = .049) in health between males in arranged vs. males in marriage of choice; males in arranged marriages reported fewer cases of diabetes and hypertension than did males in a marriage of choice. Only 6.8% of males in arranged marriage reported diabetes vs. 18.4% males in marriage of choice; 20.5% males in arranged marriage reported having hypertension vs. 21.4% males in marriage of choice. However, males in arranged marriage reported more asthma than did males in marriage of choice: 9.1% vs. 5.6%.

In Table 2 we present the differences between females in arranged vs. females in marriage of choice. Females in arranged marriage received more social assistance than do females in a marriage of choice. The majority of females in arranged marriage were Muslims and they lived with more kin. Furthermore, the women in arranged marriages were married at younger ages, were less likely to divorce (6.6% vs 37.7%), were younger at age of first birth ($16.88^{SD\pm}$ 0.72 vs. $17.72^{SD\pm}$ 1.85) and older at the age at last birth ($27.59^{SD\pm}$ 4.76 vs. $25.51^{SD\pm}$ 3.65). These women also experienced more pregnancies ($8.25^{SD\pm}$ 3.09 vs. $6.23^{SD\pm}$ 3.31), more full term pregnancies ($4.22^{SD\pm}$ 1.57 vs. $3.42^{SD\pm}$ 1.38), and had more surviving children ($4.19^{SD\pm}$ 1.53 vs. $3.35^{SD\pm}$ 1.34) than did females in marriage of choice. These women also were stronger in their support of having a marriage arranged by parents and families, and finally, they were more likely to perceive women as having subordinate position in a family more than were females in marriage of choice.

We found no other statistical differences in regard to the other variables (age, SES, BMI, self-rated diagnosis of chronic disease, age at first menarche, smoking, daily stress levels, kin support, decision in family/marriage and reasons for dispute in family). It is of interest that the reasons given for a family dispute and power decisions in marriage/family did not differ by the type of marriage, but they did differ by gender. The majority of Roma females, regardless of the marriage type, stated that the most common cause of family dispute is husbands' drinking and jealousy, while males claimed they are most likely to argue about their wives' spending habits. The majority of females (almost 80%) perceived themselves as subordinate at home which was associated with the fact they seemed to have less

power in decision making within a home. The majority of males (almost 60%) argued the opposite.

In addition to two-tailed tests, we used simple linear regression to predict the value of a dependent variable, "self-rated prevalence of chronic disease," among Roma females. Single, independent variables were age, social assistance, SES, employment, health care utilization, religion, type of marriage, kinship support, position in a family, age at first marriage, age at first and last birth, total number of pregnancies, number of surviving children, number of abortions and miscarriages, height and weight, smoking and drinking, and daily level of stress.

In the linear regressions, several variables (age, type of marriage, age at first menarche and age at first and last reproduction, height, weight, SES, total number of pregnancies, smoking and drinking and position in a family) reached statistical significance with varying but mostly weak degrees of correlation in regard to prevalence of chronic disease. Other variables (religion, employment, health care utilization, age at first reproduction, surviving children, abortions and miscarriages, daily level of stress, education, receiving social assistance, and kinship support) were not found to be statistically significant.

In the multiple regression model, in regard to the variables with statistical significance, status/position in a family/marriage showed both strong correlation and statistical significance regarding self-rated prevalence of chronic disease (see Table 3). The regression model showed that self-rated prevalence of chronic disease rose with age, and independent variables "age at first menarche", and "age at last birth", were positive and significant, The independent variables "age at first birth" and "smoking" were negative but significant; however, these variables influenced dependent variable/chronic disease less than the independent variable "(subordinate) position in a family," with a higher coefficient of .233. That is, for Roma women, regardless of the marriage type, a non-subordinate status within the family was the strongest predictor of relatively "good" subjective health as identified by the reported absence of chronic disease.

Discussion

This is the first study to assess SRH (prevalence of chronic disease) and its association to the type of marriage, arranged vs. marriage of choice, among Roma.

Our findings suggest several important points. In the current study, the Roma perceived themselves to be relatively healthy. Only one third of participants reported their health as "poor", with the most common complaints being hypertension and diabetes. In regard to the type of marriage for the sample as a whole, and with respect to SRH, the Roma in arranged marriages and marriage of choice did not differ. On a number of other variables, the Roma differed significantly. The majority of Roma in arranged marriages were Muslims, living in an extended families. In addition to polygyny, religion (Islam) and extended family residential pattern are two well-known factors that influence this type of marriage (Hartung et al. 1982;

Fraser 1992). The Roma in arranged marriages entered the first marriage earlier, but were less likely to divorce than were those individuals who selected their own partners. Early marriage is customary in many cultures with arranged marriages, in different non-religious and religious contexts (Applebaum 1995; Talbani & Hasanali 2000; Hense & Schorch 2013). Regarding marriage stability, our finding is consistent with patterns of global divorce rates; in 2013, the global divorce rate for arranged marriages was 6 %, a significantly low number compared to the 55 % divorce rate for marriages in which people find each other on their own and romance is the foundation (Lee 2013; Epstein et al. 2013). Additionally, both males and females in arranged marriages perceived women as having a subordinate status in a family/marriage and they also supported more the custom of having arranged marriage by parents and families (more so than Roma in marriage of choice).

When we divided the sample by the type of marriage into males and females, in addition to the shared characteristics such as religion, we found that Roma males and females differ in a number of variables. Males' gender specific variables showed that males in arranged marriages had lower BMI than males in marriage of choice, and they were less likely to smoke. Drinking, BMI and smoking are well known risk factors influencing overall health (Fine et al. 2001; Barclay et al. 2008). In regard to SRH (diagnosis of chronic disease), males in arranged marriages reported better health, i.e., lower prevalence of diabetes and hypertension than did males in marriage of choice.

In regard to females gender specifics, females in arranged marriage received more social help than did females in a marriage of choice; females in arranged marriages lived in larger households as they lived with more kin. Furthermore, these women reproduced for a longer period of time, as they were married at a younger age, gave birth at a younger age, but were more likely to experience their last birth at an older age. They also had more pregnancies, more completed pregnancies and more surviving children. In regard to health risk behaviors, they drank less frequently. They were more likely to support the custom of having a marriage arranged by parents and families. Finally, the women in arranged marriages were more likely to perceive women as having subordinate position in a family than were females in marriage of choice. Additional analyses revealed that for Roma women, regardless of the marriage type, a non-subordinate status within the family was the strongest predictor of relatively "good" subjective health. In addition to the status, age and reproductive variables: age at first menarche, age at first birth and last birth, along with (non) smoking also exerted an influence on self-rated health.

We were unable to find studies that directly compare self-rated health status in arranged vs. marriage of choice, but our findings are consistent with what is known to be a selection criteria for marriage in societies with arranged marriages. Health, in addition to family alliances, stands out as one of the most important criteria (Xu et al. 2000; Stephens 1963). In general, young people with undesirable behaviors and characteristics (e.g., hard drug use, obesity, and short stature) do have lower marriage rates than do their healthier counterparts (Goldman 2001). The available data on arranged marriages point out that the mate selection process could be the main factor in creating large differences in life span (Goldman 1993). In cul-

tures with traditional arranged marriages, unhealthy individuals could not get married, thus leading to a greater number of healthy individuals in the married population (Ikeda et al. 2007). In South Asian countries such as India, a diagnosis of diabetes can hinder a young female's marriage prospects, as families preferentially arrange marriages to "healthy" individuals without barriers to bearing children (Goenka et al. 2004).

Furthermore, arranged marriages among Roma when combined with bride price, may serve as a form of social selection— fitter Roma females are chosen for marriage by socially/economically successful Roma males, and this process of assortative mating in turn may create gradients in their offspring (Blane et al. 1993). Bride price, besides allowing for "screening" the financial resources and abilities of the future in laws (Apostolou 2008) serves to additionally differentiate among Roma groups, while the preferred endogamy further socially separates not only one Roma group from another but also from non-Roma as well. We did not find significant differences regarding self-rated SES in this sample, but given Roma dependence on government benefits, it is possible that economic differences were underreported.

Why do we observe the relationship between SRH and type of marriage among Roma males but not among Roma females? In our sample of Roma women, regardless of their marriage type, a non-subordinate status within the family was the strongest predictor of relatively "good" subjective health. One possible explanation is that Roma females perceive their status in a family as being so low that the type of marriage does not make a difference in everyday life. For women, growing older, variations in marital quality and having a low education negatively impacts self-rated health (Golini & Egidi 2016). On top of all this, married women assume many more of the burdens of family life than married men and show greater physiological responses to relational conflict (Brines 1994; Greenstein 2000). This uneven "load" sharing could be metabolically costly resulting in negative physical outcomes (Sbarra 2009), as a perceived woman's status rises and falls over her life cycle (Das Gupta 1995). The majority of women in our sample, regardless of the type of marriage, were middle aged, unschooled housewives with long reproductive periods resulting in numerous children. They also lived among extended family members who all required their attention on a daily basis. Only those Roma women who perceived themselves outside the stereotypical female gender role, reported their health as "good".

And although we did not find the direct link between the type of marriage and kin support, marriages in which spouses were selected by their families may benefit more from the approval and support of family members, and in turn, this family support may improve marital quality (Applbaum 1995; Allendorf & Ghimire 2013). This could be another possible explanation for better SRH of Roma males in arranged marriage-- the quality of marriage relationship is also linked to health: among the married, those in distressed marriages are in poorer health than those in non-distressed marriages (Umberson et al. 2006). So, is it possible that we are seeing "Happy marriage, happy life" among Roma males with subordinate wives?

Cross-culturally, marriages in which the husband dominates the wife in economic contributions, nonverbal behavior, and decision making tend to be more satisfying (Weisfeld & Weisfeld 2002). In addition, a (happily) married wife may be highly motivated to provide care and practical support to her husband, such that even an unhappily married man may receive practical benefits that enhance his overall well-being (Carr et al., 2014).

Arranged marriage, as a "true" Roma tradition, was approved by the majority of both males and females in our sample. For a marriage to be happy, several key aspects must be met, such as good health (Bornmann & Marx 2011) and in the case of Roma, family dynamics. To paraphrase Tolstoy's famous quote on happy marriage ("Happy families are all alike; every unhappy family is unhappy in its own way"), all happily married Roma men are alike in that they think they have subordinate (house) wives (if only they talk less) and all happily married Roma women are alike in that they think they are non-subordinate to their husbands.

For Roma males, we found support both for selection into marriage and for protective effects of marriage (Murray 2000). Both Roma males and females in arranged marriage engage in fewer risk behaviors -- drinking (females) and smoking (males) -- when compared with their counterparts. Health-related (risk) behaviors for both males and females in arranged marriages, BMI for males in arranged marriages and (non)subordinate position for females regardless of the marriage type influenced SRH. Furthermore, arranged marriages appeared adaptive for both males and females, in that they had more offspring, but they seemed to benefit the males and not females in terms of health.

These findings depend on whether males and females perceive and reported their health conditions in the same way (Crimmins et al. 2010). As we have seen, the same cultural variables influenced subjective health and wellbeing among Roma males and females in different ways. Furthermore, the study sample included volunteer participants while variables were self-reported, which may have led to numerous biases; additionally, given the heterogeneity of Roma, within other groups the overall findings may differ from the ones observed here. Finally, because type of marriage is likely to be both a cause and a consequence of self-rated health among Roma, future studies on marriage and health should focus on sorting out the influences of selection and protection in order to separate the underlying influence of marriage on health.

Declarations

Ethical Approval. Informed consent was obtained from all participants. Approval to conduct a study of human subjects was awarded by the Institute of Ethnography SASA research committee.

Tables

Table 1. Differences by type of marriage:
arranged vs. free choice for the whole sample

Variables	Sig. (2-tailed)
Age	.485
Gender	.225
Social assistance	.000
Religion	.000
Marriage status	.792
SES	.322
Number of marriages	.001
Age at first marriage	.031
Employment	.071
Members per household	.000
SR Diagnosis of chronic disease	.099
Kin support	.058
Smoking	.204
Drinking	.727
Daily level of stress	.133
Women subordinate position	.050
Decision in family	.179
Disputes in family	.594
Arranged marriage attitude	.001

Table 2. Differences females in arranged vs free marriage

Variables	Sig. (2-tailed)
Age	.160
Social assistance	.001
Religion	.000
SES	.621
Number of marriages	.012
Age at first marriage	.020
Members per household	.009
BMI	.420
SR diagnosis of chronic disease	.375
Age at first menarche	.524
Age at first birth	.005
Age at last birth	.007
Number of pregnancies	.001
Number of full pregnancies	.001
Number of surviving children	.000
Smoking	.143
Drinking	.012
Daily level of stress	.098
Kin support	.861
Disputes in family	.137
Decision in family	.125
Women subordinate position	.031
Arranged marriage attitude	.001

Table 3. Multiple regression Roma women/predictors of chronic disease

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
Number of pregnancies	-.009	.014	-.070	-.647	.519
Age	.015	.003	.429	4.201	.000
SES	.021	.062	.028	.343	.732
Type of marriage	.053	.077	.061	.695	.488
Age at first menarche	.059	.034	.135	1.726	.047
Age at first birth	-.039	.021	-.161	-1.837	.049
Age at last birth	.046	.010	.448	4.767	.000
Smoking	-.006	.003	-.178	-2.177	.032
Drinking	.118	.107	.086	1.095	.276
Subordinate position in a family	.233	.097	.187	2.410	.018
Weight	.006	.004	.119	1.358	.177
Height	.007	.007	.096	1.110	.269

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